The Chest-Piece

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(Malta Branch)

"In necessariis unitas, in non-necessariis libertas, in omnibus caritas."

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EDITORIAL

With the appearance of this number, The Chest-Piece passes into its third year. Many difficulties have been overcome so far, but still many remain to be attended to, chief amongst which is the apathy of some medical students and members of the Profession. We have not always appeared on time, but this has rarely been our fault. We shall try to remedy this in coming numbers.

In this issue four of the five major contributions are by new comers to our journal. Prof. Galea deals with the question of Alcohol, its Use and Misuse, and Dr. Briffa has written a paper on the equally topical Pre-Cancerous Dermatoses considering only the cutaneous lesions. Dr. Damato deals very simply with Ophthalmology in General Practice, while Prof. Zahra Neumann has dealt with some Modern Trends in the Treatment of Infantile Gastro-Enteritis.

The Study of the Personality of the Maltese Patient by Dr Cassar is as interesting as all his previous contributions have been. Dr. Cassar's Questionnaire on the typing of personality will, we are sure, be warmly welcomed by senior students and general practitioners who will find that it simplifies their investigation of psychiatric cases immensely.

Out of the eighty or so students composing the medical courses, only a mere half-dozen have bothered to put pen to paper and tell why they joined a medical course. Naturally every one has his or her reason for doing things and that is what made us invite students to send us their views, whatever these may be, about this subject. The Muse must be very far from most of us when only so slight a response is given to our invitation. Still we heartily thank all those who have responded, and those who have written us letters on other subjects.

This year, as has been known to have happened in previous courses, the Academical Course is reading Venereology and Dermatology instead of in the final year. This was the fruit borne by a nine-month-old petition sent by the Council of the Association to the University Authorities. Before acknowledgement of receipt of this petition was made, the Hon. Secretary had to write out three reminders over a period of several months. Finally, like a bolt out of the blue and without the Association having any information whatsoever of what was going on regarding this matter, the petition was granted. This is not the first time that correspondence between the Association and the University ha been submitted to unreasonable delays.

Now that two years have passed since the commencement of the junior course, enough time has elapsed for the new students to understand somewhat the machinery of the University as also to realise their duties as students. Students have grave (perhaps not so grave!) responsibilities to perform during their all-too-short student life. They must, besides filling their minds with what will eventually be useful to them in their chosen careers — the primary scope of their taking a University course — develop a sense of responsibility towards the student societies which make up so much of University life.

Every three years a group of new immature undergraduates enter the University, as a group of older, equally immature, graduates are preparing to leave it. It is all a cyclic process of replacement. The younger students must gradually feel that they will be some day called upon to continue the work started by others before them. To train themselves for this, they should attend as frequently as possible, the activities organised by the various student societies, or rather by the societies in which they are most interested. In this way they can see student machinery in action, they can get a better outlook on their problems as well as on those of their fellow students, and best of all they can develop that "student spirit" which always evades definition. They must appreciate that other students — equally busy — are spending some of their time arranging activities and righting grievances, and that student societies — irrespective of their name — merit their wholehearted support.

CONTRIBUTIONS

All members of the Medical Profession and all Medical Students are invited to contribute to "The Chest-Piece". Correspondence and contributions should bear the signature of the author (not necessarily for publication), and should be addressed to:

The Editor of "The Chest-Piece"
26 Cathedral Street,
Sliema.

ALCOHOL, ITS USE AND MISUSE

By JOS. GALEA, M.B.E., M.D., D.P.H.
Lecturer on Forensic Medicine.

Drink is a habit which in recent years has assumed universal proportions. In every country in the world people are progressively indulging in alcoholic liquor and strong drink. Whereas in the age of our grandparents it was only the male species of human race that was suffered to get drunk, and strong liquors were taboo amongst nice females, in our days women have asserted their equality with men not only in domestic and social matters, but also in the matter of inebriation and intoxication. Perhaps this state of affairs is the result of the modern conditions under which we live: the present is unsettled, the future is dark, nothing appears to be stable and solid in this modern world of ours. The whole outlook is depressing and an overwhelming sense of frustration pervades our thoughts and actions. No wonder that very many people would like to escape from their worries and are prone to bury their troubles under the fumes of forgetfulness.

The popular idea is that alcoholic drinks soothe the nerves — later we shall discuss whether this idea is correct or not — and this idea is certainly responsible for the extreme popularity of spiritous liquors. Ours is a life of great strain and stress; speed is the keynote of our existence; we have no time to relax, nerves are stretched to breaking point, and thus we turn to stimulants for further efforts or to sedatives in the hope of soothing our nerves. This popular belief about the actions of alcohol has made of this luxury an object of necessity in life; it has become indispensable even to the point of supplanting other important amenities which used to enliven our existence. The craving for drink has taken such a grip on the masses, that these would far sooner do away with useful commodities than be deprived of this indulgence. Indeed, during the chaotic shortages resulting from the late war, we have witnesssed the extraordinary event when the value of drink had soared so high as to compete with gold and other precious metal, and in certain of the countries mostly hit by the upheaval, commodities of life were traded not in terms of currency but of bottles of whisky and gin.

The popularity of drink has created a reaction. It is a fact that every popular trend raises an opposition to it: there is always a brave band of reformers who make it a point to go against current tendencies; the stronger the current the fiercer they fight against it. The army of teetotallers has even fought against alcohol, and the increased popularity of the tot has only excited the fiercest onslaughts against alcohol, which has been held responsible for all the sins and evils that afflict human life, having even been dubbed as poison.

Alcohol is one of the narcotic poisons and its action is very similar to that of certain well known narcotic drugs such as Ethyl Bromide, Ethyl Chloride, Ether and Chloral. If taken in large amounts, it produces intoxication which may pass on to narcosis

In an unexperienced drinker, strong liquor will produce an unpleasant sensation of burning along the gullet, because it irritates the mucous membrane and sometimes induces nausea and even vomiting. Alcohol is quickly absorbed into the blood stream through the mucous lining of the stomach, from where it is carried by the circulation to all the organs of the

body. Alcohol has a special affinity for the brain. This is due to the fact that it is fixed by certain fat-like substances known as lipoids; these are found in all cells of the body especially in the brain and nervous tissue, hence the greater concentration of alcohol in these tissues. In a man who had died of acute alcohol poisoning, the following proportions of the substance were found in his system: 20% in the liver, 33% in the blood and 47% in the brain.

After absorption alcohol is destroyed by oxidation, being burned up into carbon dioxide and water. The system becomes accustomed to deal with alcohol in this way, and this explains the reason why in habitual drunkards an increasing amount of alcohol is required to produce the sense of exhiliration consequent on paralysis of the inhibitory centre. It follows that a habitual drunkard requires a larger amount of alcohol to get intoxicated because good deal of the intake is oxidized, but the amount that remains unoxidized and produces drunkenness is more or less equal to the amount which causes drunkenness in a non-drinker. This explains why the only reliable proof of intoxication is that resulting from a blood test, as it shows the amount of alcohol present unchanged in the blood, independently of the quantity taken by the mouth.

A good proportion, about 90% of the alcohol, is oxidized and the remaining 10% is excreted by the kidneys and the lungs; the disappearance of the alcohol from the body has been calculated on an average of 10 c.cm. per hour; about three hours therefore are required to eliminate from the blood one single large tot of whisky. The concentration of alcohol in the urine during elimination bears a certain relation to that in the blood, and for practical purposes, it may be held that the concentration of alcohol in urine is equal to the concentration in the blood during the time that the urine was collecting in the bladder.

