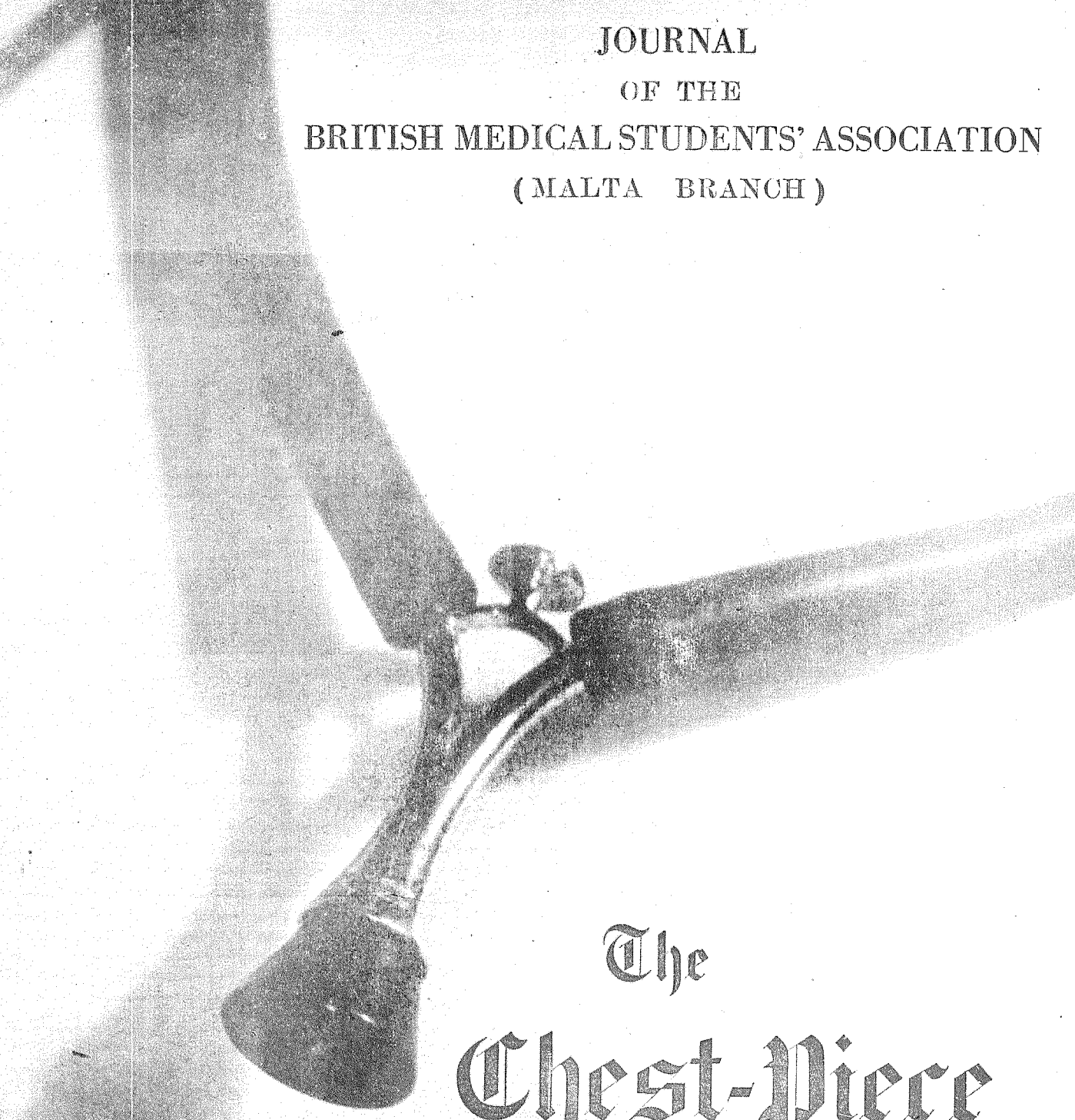
JOURNAL
OF THE
BRITISH MEDICAL STUDENTS' ASSOCIATION
(MALTA BRANCH)



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Vol. 1. JUNE, 1953. No. 8.