As we have said, in the habitual drunkard the system becomes accustomed to oxidize an ever increasing amount of alcohol, but this is fraught with danger, and may be the cause of harm to the system itself. The presence of the alcohol in the blood causes a constant irritation of the cells with which it comes into contact and, as a result, we have disturbance of their function. The most serious action is exerted on the brain cells which fix the alcohol in greater proportion and, in consequence, serious symptoms develop in the higher centres which may eventually lead to impairment of the brain and cause Delirium Tremens. As a matter of fact, alcoholism is considered as one of the main causes of insanity, but its deleterious action is exerted on the various systems of the human body: it produces irritation and inflammation of the mucous membrane; it enters into the circulation and its presence weakens the various structures and organs to which it is carried, and as a result they fall an easy prey to infections and diseases.

Apart from these considerations, alcoholism is a social evil because it causes degeneration in the behaviour of drunkards. In the long run, they lose the power of self-control and self-respect; they become irritable, aggressive and unstable, they take an intolerant view of persons and things, and this leads to all sorts of friction and unpleasantness; such an attitude may be the cause of endless troubles and serious complications; it may even produce deplorable incidents and serious assaults. Those who indulge excessively in alcoholic drink are a menace not only against the social order, but also against the national economy of the country; apart from financial loss and absenteeism one should consider the fact that such workers become slothful and

careless, their productive power is diminished and they are more prone to accidents than others who are free from the drinking habit.

When it reaches the brain, alcohol exerts its influence by paralysing the cells which control muscle action and also those elements known as inhibitory or common sense fibres; as a result we get staggering gait and uncontrolled behaviour. A person under the influence of drink will usually be unable to stand steadily, and very often loses control of his emotions; he may laugh, weep, become aggressive or display unwarranted affection. It has been said that the effects of alcohol rise by degrees from the lowest to the highest senses of the human body, but this is not invariably so. Under the depressive action of alcohol a person loses the ability to concentrate, he will be unable to consider and reflect, his powers of appreciation are diminished and in consequence it becomes difficult for him to correlate ideas and impressions. In this condition an individual may become a menace to himself and to society.

Drunkenness therefore is a condition fraught with danger to the tipster himself as well as to other persons with whom he comes in contact; if he happens, for instance, to be driving a car then his condition becomes a menace. A medical practitioner is often called to give his opinion about the condition of a car driver accused of being under the influence of alcohol. Such a case should receive very careful consideration and should be proceeded with cautiously and diligently. In the first instance, it should be ascertained whether the individual has really consumed liquor and if so at what time prior to the examination. Apart from other evidence or statements, smell plays a very important part in this respect, but smell by itself is not a proof of drunkenness; for instance, a person may have a small drink, and if his mouth is smelt soon after, a strong smell of alcohol may be perceived.

A second important observation is that relating to the control of faculties. It should be borne in mind that there is no test for determining the amount of alcohol required to prevent a person from carrying on with his normal occupation in a proper manner. We have already stated that the effect of alcohol differs in different individuals and depends on their habits. An opinion may be gathered from the continued observations on general demeanour, character of speech, manner of walking, standing up or sitting down, memory of incidents, character of breathing, hiccough, etc. Finally, it should be kept in mind that there are various pathological conditions simulating alcohol intoxication: vascular lesions of the brain, sudden nervous shocks, acidosis, hysterical trance, acute effects of drugs, chronic effects of chemicals, results of head injuries.

It will be appreciated that a diligent examination is necessary and extreme care is required before the examining medical practitioner can certify a state of drunkenness, but once his observations have established this fact, he should definitely state so, and on no account should he try and shield a confirmed drunkard who, as we have seen, is a menace to society and a danger to law and order.

Pre-Cancerous Dermatoses.

R. Briffa, B.Sc., M.D.
Lecturer on Dermatology and Venereology

There are some dermatoses in which or on the basis of which carcinoma may develop in predisposed persons.

MacKee and Cipollaro give the following alphabetical list of such dermatoses:

Cicatrix
Cornu cutaneum
Erythroplasia
Farmer's or sailor's skin
Keratoses: Arsenical
Seborrhoeic
Senile
Occupational (Tar, oils etc.)
Kraurosis vulvae
Leucoplakia
Lupus erythematosus
Lupus vulgaris
Naevi
Radio-dermatitis
Sebaceous cysts
Syphilis (leucoplakia, interstitial glossitis, scars)
Ulcers
Xerodermia pigmentosum

Other authors add Bowen's disease and Paget's disease of the nipple and areola of the breast in women. Quite rightly these have not been listed above as they present sufficient changes to have been considered as malignant from the start by most authors and so they are included with the carcinomata and not with the pre-canceroses.

The actual incidence of malignant degeneration is not very high in all of the above. In Xerodermia pigmentosum malignant degeneration is the rule. About 15% of senile keratoses turn malignant in time. All the same the doctor should always have a high index of suspicion in presence of the rest of the dermatoses mentioned in the list and should always be on the alert to institute appropriate treatment to forestall such degeneration.

In this article only the cutaneous lesions will be considered. These may develop into basal or squamous carcinomata unlike those on the mucous surfaces which always develop into squamous-celled neoplasias.

CICATRIX (Scar). The scars following Roentgen and radium ulcers are especially prone to malignant degeneration. When Lupus vulgaris and Lupus erythematosus were treated with X-rays, carcinomatous degeneration of the scar tissue was not infreqent. Cancer may develop on scars of burns. It usually begins on the edges of the lesions. Occasionally cancer develops on old syphilitic scars. It is thought that constant irritation is the cause of such degeneration.

CORNU CUTANEUM (Cutaneous horn). A rare form of neoplasia. The horn may may be very small or of large size. It may begin on apparently normal skin or on a senile keratosis. Some cases undergo spontaneous cure. In about 10% of cases malignancy sets in. The horn falls and the base becomes carcinomatous.

FARMER'S OR SAILOR'S SKIN. People who are continuously exposed to the sun may develop in the long run what is known as Chronic Actinic Dermatitis. This is common amongst persons who have lived in the tropics and amongst farmers, sailors and gardeners especially in sub-tropical climates. The exposed parts of the skin (hands, face and neck), get atrophied and pigmented. Later on hyperkeratosis sets in with the development of wart-like neoplasias which are potentially malignant. Similar changes are common in Australia, in fair people especially if red-haired and blue-eyed. Prospective Maltese emigrants to Australia who belong to the latter category should be dissuaded from excessive sun exposure when "down under".

KERATOSES. These are localised areas of hypekeratosis. The etiology varies but the clinical type is essentially the same viz. small, warty excrescences of a yellowish or a dark colour.

Etiology: Senile. The senile keratoses are the most common and the ones most liable to malignant degeneration. They usually appear after the sixth decade but younger people with a senile type of skin may develop these lesions prematurely. They may be single or multiple and favour the exposed parts of the skin. Each keratosis begins as an erythematous, slightly atrophied, scaly region. The scales are adherent and removed with some difficulty. If bleeding follows such detachment, this usually means that the lesion has already become malignant; 15% of these keratoses usually become carcinomatous.

Occupational. It has been known since some time that sufficient exposure to tar (and other coal tar distillates such as pitch, creosote and anthracene) results in the formation of keratoses which are definitely pre-malignant. It is well known that the first studies in experimental carcinogenesis were undertaken on the skin of rabbits and mice with the use of tar and its derivatives.

Tar keratoses are located usually on the arms, hands and scrotum. They develop on a chronic hyperplastic dermatitis and eventually malignant degeneration sets in.

Arsenical. Arsenic as a cause of carcinoma was recognised by Hutchinson in 1880. Inorganic arsenic is far more dangerous than organic. Keratoses appear as early as one month and as late as thirty years after the first ingestion of the chemical. Carcinoma develops in about 26% of the keratoses. Men are more affected than women. The hyperkeratosis usually shows itself on the palms.

At one time it was the universal practice to give Liquor Fowleri over prolonged periods in nearly all skin diseases. Nowadays Liquor Fowleri is used with more discretion and hence arsenical hyperkeratosis is very much rarer.

Seborrhoeic. Carcinomatous degeneration is very rare. Their only importance, apart from being a cosmetical blemish, lies in the differential diagnosis between them and the senile type. They usually appear rather earlier in life than the latter, being fairly common thereafter. They are very much like the senile warts, but unlike these they are covered with a greasy or waxy scale ("candle-grease scale") which can usually be scraped off easily, leaving no bleeding surface. They are more commonly encountered on covered parts of the body—chest, back, abdomen and arms—the face being rarely affected.

LUPUS ERYTHEMATOSUS AND LUPUS VULGARIS. Some years ago carcinomatous degeneration was fairly frequent in these diseases, probably because of the irritant treatments then in vogue, namely scarification, chemical caustics etc. With the advent of more biological lines of treatment it seems that such degenerations can be totally eliminated.

NAEVI. Although all naevi can undergo malignant degeneration, the real danger lies only with "lentigo maligna". Contrary to the common belief, moles of any variety whether pigmented or not pigmented, hairy or not hairy, may undergo malignant degeneration. This usually takes place in adult life, but cases in a younger age are anything but uncommon. The mole may suddenly start growing and form a large brown or black pigmented plaque or a warty elevation. The tumour usually feels hard to the touch but eventually tends to ulcerate. New lesions may appear in the vicinity. The glands are involved early and visceral metastases are common. Any mole should be treated

with great respect. They should be either excised completely, preferably surgically, or left well alone. Any sort of constant irritation is liable to precipitate malignant degeneration.

RADIO-DERMATITIS. This may be produced by radium or X-rays. It is a definitely pre-malignant condition. Thanks to reliable dosimeters and modern technique this type of dermatitis is now very rare. I have only seen one case in Malta and that many years ago.

SEBACEOUS CYSTS. (Steatoma). This is usually seen on the scalp (where it is known as a "wen",) but can also occur on the back, scrotum or other parts of the body including the prepuce. The clinical picture is known to every doctor. The cysts may persist for years or may disappear spontaneously. Frequently they may become infected and very rarely malignant degeneration takes place in old people.

SYPHILIS. Tertiary syphilides have been long considered as liable to malignant degeneration. The carcinogenetic factor in this case is the long continued phlogistic inflammation. It seems that the same factor plays a part in the development of carcinoma on leprosy. I have seen three such cases in our leprosy hospital within the last five years.

ULCERS. Any ulcer of very long standing, whatever its etiology, may undergo carcinomatous degeneration. Non-rational treatment and constant irritation probably play the major role in the change although the chronic hyperplastic element is not to be ignored.

XERODERMIA PIGMENTOSUM. This is luckily a rare disease which begins at an early age. The patients rarely survive early youth. It may affect several members of the family. The parents of such persons are usually closely related. Clinically the disease corresponds to "farmer's and sailor's skin" already described, viz. permanent freckling, telangiectases, atrophy of the skin and the formation of warty tumours which in this case inevitably become malignant.

I have only seen two cases in Malta of this disease a brother and a sister. The parents of the patient's were first cousins. The sister was one year younger than her brother and died at the age of twelve. The brother is now at the St. Vincent de Paule Hospital and is about twenty-one years old. This unfortunate young man has already undergone some twelve operations for epitheliomata and is now sinking fast.

It has been proved beyond any doubt that patients suffering from this disease have an idiosyncrasy to the actinic rays of light.

PROPHYLAXIS. 1. Strict industrial hygiene for workers in tar and coal-tar derivatives.

2 Discriminations in the therapeutic use of inorganic arsenic.

3. X-rays and radio-active substances to be handled only by experienced specialists.

4. Exposure to the sun should not be excessive and should not be prolonged. Fair-skin people with blue eyes and red or auburn hair should be specially careful.

5. Last but not least the prevention of constant traumatic irritation (whether chemical, physical or parasitic) to any pre-cancerous lesion.

TREATMENT. The main principle of skin onchology is: when in doubt excise. Radium, x-rays and CO_2 have all their advocates, but at their best they can only act like the old-fashioned caustic pastes. One can never be sure that every malignant cell has been destroyed. At their worst they may even act as irritants and so hasten the malignant process. Surgical excision ought to be the treatment of choice. Furthermore no biopsy is to be performed unless removal of the neoplasia (if proved malignant) can be undertaken immediately.

The Study of the Personality of the Maltese Patient.

P. Cassar B.Sc., M.D., D.P.M.
Resident Medical Officer, Hospital for Mental Diseases.

The "typing" of the personality of patients attracted the attention of physicians since the time of Hippocrates; but it was only in relatively recent times that the study of the patient's personality, as an aid to treatment, was taken seriously in hand in the field of medicine.

The current approach to illness is to think of our patients not only as belonging to various groups of pathological conditions, but also as representing some one or other class of human personalities (1).

Personality studies are useful for the following reasons:—

1) From a knowledge of what the individual's reactions have been in the past, we can foretell what his future behaviour pattern is likely to be.

2) Knowing the patient's psychological make-up, we are in a position to overcome the difficulties that may arise during the management of his illness, and to use that kind of approach in investigating and treating his malady which best suits him. For instance, we can determine whether a sympathetic or a firm or a persuasive attitude is most likely to be attended with therapeutic success.

3) By ascertaining what his "standard of normality" was previous to his illness, we can judge to what extent we are able to modify his illness. In other words, the prognosis of the case is determined to a large extent by the limitations of his personality.

4) As Henderson and Gillespie point out, personality studies are particularly important in connection with prophylaxis and the training of children, for knowing the individual's psychological make-up we are able to guide him along channels which are in harmony with his dispositions (2).

5) The choice of physical and psychological treatment may be dictated, in certain instances, by the particular personality of the patient rather than by the clinical picture which he presents. It has long been known, for instance, that analytical treatment may be harmful to schizoid personalities; while more recently, it has been suggested that leucotomy for obsessional states in schizoid personalities may be undesireable, as it may cause the schizophrenic personality to make headway (3).

6) Curran and Guttmann, after stressing the paramount importance of investigating the patient's personality, remark that the significance of the symptoms shown by the patient varies enormously according to the personality setting in which they occur (4). Hence the necessity of studying the patient's personality before assessing the value of the symptomatology presented by the patient.

Obviously, we cannot afford to neglect personality studies in clinical psychiatry. We have now started to recognise their value also in clinical medicine. In fact they form the basis of the current psychosomatic concept in medicine. "Personality study" say Weiss and English," is just as important in the problems of illness as laboratory investigation" (5).

Psychologists have yet to devise a quantitative method of rating personality. In the meantime, the most practical method consists in an evaluation of certain traits that have been found to "hang together" statistically. Numerous tests and various techniques have been evolved with this

end in view. The varieties of personalities that have been discovered by means of these tests occupy a wide range, but in practice it will be found that the majority fit into one of the following types:—

a) Cyclothymic (Syntonic of Bleuler, extravert of Jung)
b) Schizoid (introvert of Jung)
c) Anxious
d) Obsessional.

As detailed analysis of the features of each of these personality types are to be found in all standard works on psychiatry, it is unnecessary for the purpose of this paper, to concern ourselves with their description. In fact, this paper deals only with the practical application of existing knowledge and techniques to the problem of studying the personality of the Maltese patient.

The importance of spoken language as an instrument in psychiatric work, is not sufficiently appreciated except by psychiatrists. Elsewhere (6) I have discussed at length the various problems arising out of the use of the Maltese language in psychiatric investigation and treatment.

The Maltese physician and psychiatrist are trained to think and, very often, to express themselves in English — a language which unfortunately is, in the majority of cases, foreign to the culture of the Maltese patient. Difficulties, therefore, crop up when the psychiatrist tries to obtain a profile of the patient's personality. The Maltese psychiatrist has to depend for his guidance on English tests which are intended for the use of patients who not only *speak* that language but who have *thought* during their entire life in that language. A common difficulty experienced by doctors when they first come to the mental hospital, consists in the fact that they find it hard to interview patients or relatives in Maltese, and to use a Maltese vocabulary that will convey exactly to the patient or relative what kind of information is wanted from them. It has been stated that, while the interview is the commonest method of investigation in psychiatry, it is also the most difficult to carry out (7). Illiteracy makes things worse, so much so that even seasoned psychiatrists have complained about the difficulties of obtaining full psychological data from peasants (8).