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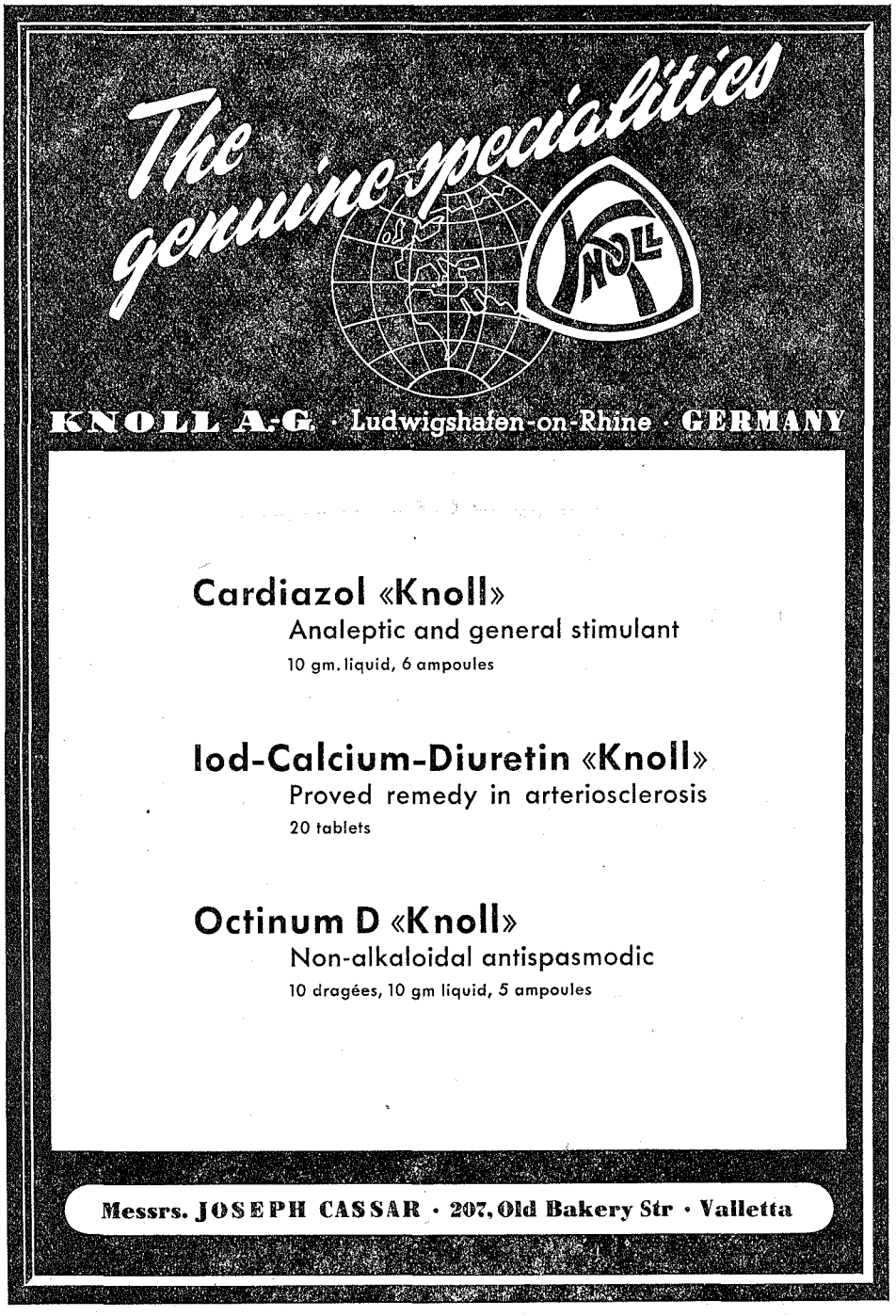
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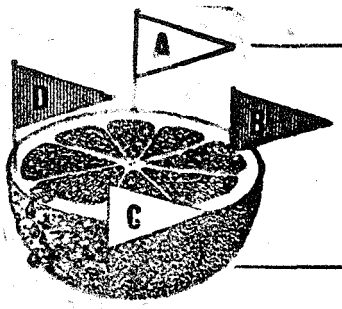