It is our experience that, while the patient's relatives are ever ready to express moral judgments on the patient's way of life, more often than not they are unable to give a satisfactory factual history of the onset and development of the patient's illness — let alone an adequate description of the patient's personality. Gozitans are especially notorious in this respect. Indeed, either through their illiteracy or their characteristic reticence, or both, they give one the impression that they are barren of an emotional and intellectual life.

The following questionnaire in Maltese has been devised in order to overcome these handicaps of both psychiatrist and informant. Its final casting was arrived at after the questions were tested on many subjects interviewed during the past six months. This procedure was adopted in order to ascertain that the questions were drawn up in a form which the informant could understand. Many of the questions in fact, are more or less exact reproductions of expressions or idioms used by the informants themselves.

This questionnaire contains a number of questions which are meant to elicit information about the behaviour, thoughts and emotional reactions of the subject. They have been so selected that their affirmative replies should reveal the basic features of the individual's normal psychological make-up, and should enable the investigator to classify the subject according to the personality types already mentioned.

The English equivalent of the question in Maltese is given on the right hand side of the page. This plan has been adopted in order to render the Maltese question

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40, *South Street, Valletta, Malta.*

clear enough where the investigator may be in some doubt as to its exact meaning; and also, to secure the description in the English language of the patient's personality in standard terms. Such a procedure will enable different investigators using this questionnaire to meet on common ground for the purpose of psychosomatic and statistical studies of personality.

The questionnaire necessarily suffers from the limitations of the descriptive approach. It is only intended to give a "silhouette" of the patient's personality, rather than a full detailed portrait. Like all questionnaires, it requires the full cooperation of the informant in order to give reliable results. It is also important that the informant should be of, at least, average intelligence, a good observer and on familiar terms with the person under investigation. A good "rapport" between informant and investigator is also essential. Unreliability of the results due to the absence of any of these factors will show itself in the test by an undue "scatter" — that is, on completing the questionnaire the investigator will find that the answer are spread in such a way that no definite type of personality emerges from their synthesis.

Since it is quite possible for a person to possess features of more than one personality-type (e.g. anxious-obsessional, schizoid-obsessional, etc.), it is important to distinguish these mixed forms from "scatter".

QUESTIONNAIRE

Cycloid personality.

1.	Bniedem li jaf ihobb u jaf jgħali?	Emotionally responsive?
2.	Ihobb jagħmilha man-nies?	Sociable?
3.	Ta' ħafna ħbieb?	Friendly?
4.	Ta' natural ferrieħi?	Cheerful?
5.	Ihobb jiċċajta?	With a sense of humour?
6.	Bniedem li jħoss? (ta' qalbu żgħira?)	Soft-hearted?
7.	Jaf imur ma kulħadd?	Gets on well with people?
8.	Jieħu l-ħajja kif tiġi?	Takes life as it comes?
9.	Javda lil kulħadd?	Trustful?
10.	Jitlagħlu malajr imma jikkalma malajr ukoll?	Flares up easily but is as easily calmed?
11.	Ħabrieki?	Active?
12.	Ma jaqta' qalbu minn xejn?	Self-confident?
13.	Jieħu gost b'kollox?	Enjoys life?
14.	Ikollu jgħidlek kelma jgħidilek? (ma jżomm xejn fl-istonku?)	Outspoken?
15.	Ihobb jiddeverti?	Fond of amusements?
16.	Ġie li jixrob għax ikun imdejjaq?	Drinks because of depressive feelings?
17.	Bniedem li ma jżommx f'qalbu?	Bears no malice?
18.	Bniedem li ddawru malajr?	Tends to give in, to compromise?
19.	Ibati bil buli?	Subject to fits of mild depression?

Schizoid personality

1.	Jieħu għalieħ mix-xejn?	Easily offended?

2. Ma jafda lil ħadd?	Mistrustful?
3. Għajjur?	Jealous?
4. Jaħseb ħażin (suspettuż)?	Suspicious?
5. Jidhirlu li n-nies ma jistmawhx biżżejjed?	Complains of lack of due respect from people?
6. Jaħseb li n-nies jagħtu każ tiegħu iżżejjed (jissindikawh)?	Complains that people pay undue attention to him?
7. Ma jagħmilħa ma' ħadd (ta' bla kumpannija)?	Unsociable?
8. Magħmul ta' għalih waħdu?	Likes to be by himself?
9. Iżomm ruħu lura (timidu)?	Timid?
10. Mistħi?	Shy?
11. Ta' ftit kliem?	Reticent?
12. Jippreferi joqgħod id-dar għax in-nies idejquh?	Avoids social contacts?
13. Imur passiġġati waħdu fejn m'hemmx nies?	Prefers loneliness?
14. Ma jiftaħ qalbu ma' ħadd?	Reserved?
15. Ma jiddelitta b'xejn?	Has no interests or hobbies?
16. Ta' rasu iebsa?	Stubborn?
17. Bniedem li ma jafx jiċċajta?	Devoid of a sense of humour?
18. Bniedem serju żżejjed?	Too serious?
Anxious personality	
1. Jinfena għall-iċken inkwiet?	Easily worries?
2. Jinfixel meta jkollu jagħmel xi biċċa xogħol malajr?	Gets flustered when doing things quickly?
3. Jikkonfondi jew jistħi meta jkellem xi superjur tiegħu?	Feels upset when he speaks to a superior?
4. Jinfixel meta jkollu jiltaqa' ma' nies li ma jafhomx?	Afraid of meeting strangers?
5. Jitilgħulu n-nervi malajr għall-iċken ħaġa?	Trifling things make him irritable?
6. Jirrabja jekk meta jkun irid xi ħaġa ma jakkwistahiex malajr?	Loses his temper when he is frustrated?
7. Jaqta' qalbu mix-xejn?	Lacks self-confidence?
8. Jinqata meta jisma' ħoss għall-arrieda?	Jumpy on hearing unexpected noises?
9. Ma jissaportix fil-magħluq?	Cannot bear being in enclosed spaces?
10. Jiddejjaq fil-folla tan-nies?	Cannot bear being in a crowd?
11. Ġie li jaqbdu bħal biżgħa mingħajr ma jaf għaliex?	Does he feel anxious without knowing why?
12. Jgħejja malajr fuq ix-xogħol?	Easily fatigued?
13. Jisbaħ għajjin filgħodu avolja ikun raqad bil-lejl?	Gets up feeling tired in the morning?
14. Meta jinqwieta jħoss—	When he is upset, does he
a) nifsu qasir?	a) feel breathless?
b) uġieħ in-naħħa ta' qalbu?	b) feel pains near his heart?
ċ) qalbu tferfer?	c) feel his heart racing?
d) bħal rogħda?	d) shake or tremble?

e) għoqda fl-istonku jew griżmu?	e) feel fullness in stomach or throat?
f) toqla f'rasu?	f) get a heavy head?
15. Spiss jegħreq anki meta ma tkunx sħana?	Sweats a lot even when weather is not hot?
16. Jibża ż-żejjed mil-mard?	Is he unduly afraid of disease?
Obsessional personality	
1. Jagħmel l'affarijiet bir-reqqa?	Meticulous?
2. Jagħmel l-affarijiet bil-mod biex ikun ċert li jagħmilhom sewwa?	Does things slowly to be certain that they are done right?
3. Ġieli, wara li jkun spiċċa xi biċċa xogħol, iħoss li jrid jerġa' jaraha biex ikun ċert li għamilha sewwa?	Does he feel the urge to check whether he has done a thing properly?
4. Ġieli jirripeti l-istess ħaġa bosta drabi (per eżempju, irod is-salib aktar min darba)?	Does he repeat actions over and over again?
5. Jaħseb fil-bogħod?	Anticipates the future?
6. Ix-xogħol tiegħu biss jogħġbu?	Satisfied only by his own work?
7. Diffiċli tikkuntentah?	Difficult to please?
8. Skrupluż?	Over-religious?
9. Ta dixxiplina qawwija?	Strict disciplinarian?
10. Fitt fl-indafa?	Over concerned about cleanliness?
11. Ibati biex jieħu deċiżżjoni?	Indecisive?
12. Jitqażżeż iż-żejjed?	Has excessive fear of dirt?
13. Jaħsel idejh ta spiss?	Washes his hands frequently?
14. Jiffitta f'affarijiet bħal ma huma:— għalaqx il-bieb ta barra, tefhiex id-dawl, qalx l'orazzjoni sewwa?	Subject to obsessions about closing of doors, putting out lights, saying prayers properly?