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EDITORIAL

The visits of the Queen to hospitals here will always be a most happy memory. The Coronation, the symbolic dedication of the Soverign to the service of her peoples, celebrated with great rejoicing in all parts of the Commonwealth, marks the beginning of a new age of adventure. In the reign of Elizabeth I of England men of great courage and determination ventured on frail craft into stormy, uncharted seas. In the New Elizabethan Age men, and women, with even greater fearlessness and tenacity, undaunted by the tediousness of the work and often handicapped by lack of funds, will also go out and grapple with the great problems of diseas which have so far been unresolved. Will this reign see the great menace of Cancer controlled? The tide of Tuberculosis stemmed? There is certainly no lack of material to work on. We know much more about disease now than they knew in the time of the first Elizabeth, but there is a vast amount of things that we do not know.

It is an interesting thought that as Medicine has progressed so enormously, so also has disease. As the less virulent pathogens have been in some measure controlled, the more powerful ones have become relatively more common and as it would seem the immunity given by an attack of the milder strain tends to be curtailed by the possibly injudicious use of the 'miracle' drugs, the patient has less natural defence.

We welcome the formation of a branch of the Save the Children Fund in Malta. This was made possible by the generous and inspiring help of one of the greatest women of modern times, the Countess Mountbatten of Burma, who is President of the international fund and also of the Malta branch. Mrs. J. E. Debono the Chairman, and other members of the committee, have worked extremely hard to set the organisation on its feet. His Grace the Metropolitan Archbishop is patron and has shown his great love for the children of Malta by his kind and wise help. The scheme could not of course have been put into operation were it not for the help and cooperation of the Minister of Health, the Hon. Dr. P. Boffa, the Chief Government Medical Officer, Professor J. Galea, the Senior Physician, Professor J. E. Debono, Professor C. Coleiro and all the other doctors who have offered their services. The first problem the S.C.F. has tackled is that of ante-natal care. The need for this is very great especially in some of the villages. It is hoped to open a number of day nurseries were children who are too young to go to school could be looked after by qualified staffs and given any extra nourishment they need in hygenic surroundings. This besides being of great benefit to the children would be a tremendous boon to countless mothers who are often too weak to cope with the normal housework and have to go out to work leaving their little children in the care of an elder sister. We should also like to see a convalescent home for children, where they can recover completely before returning to homes which are often not very healthy. A country place where weak children could regain their health, and where perhaps they could stay for a time while their parents were ill in hospital. It is a thankless task for the doctors to cure a child only for it to go home to dark and overcrowded rooms be-

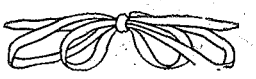
fore it can build up enough resistance and fall a victim to some other disease.

There are other signs of progress, which are also very welcome. The new out-patients block is nearing completion. We have been shown a new lecture hall for Medical Students which promises to be a very great improvement on the most uncomfortable room the lectures are delivered in at present. The new University Science Laboratories overlooking the Grand Harbour are also progressing. The new building, dazzlingly white in the sunlight, is only a few yards from that sadly desecrated place which was one of the first hospitals and where the flower of Europe's chivalry used to serve the sick. It is with a sense of shame and sorrow that we pass the Knight's Hall in its present state, with the feeling that the ghostly figure of some knight might be looking on wondering with scorn why we could not have found a better use for this once noble hall.

This journal is at the moment the only Medical publication in Malta. As such it is our privilege and duty to publish articles of Medical interests by doctors and medical students in Malta, which form any useful contribution to medical knowledge or which show the particular aspect a disease may take here.

There seems to be an idea that this journal only publishes articles by members of the University teaching staff. This is not so. Any member of the medical profession in Malta may submit articles for publication in the CHEST-PIECE. We intend to increase the circulation of this journal and to send many more copies to medical schools abroad. The standard of the work must necessarily depend on the amount of support we receive.

Progress in Medicine is often retarded by the publication of results of experiments which are not altogether sound. We deplore the habit of "rushing into print" with articles which are quite premature and liable in fact to lead red herrings across the path of true scientific research, though we fully realise that such articles have lead quite accidentally to some brilliant discoveries. On the other hand undue reticence in giving to the world worthwhile valuable fruits of personal experience in the wards or in the laboratory must necessarily lead to much wastage of original thought and to stagnation in the development of new techniques and ideas. The value of articles based on genuine medical research and clinical observation cannot be overestimated. However we are of the opinion that even these articles should not purport to draw conclusions but to suggest possible answers to unsolved problems.



Common Pitfalls in Obstetric Practice

Dr. O. ZAMMIT M.D., M.Sc., (L'pool), M.R.C.O.G.
Demonstrator in Obstetrics and Gynaecology, Royal University of Malta.

It is a well known fact that many obstetric procedures are controversial and that an obsetrician can achieve equally good results by adopting either of two seemingly diametrically opposite methods of treatment. The reason for this happy ending is that in some instances the processes of pregnancy and labour, like most biological problems, still belong to the realm of mystery. More often, however, Nature takes matters into her hands and repairs or mitigates the damage done by the obstetrician. Unfortunately Mother Nature has her limitations. It is my intention to point out some of the conditions in which the obstetrician can evoke the services of nature as an ally and not as an enemy.

Some of the errors mentioned are of little consequence but others may make all the difference between the life and death of the patient.

PREGNANCY.

1. Omitting the periodic examination of the Blood Pressure.

The importance of having the blood pressure tested is not known to most pregnant women in Malta. Antenatal care is mostly in the hands of midwives and consists mainly in a periodical examination of urine for albumen and glucose. Of the three cardinal signs of pre-eclamptic toxaemia, albuminuria is the last to appear and that is because the albuminuria is brought about by spasm of the afferent arterioles of the glomeruli which is liable to occur when the blood pressure reaches 160mm. of mercury systolic. Toxaemia occupies one of the first places as a cause of maternal death and is responsible for a high percentage of foetal wastage.

2. Relying on external pelvimetry as a means of assessing disproportion.

Except for the diagnosis of gross disproportion, external measurements are worse than useless because they are often misleading. Quite frequently the external measurements are normal and yet the dimensions of the true pelvis are below the average. I have now stopped teaching my students the technique of external pelvimetry. What is really useful is internal pelvimetry; this gives information as to the type and shape of the true pelvis, as to whether the sacral promontory can be easily reached and above all as to whether there is disproportion between the foetal head and brim (Essen Moller's manoeuvre). The aphorism: "The best pelvimeter is the foetal head" is as true today as when Freeland Barbour first said it. If Essen-Moller's manoeuvre proves difficult or inconclusive, the patient should be referred for X-Ray pelvimetry.

3. Failure to correct a breech presentation before the 36th. week.

External version in breech presentation has not received its due attention. The foetal mortality rate attached to this operation does not exceed 2%, whereas the foetal and neonatal mortality rate attributable to a breech delivery is in the neighbourhood of 15 - 20%.

The first attempt at correction should be made at 30 weeks and repeated, if need be, each subsequent week. External version is naturally more difficult the nearer the pregnancy advances towards term.

4. Performing a vaginal examination in cases of APH destined to be sent to hospital.

A vaginal examination would only excite further bleeding should the placenta be praevia, owing to the increased detach-

ment of the placenta which such an examination entails. Moreover, the first haemorrhage of placenta praevia is usually slight — a 'warning haemorrhage', demanding the immediate removal of the patient to hospital. If this danger signal is not heeded, a second and more severe bleeding will sooner or later occur, making the journey to hospital more perilous.

5. Sending a case of Eclampsia to hospital without giving her morphia.

In this connection, in removing such a patient the doctor himself should accompany her, duly equipped with chloroform, Schimmelbusch mask, a mouth gag and an airway, in case an eclamptic fit occurs in transit.