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"The wards are the greatest of all research laboratories"—
Sir Henry Wade.

"If it is a question of doubt in diagnosis, you may often observe that one man solves the doubt when the others could not, and the way in which one man happened to solve it is this: he applied to the diagnosis of the case some method which the others have not applied." — C. B. Lockwood.

Modern Trends in the Treatment of Infantile Gastro-Enteritis

By Prof. C. ZAHRA NEUMANN, B.Sc.,M.D.,D.C.H.,M.R.C.P.(Lond.)

Recent work on the aetiology of infantile gastro-enteritis tends to incriminate various strains of B.coli classified under two types: B.coli alpha and B.coli beta. The former is also known as B.coli neapolitanum. There are however many variants and sub-types of both alpha and beta B.coli so that the position at present is very fluid and uncertain; besides it is hardly likely that one single cause can explain adequately the different manifestations of infantile diarrhoea. It is to be remarked that, whatever the initial agent responsible, progressive and often irreversible metabolic changes are produced that, like a chain reaction, cause still further metabolic disturbances until life may be impossible. For instance, the toxins present in the gut produce an increased permeability of the vascular bed, probably through the presence of histamine and allied bodies. This leads to a great loss of fluid and minerals especially bases, which in turn gives rise to dehydration and acidosis.

This leads us to consider certain basic principles in the treatment of infantile gastro-enteritis. The elimination of the causative agent should be our first aim. Since so far there is no certainty as to the nature of this, our treatment in this respect is largely empirical. Good reports (and also some adverse ones) have been published on the results of administering sulpha drugs, penicillin and streptomycin. Recently chloromycetin and aureomycin have been recommended. My own experience with the sulpha drugs has on the whole been favourable and I was unable to find any difference in action between the freely diffusible sulpha drugs such as sulphadiazine and sulphamezathine. and the non-diffusible ones such as phthalylsulphathiazole and succinylsulphathiazole. Recently, when the response to a sulpha drug has not been satisfactory, I have used in a few cases chloromycetin and aureomycin with gratifying results.

As dehydration is such an important symptom in enteritis, it must be promptly and adequately treated. Since there is evidence that the profuse loss of fluid depends on the presence of histamine and allied bodies in the tissues of the gut, I think it reasonable to administer an antihistaminic such as benadryl or anthisan in cases of enteritis. I give one milligram every four hours for every month of age of the patient. Manzina in the "Gazzetta Sanitaria" June-July 1950 recommends Neobetramine as the most suitable antihistaminic, as it can be given in relatively larger doses than benadryl without causing unpleasant side effects such as sleepiness.

If the dehydration has progressed to the point of producing toxic symptoms then the loss must be made good by oral or parenteral administration of fluids. The former method may be used in mild cases without vomiting. The latter must be adopted in those serious cases where either profuse vomiting is present or the infant is in a condition of stupor and is unable to drink. In diarrhoea owing to the loss of basic ions in the stools the pH value of the blood is shifted towards the acid side; thus in addition to dehydration, acidosis sets in with deterioration of the patient's condition. Further, the dehydration, because of the decreased blood volume, will lead to increased viscosity of the blood

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**Preliminary statement by the Medical Council, Lancet, 1949, ii, 1237.*

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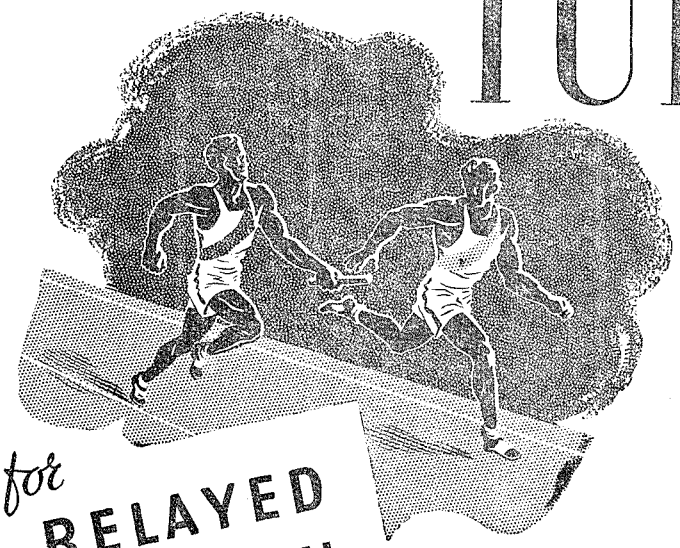

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and this results in an insufficientcy of the circulation of acid metabolites.

If vomiting is present, loss of chlorine ions leads to alkalosis. If both vomiting and diarrhoea are present sodium and chlorine ions are lost simultaneously, the former through the stools and the latter from the vomit; the acidosis balances the alkalosis until renal failure supervenes through the dehydration.

The administration of isotonic saline solution is not to be recommended. Since in any particular case it is not easy without laboratory assistance to determine the degree of acidosis or alkalosis, it is recommended that a buffered isotonic solution such as Hartmann's, which is a solution of sodium lactate in Ringer's fluid be used. To increase the calorific value, a 5% solution of glucose is sometimes administered. The fluid may be given by slow intravenous drip which presents technical difficulties in dehydrated infants or it may be given subcutaneously. In this case the absorption of the fluid may be very slow owing to the circulatory asthenia often met with in cases of enteritis. The addition of Hyaluronidase will speed up the absorption very considerably by increasing the permeability of the subcutaneous tissues. Hyaluronidase is a ferment obtained from bull's testes which has the property of disintegrating hyaluronic acid present in the "tissue cement" of connecting tissues.

Besides treating dehydration in enteritis, it is important to supply an adequate amount of nourishment. After the initial and customary starvation period of from 12 to 24 hours, it is advisable in most cases to administer some form of milk and perhaps the most suitable is buttermilk (Eledon or Beurlac) which is poor in fat and contains a certain percentage of lactic acid; the latter is useful in compensating for the loss of acid ions in gastric juice through combination with bases (mineral) and proteins in the milk. The buttermilk is given in gradually increasing doses and then after a suitable time replaced by a half-cream milk preparation. Finally a full cream variety of milk is given when thought proper.

It has been proposed to feed an infant entirely by parenteral means; the protein requirements can be fulfilled by injecting one of the various amino acid complexes now on the market. The carbohydrate requirements can be easily covered by administering glucose and for a short time fats need not be given. It is as yet difficult to assess the value of such methods and time will show whether it is practical.

In a review such as this, many details have been omitted and only general principles have been described, showing in which direction modern trends are leading in the hope that more and more lives may be saved by means within the reach of every practitioner.