6. Packing the vagina in cases of Abortion or APH.

In order to be effective packing should be done under anaesthesia. Placing a few tampons in the vagina does not arrest the bleeding, but would only pave the way for sepsis. Those who are in favour of such packing argue that the insertion of a few tampons gives the relations of the patient an assurance that something is being done for her. However ignorant the lay people are, they can be certainly persuaded that the correct method of treatment is not to tamper with the vagina.

7. Failure to inject ergometrine in cases of inevitable abortion or retained placenta before removal to hospital.

Ergometrine 0.5 mg. injected intramuscularly exercises its effect on the uterus after a lapse of 5 to 10 minutes; if a firm Crede is performed immediately after this time, a retained placenta may be expelled. Failing this, no harm will have resulted from the administration of ergometrine; on the contrary, the spasm it will have induced in the uterus would check the bleeding for about an hour; in other words it would give sufficient time for the obstetrician to send his patient to hospital with comparative safety.

8. Omitting to ban coitus in the event of an early pregnancy in cases showing a history of repeated abortions.

LABOUR.

FIRST STAGE OF LABOUR.

1. Leaving out the administration of an enema.

2. Allowing distension of the bladder.

A full bladder interferes with the neuromuscular coordination of the uterus besides rendering the patient uncomfortable.

3. Ignoring the general condition of the patient.

The temperature and pulse rate should be taken at regular intervals. Increasing pallor of the face and accelleration of the pulse rate may be the only striking indication that a concealed accidental haemorrhage is in progress. One of the causes of foetal death during this stage is infection; in a long and tedious labour, when the membranes rupture early, the administration of Penicillin to the mother may result in foetal salvage.

4. Not giving the patient sufficient nourishment or overfeeding her.

In the former case acidosis may develop increasing the risk of anaesthesia should this become necessary; moreover a starved patient does not have the requisite energy to stand up to the ordeal of labour. A full stomach may on the other hand conduce to inhalation pneumonia should this patient need an anaesthetic. It is important to remember that the food should be easily digestible and assimilated for during labour the functions of digestion and assimilation are extremely sluggish.

5. Withholding the use of Pethidine and/or of Trilene.

There is no need for me to labour this point as many women are solving the problem themselves by demanding some form of analgesia.

6. Letting the patient bear down.

This would only lead to exhaustion and the subsequent development of prolapse of the uterus.

7. Making futile attempts to deliver with forceps.

There is no telling the extent of damage that may be caused by this. Suffice it to say that the maternal mortality rate is 10% and the foetal mortality rate 40% in cases of failed forceps. Now one of the commonest causes of failed forceps is an undilated cervix. Forcible dilatation of the cervix by forceps results in shock of varying degrees of severity; lacerations may be very extensive; post-partum haemorrhage is the rule and the woman is left with a legacy of a tendency to prolapse; in addition, the foetal head is apt to suffer irreparable damage. The correct method of treatment in cases demanding urgent delivery in the presence of an insufficiently dilated cervix is to carry out Duhrssen's incisions or else to perform Caesarean section, according to the circumstances of each individual case.

8. Failure to institute first aid measures in cases of prolapse of the cord.

The simplest of these is the adoption of the Trendelenburg position. Many babies can be saved by this means. This position should be maintained during the time when preparations are being made for delivery. During the time of induction of anaesthesia this method by itself may not be adequate; so it is necessary that during this interval the doctor or midwife should push up the presenting part in order to prevent it from pressing the cord against the brim.

9. Failure to ascertain the position of the chin i.e. whether anterior or posterior, in face presentation.

When the chin is anterior, delivery is not only possible but sometimes surprisingly easy. On the contrary, a face lying with the chin posterior cannot be born as such. In this case, one of the methods of treatment is internal version. Internal version in face presentation is fraught with much danger to the mother; if it has to be done, it must be done early or not at all; in other words, the head must not be allowed to become impacted in the pelvis, in which case if version is resorted to there is great likelihood of rupture of the uterus.

SECOND STAGE OF LABOUR.

1. Failure to auscultate the foetal heart in order to detect early signs of distress.

Routine listening to the foetal heart during labour is far from sufficiently practised. The reason for this neglect is not clear. Is it because the idea still prevails that the life of the mother is the all-important consideration and that therefore both doctor and midwife focus all their attention on the mother? In modern times extremely few mothers should die at child-birth and very few babies should be lost.

When the foetus dies, it does not die instantly but it shows signs of distress long before. A timely application of forceps would result in many babies being saved.

During the first stage, the foetal heart should be auscultated every 30 minutes and during the second stage every 5 minutes at least.

2. Ironing the perineum and/or kneading the uterus, with the erroneous view that labour may thus be hastened.

Ironing the perineum should be reserved for dilating the ostium vaginae in order to obviate or minimise an extensive tear. If it is employed for the purpose of exciting a uterine contraction, one would only exhaust the patient, as the contractions that are produced thereby are usually ineffective. The same may be said of the widespread custom of kneading the uterus. It

should be remembered that uterine action is under the control of a neuro-muscular mechanism which is so delicate as to be easily deranged by the stimulation of kneading.

3. Unnecessary traction on the foetal head.

As soon as the foetal head is born, it is a much too common practice to pull on the head, with the mistaken view that the foetus might choke to death unless the remaining part of the delivery is not speeded up. Once the mouth is free the foetus will be able to breathe even though the trunk is still in the birth canal. After the head is born the correct attitude of the attendant should be to wait for the next pain, when the shoulders would come out; namely by downward pressure of the uterine muscle itself. Traction from below may result in Erb's palsy. That is why cases of Erb's palsy are so common in Malta. If speed is essential, traction on the head should be exerted only after making sure that the anterior shoulder is not impinging on the symphysis pubis. An attempt should first be made to bring the shoulders in the transverse diameter of the brim; if this does not succeed, pressure should be applied suprapubically in the hope that the anterior shoulder is dislodged.

4. Not holding the baby by the feet immediately after extraction.

In some cases the inhalation of liquor or blood may set up an inflammation in the lungs which might prove fatal.

5. Not taking into account the general condition of the patient prior to undertaking Obstetric Operations.

Quite often a patient has to be rescuscitated before she is able to withstand the strain of an obstetric operation. Thus it comes about that after the performance of an 'easy' version or forceps operation, the patient drifts into deep shock from which she may not recover.

6. Withholding the use of anaesthesia in operative procedures.

This custom is still widely followed. No wonder most women in labour are terrified at the very sight of the doctor. Others are delighted with his presence only in so far as he would employ anaesthesia. Besides the amount of pain that operative procedures entail, there is greater danger of causing damage to the mother and/or child when anaesthesia is not employed. To those who entertain the idea of performing version on the non-anaesthetised patient, I would only say that they should re-read the oath of Hippocrates.

7. Standard application of forceps irrespective of the position of the occiput.

Certain doctors adopt the procedure that if the forceps lock, all is well and good. Surely, this attitude is most unscientific, to say the least. The rational method is to ensure a cephalic application of the forceps. This, of course, presupposes a correct diagnosis which in cases of doubt can always be reached if the operator introduces his half-hand in the vagina — a thing which is not difficult to do provided the patient is anaesthetised. The principle underlying the advisability of a cephalic application of the forceps is that the base of the skull is the least compressible part of the foetal head, and that therefore tentorial tears are less likely to be induced. It is only by this means that one can minimise the incidence of intracranial haemorrhage with the disastrous consequences that follow in its trail.

8. In breech deliveries failure to have a pair of forceps ready or failure to administer anaesthesia in nervous patients.

These omissions are responsible for a great many foetal deaths. On occasion the Mauriceau-Smellie-Veit manoeuvre fails

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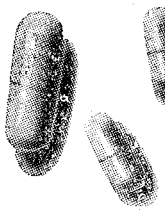

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and forceps will have to be applied if the baby is to be saved. In this connection, it is better that the patient is not anaesthetised at all rather than that she should be only half anaesthetised.

THIRD STAGE OF LABOUR.

1. Failure to empty the bladder.

As was said before a full bladder interferes with the function of the neuromuscular mechanism of the uterus. In addition, pressure on it causes pain. This is one of the reasons why Crede's method of expressing the placenta may not succeed.