AS OTHERS SEE US

"Maltese Doctors. — *The steadily increasing output of doctors of medicine from Malta University — oldest in the Empire — gives the Island a ratio of more physicians per head of population than most other countries. Well-trained and fully graduated, some of these young doctors would make excellent staff men in the Colonies and other places where doctors are scarce. Even in Britain overworked medicoes might profitably engage Maltese assistants.*" — The Crown Colonist, April 1950.

Ophthalmology in General Practice.

F. J. Damato, M.D., D.O. (Oxon), D.O.M.S. (Lond.), F.R.C.S.
Lecturer on Ophthalmology.

With relation to eye affections, patients usually consult their family doctor for two chief complaints: 1) pain in the eye, 2) something wrong with vision.

A foreign body in the eye is a common cause of pain. The patient may remember something getting into his eye, or the eye has suddenly started to ache, and the patient is not aware of the presence of a foreign body in his eye. If the eye is examined in good illumination, one might be able to see the foreign body on the cornea. It is usually a piece of grit or steel, and can be removed by instillation of a drop of 4% solution of Cocaine Hydrochloride or 1% Pantocaine, and by employing a foreign body needle to dislodge it. If nothing is seen on the cornea, the patient should not be discharged before everting the upper lid and examining well the upper sulcus subtarsalis which is a favourite site for foreign bodies. A foreign body can be easily removed from this site by the tip of the little finger. The relief of pain is almost instantaneous. If no foreign body is found, a drop of Fluorescein 2% should be instilled into the eye. This will stain the cornea where the epithelium has been injured and will reveal the cause of the pain, usually a corneal abrasion. A drop of penicillin solution or Sulphacetamide and a bandage applied to the eye is all that is necessary.

Stayes (hordeolum) and inflamed meibomian cysts (chalazion) are common painful complaints which the doctor is asked to treat. These are usually inflammatory conditions due to staphylococcal infection of the sweat and sebaceous glands of the lid, leading to the formation of a small abscess. The general condition of the patient is not usually at its best, measures should be taken to improve it. Fomentations, calcium sulphide gr. 1/8, preparations of tin, are usually prescribed. The refraction should be corrected. If the inflammatory condition does not get better, an incision will be necessary.

Attacks of acute glaucoma or acute iritis are amongst the common causes of severe pain in the eye. It is very important to be able to distinguish these two conditions, as they require opposite lines of treatment. In acute glaucoma there is a sudden rise of intraocular tension. Pain is very severe in and around the eye, and vomiting is rather frequent. Signs outside the eye are often so marked, that one is sometimes led to diagnose an abdominal trouble. Vision comes down quickly. Examination of the eye reveals a congested globe, a hazy cornea and a wide dilated pupil. Prompt reduction of tension is necessary. This is obtained by frequent instillations of a strong miotic, eserine sulphate 1% solution, hot bathings, and a purgative. Hospitalization is usually necessary. A glaucomatous eye is often a "sick eye in a sick body" and the general condition of the patient should be thoroughly investigated.

In inflammation of the iris, there is pain in and around the eye. Vision is impaired. There is circumcorneal injection of the blood vessels. The cornea is bright and the pupil is contracted. It is very important to keep the pupil fully dilated to give rest to an inflamed tissue and to prevent adhesions of the iris to the lens capsule, which might lead to various

complications. To obtain this, atropine drops should be instilled. A systematic and thorough search for septic foci should be carried out. Sulpha drugs are often of great help.

Disturbance of vision often brings the patient to his doctor. Loss of vision in one eye may be sudden or gradual. Retinal detachment, thrombosis of the central retinal vein or artery, disseminated sclerosis (retrobulbar neuritis) are amongst the most important causes of sudden loss of vision.

In retinal detachment the patient is much alarmed by noticing a sort of curtain being suddenly drawn in front of his eye. Vision is much reduced. Diagnosis is usually made by the ophthalmoscope. A hole is torn in the retina; vitreous fluid passes behind the retina and slowly pushes it away from the choroid. The only treatment for this condition is replacement of the retina by operation.

Embolism of the central retinal artery gives rise to sudden and complete loss of vision. A non-infected embolus plugs the main trunk of the artery. Pain is completely absent. The patient is often suffering from valvular heart disease, atheroma or Bright's disease. Ophthalmoscopic examination reveals a characteristic picture. The retina is greyish and oedematous and the macula shows itself as a central "cherry red spot". Treatment aims at dilating the artery in the hope that the embolus will be driven into one of the smaller arterial branches, thus reducing the extent of the damage. Massage of the globe, subconjunctival injection of 1/2cc. Acetylcholine 2% and paracentesis are the measures usually taken.

In thrombosis of the retinal vein, though vision is much impaired, light perception remains for some time. Ophthalmoscopic examination reveals enormous large haemorrhages and a swollen blurred disc. The arteries are thin. The patient is generally elderly and is suffering from arteriosclerosis, diabetes or nephritis. Focal infection may give rise to it in young people. In a certain percentage of cases intraocular tension rises and glaucoma develops.

Acute retrobulbar neuritis is one other cause of sudden impairment of sight. Central vision is mostly affected, the loss is rapid and may proceed to complete blindness. The patient is usually young. Disseminated sclerosis is generally the most common cause. Sight may return to normal or the recovery may be partial.

The impairment of vision may be gradual. Lens changes such as nuclear sclerosis, and the development of central and peripheral lenticular opacities lead to the formation of a cataract. The patient notices that vision is getting misty, until light can only be perceived. Sight can only be restored by the removal of the altered lens.

Patients are often mystified by observing that, though their vision for distance is good, they are unable to read or sew. The disability is usually attributed to all sorts of causes. There is great reluctance on the part of the patient that it is due to the passing of time. The lens becomes harder, sclerosed and less easily moulded. As a consequence of this, the power of accomodation, that is the ability to see things at close range, becomes weaker. The patient is relieved by the prescription of a convex lens of suitable strength.

The doctor is sometimes consulted for double vision. The development of diplopia may be sudden and the patient is very worried by seeing two of everything he looks at. Arteriosclerosis, high blood pressure or diabetes are often present. Thrombosis in the region of the nuclear centres of the midbrain, controlling the movements of the eyes, may be the cause. The patient is relieved by keeping one eye covered. Very often the condition improves after some weeks.

Mothers are sometimes much alarmed

by the movements of their childrens' eyes. They notice that whilst one eye looks straight, the other deviates inwards or outwards. This may start at birth or soon after. It may however appear when the child is three years old, after an attack of one of the enanthemata. An examination of the eyes after pupillary dilatation is necessary to exclude lesions in the fundus. If the child is very young, a tonic should be given to impress upon the mother that something is being done. If the child is old enough to carry glasses, correction of the refraction is often quite enough to improve the squint. It is usually necessary to give the child a course of orthoptic exercises. Vision in the deviating eye is improved by special training and the child is taught to look straight with both eyes. In unsuccessful cases the squint may have to be corrected by means of an operation.

Two further affections remain to be considered, the "sticky eye" and the "watering eye". In the former, the patient complains that in the morning the lids are glued together and that he feels as if there is sand in the eyes. Examination of the eye shows an inflammatory condition of the conjunctiva, which is red and congested. There is also some discharge along the lid margins and inside the eye. The pathological process soon shows quick improvement upon frequent installations in the conjunctival sac of guttae penicillin or guttae sulphacetamide 30%.

"Watering eyes" is a common complaint of middle aged and old people. In many cases, it is due to the general relaxation and loss of elasticity of the tissues brought about by old age. A varying degree of blockage of the lacrimal passages is the cause in other cases. The instillation of mild astringents such as zinc sulphate (½ gr. to ½ oz.) and Adrenaline Hydrochlor 1/1000 may bring some relief. However syringing of the lacrimal passages with boric lotion is often necessary. Surgical intervention, by establishing a communication between the lacrimal passages and the nose is the only treatment in a good number of cases.