2. Withholding the use of ergometrine and pitocin.

3. Not having an intra-uterine douche handy.

A hot douche is one of the most efficient ways of arresting post-partum haemorrhage. The Temperature should be 118-120 degrees. A lower temperature would excite more bleeding whereas a higher one would bring about scalding of the vulva and thighs.

4. Inadequate suturing.

There is a widespread belief among the laity that two, three or at most four stitches would be needed for the repair of the perineum. This belief is perpetuated by doctors who make it a habit not to exceed this number of stitches whenever they have to repair any perineum. These doctors 'get away with it' because the effect of inadequate suturing is not at once apparent. The perineum should be repaired in layers, i.e. vaginal wall, levatores and skin. Incidentally I have found mattress suturing of the skin most effective as the edges are brought into accurate opposition.

POST-NATAL EXAMINATION.

This is very often omitted altogether here in Malta. Not infrequently, parturition incapacitates the woman in all her activities except in that of child-bearing. There are circumstances when a subsequent pregnancy might be risky or might result in the death of the patient. It is the midwife or doctor who should guide her in this respect.

Another obvious advantage of a post-natal examination is that the defects which are the result of pregnancy and parturition can be stemmed at their origin, before they have time to assume greater proportions.

CONCLUSION:

Some of the statements mentioned in the above discussion may sound harsh or unwarranted. I may assure my readers that they were made in a vein of constructive criticism.

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"
83 Rudolf Street,
Sliema.

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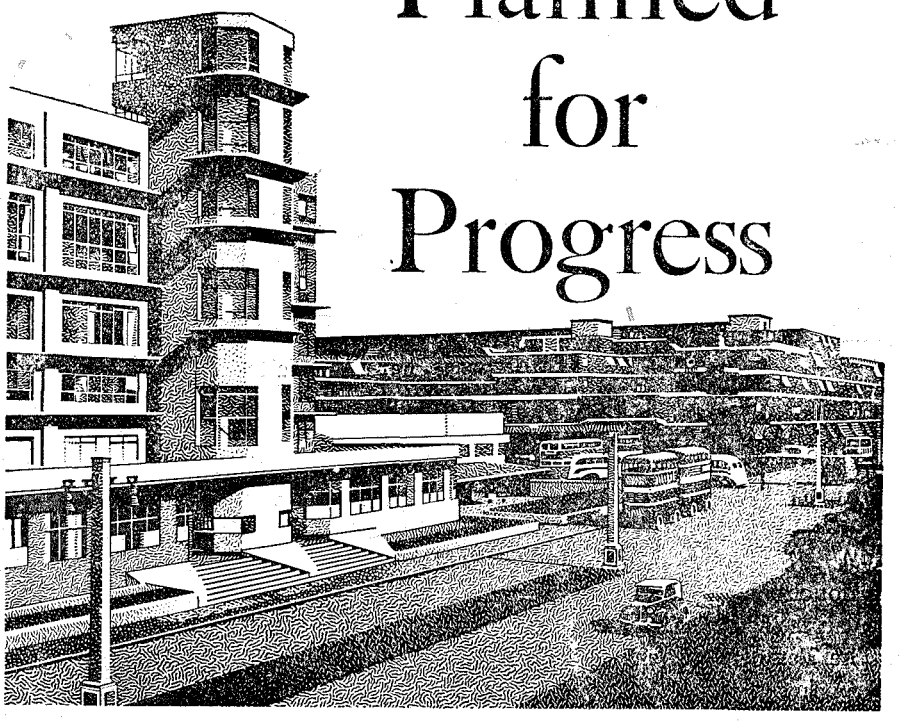

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The Save the Children Fund (Malta)

The Save the Children Fund is a world wide organisation and it is with great pleasure that we publish a broadcast made by two ladies who have done so much to start the Fund in Malta.

The first speaker is the Countess Mountbatten of Burma, who is not only the President of the Save the Children Fund, but also the Honorary President of the International Union for Child Welfare.

This latter organisation has its Headquarters at Geneva, its founder-member being The Save the Children Fund.