We acknowledge receipt of the following Journals; we apologise for any omissions :

"Melita Theologica"
"The British Medical Journal".
"The Practitioner".
"The British Medical Student's Journal".
"Scientia".
"Revue Médicale Université de Montreál".
"Health Education Journal"
"Journal of Obstetrics and Gynaecology of the British Empire".
"Archives of Disease in Childhood".
"British Medical Students' Association Eight Annual Report 1949-50"

WHY I JOINED A MEDICAL COURSE

Two senior students have written us as follows:

I had been doing extremely well in Mathematics and Physics for the three years prior to matriculating. This made me think that, once I had decided on going to the University, the obvious thing would be for me to join the Course of Engineering and Architecture.

Up to a few days before the beginning of the academical year five years ago, that is what I intended doing. Then I had a number of chats with friends and with my brother who was just finishing a medical course himself. I suddenly found myself enthusiastically registering as a medical student.

Now, after five years of it, I have had enough experience to show me how correct my choice was. I have found that all the subjects in this course are to my liking, that they are what I had wanted to learn six years ago. I have now got very involved in the medical subjects of the final years, and the more involved I get the more I enjoy them.

I think that in all fairness I must say that I have never felt what is by many called a "natural craving" for joining the Medical Profession. But in this age of materialism and suppressed sentimentality, I have made a logical choice with the aid of my reasoning alone, which I am sure I shall never regret.

* * *

I was always under the impression that an office routine was mere drudgery. It is a denial of one's power of observation.

This opinion led me to choose a career which had scientific enquiry as its basis. Furthermore I sought that such a scientific study should not merely stop at the inanimate.

A medical training was the best field which could offer an abundance of knowledge. An accumulation of such a knowledge would give a comprehensive concept of human life. From my limited experience I could recollect the restrictions which a disease can bring about. A medical education was the only means whereby I could acquire a skill in the prevention of disease and the improvement of health.

* * *

Two junior students have written us as follows:

The choice of a career is a problem which most living souls must face at some time or other. Everyone has his own views about this, but in certain careers — amongst which we find the medical — some points stand out as a basis for such a choice. Before joining a course at a University one must weigh the pros and cons for the particular choice, otherwise serious repercussions may follow.

In my case, the Medical Course had an innate attraction, which I cannot explain. This has happened to a great number of students before me, but this was not my sole reason. My other reasons are such as occur to most prospective candidates for this profession. There is the humanitarian point for instance — most people seem to have an urge for helping others in a low state of health: this is so developed in the doctor, that it becomes his duty to see that all appropriate remedies are applied in achieving this.

The possibilities of the profession are indeed vast. We frequently read of new discoveries in the field of Medicine, discoveries which somehow help in ridding Man of troublesome diseases which tend to make such a misery of his life.

Furthermore a doctor's field is not necessarily restricted to the country in which he graduated. Whether in Malta, in England, India or the Bahamas he will find people with the same anatomy and suffering from much the same ailments as in the country where he studied.

* * *

When I matriculated, I did not intend taking up any course at the University, but later circumstances cropped up which left me with few alternatives from which to choose.

Before embarking on my University course, I had a job which was not to my liking as I never felt that I was doing my duty to the best of my abilities. After a couple of months abroad I learned to appreciate the joys of a free life, a life independent of a daily monotonous office routine. This new outlook made my job unbearable.

This was one of the reasons — but not the main one — for my joining a Medical Course. A young man who is a little ambitious, is not content simply to dig himself into the office rut without any prospects for the future. His thoughts are "long long thoughts", and a University career may provide grounds for his dreams.

But why did I choose Medicine and not Architecture or Law? I cannot say that I was driven by any great desire to save human lives or to fight the miseries which assail humanity. I liked Science more that Art, and that was a great deciding factor.

To be honest, I must confess that I could never bear the sight of men suffering, nor could I bear hearing doleful stories of pain and misery about fellow beings. The studies in the Medical Course alone could help me overcome this weakness — and it is always a satisfaction to learn how to overcome our weaknesses!

"It is not suggested that pen should never be put to paper accept to announce some epoch-making discovery. The sum-total of present-day knowledge is made up of the contributions of thousands of observers. It is the duty of all to record their observations, and to report and interpret their findings." — W. R. Bett. Health Education Journal Oct. 1950.

The Medical Faculty Bureau of I. U. S.

(In April, 1949, we published the aims, programme, and structure of the Medical Faculty Bureau of the International Union of Students. For reasons which are not very clear, that Medical Faculty Bureau did not last long.

The British Medical Students' Association has now drafted a constitution for a new Medical Faculty Bureau within the structure of the International Union of Students, through which it hopes that medical students from all over the world might co-operate, irrespective of nationality, political creeds and religious beliefs. This plan, or a modification of it, was to have been laid before the International Union of Students, at the Second World Student Congress in Prague in August.

We publish below the draft of this plan outlining machinery through which these aims can be achieved).

Draft Constitution

AIMS:

To study and promote the interests of medical students and to encourage medical student co-operation amongst such students on a scientific and cultural plane, the organisation being non-political.

It shall pursue these aims by:

1. Establishing a permanent basis of contact between Medical student associations.
2. Promoting the exchange of ideas by international correspondence and professional exchange of students from one country to another.
3. Organising international conferences.
4. Collating opinions and information on the subject of medical education, with the aim of obtaining an international standard.
5. Publishing a periodical as an official organ.
6. Providing information of general medical student and scientific interest.
7. Obtaining copies of original student work for circulation to medical students.
8. Encouraging development of National Student Organisations.
9. Supporting all work for student sanatoria.
10. Integrating the activities of medical students with those of other faculties.
11. Acting as liaison between medical students and world organisations such as WHO and UNESCO.

MEMBERSHIP:

1. Full membership shall be open to National Organisations of medical students, which in their own right or through the National Student Organisations belong to IUS.
2. Where no national organisation exists, individual medical student organisations can be admitted to full membership under the above conditions.
3. Associates shall be those organisations wishing to participate in some of the activities of MFB but which do not wish to belong to IUS.

ORGANISATION:

1. The officers shall be the General Secretary and the Assistant Secretary.
2. They may be elected from Full Member or Associate Member Countries.
3. The Headquarters of the Bureau shall be in the country of the General Secretary.
4. The officers shall be elected at the Medical Faculty Meeting.
5. The Assistant Secretary shall be available for re-election providing he has not served for more than one year.
6. In the event of an officer resigning the remaining officer shall be the General Secretary and shall have the power to co-opt an assistant.
7. No one shall be allowed to hold office for more than two years after qualification.
8. The first task of these officers shall be to depute the work agreed upon to various member organisations.

9. The General Secretary shall be reseponsible for ensuring that the work allotted is efficiently carried out and shall act as a liaison between the member organisations and the ICD.
10. The General Secretary and his assistant shall be in frequent contact and shall publish reports of progress.
11. Suggestions for the work of the MFB, within the framework of its aims, shall come from the IUS and from member organisations and from the 2 yearly conferences.
12. The programme of the work for the coming year shall be formulated by the Medical Faculty Meeting.

MEETINGS:

1. Medical Faculty Meetings.
   a) shall be held annually at the IUS Council meetings.
   b) shall consist of one Delegate from each full member country together with an unlimited number of unofficial observers.
   c) associate member countries shall have one official observer and an unlimited number of unofficial observers.
   d) Delegates shall have one vote, official observers shall have no vote but full right of discussion. Unofficial observers shall speak only at the discretion of the Chairman.
2. Student International Clinical Conference.
   a) shall be held every two years.
   b) shall not be a strictly delegated Conference.

GENERAL PROVISIONS:

1. The MFB shall not trespass in the provinces of National Associations.
2. Any propositions to vary the standing orders shall be considered by the Medical Facult Meeting and then ratified by the IUS Executive.
3. Member Associations shall be free to resign from the MFB upon condition that they express their desire to do so at least one year beforehand.
4. Any proposition to dissolve the organisation must be considered by the Medical Faculty Meeting.

"During his period of hospital training the student can rarely see a disease evolve as a complete process apart from some of the more acute infections. When the patient is first seen by him, the disease may be already well-developed, and in general his time in the wards is too short to allow of a complete study of any one case. He is educated rather upon fragments of the evolutionary history of a number of different diseases, and thus only part of the whole picture becomes impressed on his mind by visual memory; he is then naturally apt to think of that part as being the whole process, and his ideas fail to attain cohesion and sequence." — H. W. C. Vines.

Correspondence

B.C.G. VACCINATION

Sliema,
November 13, 1950.

Sir,

I have been amongst the first group of medical students who have made use of the B.C.G. Vaccination Scheme for Students arranged between Dr. Zammit Tabona and the Malta Branch of B.M.S.A.

I wish to put on record through the medium of this journal the extreme confidence and courtesy which Dr. Zammit Tabona and his staff have shown us.

I can assure all students that if they take part in this B.C.G. Vaccination Scheme they will, besides deriving material benefit from it, also prove to the organizers that such schemes have the support of all students for whose benefit they are undertaken.

Yours faithfully,
E.J. TURNER.

PRACTICAL DIFFICULTY

Sliema,
October 15, 1950.

Sir,

During the last few years we have been discussing and witnessing a number of changes and reforms carried out by our University. I do not intend to criticise in any way such steps which, I believe, have been taken towards the real advancement of University studies.

I regret to point out, however, that certain elementary improvements have not as yet been seen to. A particular point in question is the fact that the Pathology Laboratory has been equipped with a number of microscopes none of which is provided with an oil immersion lens. The result is that the senior students are now making use of a microscope which is not the property of the Royal University, and that the other microscopes are not being ultilised at all.

I am fully confident that such a state of affairs results from inadequate co-ordination between the officers concerned rather than from the unwillingness of the University authorities to provide the bare essentials for practical work.

You will agree that such matters are highly regretable and that a little more attention to details on the part of the University would pay much in return.

Yours sincerely,
JOS. L. GRECH.

A READER'S APPRECIATION

Sliema,
September 15, 1950.

Sir,

Since the first issue of The Chest-Piece appeared in October 1948, I have followed the progress of our journal very closely. I have watched it steadily progressing and gradually catering for senior as for junior students in the courses of Medicine, as for the Medical Profession.

It is really encouuraging that at present, the only journal in Malta dedicated to the Medical aspects of Science is published by a handful of students. As I am myself a medical student, I well appreciate how little time our studies leave which can be dedicated to other activities, and thus I find it rather praise-worthy that the students composing the B.M.S.A. (Malta Branch), have been able to publish this journal for the last two years.

I wish you all good luck in future issues of the journal, which I know, is appreciated by all in whose hands it somehow finds its way.

Yours faithfullly,
SENIOR STUDENT.

"Too late is the medicine prepared, when the disease has gained strength by long delay." — Ovid.

THE GOLDEN MOULD

Robert Oppenheimer
Lederle Laboratories Division, American Cyanamid Company
Pearl River, New York.

Moulds were used as home remedies as far back as the middle ages. Husbands injured during hunting trips on feudal game preserves had their wounds treated with their wives' favourite hot poultice of yeast and mouldy bread, or sprinkled with powdered punks (mushrooms) in an attempt to stop the flow of blood. It is doubtful whether these crude treatments had much medicinal effect, because gradually they lost favour and for many years little was thought of any members of the entire mould family in connection with medicine.

But in recent years, following the development of penicillin from a mould, interest in moulds has a re-birth with scientists intensively seeking new mould-derived drugs. A reflection of this was the bringing of Dr. Benjamin M. Duggar to Lederle Laboratories at Pearl River, N.Y. as consultant on mycology or the study of fungi (moulds). Shortly after his arrival at Lederle, Dr. Duggar, restless with consultation duties alone, began an attempt to develop a superior antibiotic. Antibiotic, in a medical sense, is defined as: A substance produced by the growth of moulds and bacteria, this substance being effective in the treatment or control of one or more germ diseases. Penicillin and streptomycin, the first two antibiotics to achieve medical importance, were soon to be joined by Dr. Duggar's superior, more versatile antibiotic which is now called Aureomycin.

Dr. Duggar and his associates, from earlier work in the field, felt that one of the lesser studied families of moulds (Actinomycetes) might furnish a valuable antibiotic. Since moulds are members of the plant kingdom and are inhabitants of the soil, the Lederle researchers began their project by gathering more than 600 soil samples from all over the United States. They probed these samples for strains, belonging to the actinomycete family, that would be effective against organisms upon which penicillin and streptomycin had proved to have little effect. The task was an intensive one — that of weeding out the non-producing strains, for although more than 3,400 strains showed promise, more than ten times that number were examined and rejected as inferior or as being obviously duplicates.

Those moulds tentatively approved were tested for potency by putting them on laboratory plates along with specific bacteria and watching the ability of the moulds to prevent the growth of these bacteria. Any mould with the capacity to produce a promising antibiotic substance was then carried further, and, if it passed other tests, ultimately went to the Pharmacology Department for toxicity tests — to find out if it was safe to use.

Of the entire group, Mould No. 377, producing a golden-colour substance proved to be the safest and most effective of the 3,400 strains. This was called Aureomycin, a name derived from the Latin word, aureus—meaning gold; and from the Greek form, myco — meaning fungus.

Investigators soon began to find out many wonderful things about Aureomycin. Penicillin is effective against one class of disease-producing bacteria, streptomycin largely against another sort. Aureomycin, on the other hand, battles with much success against both types of germs. Among the bacterial infections conquered by this new drug are Undulant Fever, Ratbit Fever; infections of the eye, the skin and the urinary system.

control the next smallest class of disease producing agents — the rickettsia. Rickettsial diseases such as Rocky Mountain Spotted Fever, Q Fever, Typhus, Parrot Fever, and a venereal disease call Lymphogranuloma Venereum all are brought under control quickly by Aureomycin, effecting recoveries that amaze the medical profession.

Perhaps, the most spectacular results with Aureomycin have been achieved against so-called "virus" pneumonia against which doctors were helpless. Physicians speak of "virus" pneumonia as Primary Atypical Pneumonia, and while it is seldom fatal, this common respiratory infection, before Aureomycin, usually caused many days of high fever and even longer convalescent period. But after a few golden capsules of Aureomycin were taken, fevers as high as 105 vanished after 24 to 48 hours, painful coughs became non-existent, and many a patient who might have been hospitalized for weeks was up-and-around and fully recovered 7 days after treatment with Aureomycin was started.

One of the greatest advantages of Aureomycin is that it is taken by mouth, a few capsules daily, thus relieving hospital congestion and demands on the nursing staff, when frequent injections are necessary. Another advantage is that it does not build up resistant strains of germs which make diseases harder to fight, nor does it frequently cause allergic reactions. Early batches caused some nausea, but Lederle experts have now improved Aureomycin so that the discomfort it previously produced is eliminated. In addition to the wonder-working capsules which control internal infections, Lederle recently introduced an ointment which shows amazing results in clearing up bacterial skin infections, among them impetigo, a nasty, quick-spreading, festering disease which heretofore took weeks to cure.

Day by day, more evidence of the effectiveness and the versatility of Aureomycin is being added to its clinical score. There are hopeful indications that the discomforts of certain infectious diseases typical of childhood — mumps — may be lessened by Aureomycin, and reports have been received that amoebic dysentery succumbs to this great drug. Recently, its effectiveness against whooping cough and infectious mononucleosis has ben shown.

Because Aureomycin has made such vital conquests in the battle against disease, the medical profession is today inspired with the greater hope that the viruses — a class of germ still baffling to science — may in time be fought successfully with antibiotics.

"There is a most intimate connection and almost an identity between the ways of human power and human knowledge . . . . That which is most useful in practice is most correct in theory". — Francis Bacon.

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