Lady Mountbatten has also accepted to be the President of the Malta Branch of the Fund, which was started in January this year. The other speaker is Mrs. Josephine Debono who is Chairman of the Executive Committee.

LADY MOUNTBATTEN: First of all I would like to say what happiness it gives me to know that the Save the Children Fund, of which I have been President for the last four years, and with which I have been associated for the last thirty years, has at long last come to Malta.

I feel very privileged to have been invited to be President of the Malta Branch of the Fund, and to be working with such an indefatigable Chairman as Mrs. Debono and with a most representative and hard-working Executive Committee.

His Excellency the Governor is taking an active interest in the Fund's work, and we are much honoured to have received the blessing and patronage of His Grace the Metropolitan Archbishop, which will be the greatest incentive to our work in these Islands.

Mrs. DEBONO: Although Malta has known of the work of the Save the Children Fund for many years, it would have been utterly impossible for us to have started this Branch without your inspiration and unflagging enthusiasm.

You yourself have seen so many aspects of the work in Europe and in Britain, as well as in more distantlands, would you please tell us something about it?

LADY MOUNTBATTEN: Yes, I would like to. Today we are at work, through our doctors, nurses, teachers and welfare workers, in four countries in Europe, three in Asia and two in Africa, to say nothing of certain work for children of school age and pre-school children, in our own lands, which is designed to fill gaps left by the social services and other agencies.

All over the Commonwealth there are Save the Children Funds and these all grew out of the original one founded in London thirty-four years ago by an Englishman, Eglantyne Jebb. There are also similar organisations in some forty other countries and it is the International Union for Child Welfare which brings all these national funds together.

Our Maltese Save the Children Fund will be a member of the International Union, just like the Funds in the United Kingdom, the United States, Canada, Italy and elsewhere.

It might interest you to know in one year, 1952, over forty-five thousand children have been helped in four different continents, Europe, Asia, Africa and Australia. I think I have visited every country where the Save the Children Fund is at work including Malaya, the Sudan, Korea, Austria, Germany, Greece and the Lebanon. Althogether I have seen the Fund's workers tackling their job in a dozen countries in Europe, Asia and Africa.

MRS. DEBONO: I understand that there are teams working at present in

Austria, Greece, Germany and Italy, and that the re-building of the Hermagor Hospital in Austria has made it possible to receive children suffering from tuberculosis, poliomyelitis, and various bone diseases. These children will thus be assured of the best possible treatment in a permanent institution.

LADY MOUNTBATTEN: Yes, the Save the Children Funds of Canada and Britain raised £5,000 to enable the rebuilding of the hospital to be carried out.

Government Departments and Medical Services in all the countries where The Save the children Fund is functioning have been happy to co-operate and realise the tremendous need for child health and welfare work.

MRS. DEBONO: And we are proud to be able to join in this great work for the children of our Islands and Malta has a great part to play. Perhaps you will tell us about the origin of the movement in Malta?

LADY MOUNTBATTEN: It had always been my hope that while we were in Malta some link could be forged with The Save the Children Fun, and also with the International Union for Child Welfare. There is such a real love of children here and much to be done for them.

MRS. DEBONO: The same idea came to some of us who had been serving for many years as Charity Commissioners, especially in connextion with the administration of Milk Subsidies for mothers.

Child Welfare in Malta, together with medicine in general has made enourmous strides forward, but in common with other countries some of the problems of the post war period were natutrally not covered by existing service. For example, the very severe strain to which the girls who are the mothers of today were subjected due to the stringencies of war has been reflected in the difficulties young parents are finding in bringing up their children.

When we took the advice of the Government authorities as to what we could do to help in child health and maternity care, the way seemed open to start mothercraft and prenatal centres and the main function of the organisatiton will be to continue at the very beginning of child welfare before the babies are actually born.

LADY MOUNTBATTEN: Services of this kind really form the basis of our organisation and all this is being put into force and the Branch is being gradually built on these lines. While every tribute should be paid to the existing services there is undoubtedly room for more work in this field in order to reduce the mortality and suffering amongst children.

MRS. DEBONO: The Executive Committee have organised, with the advice and help of the Government, a team of Save the Children Fund workers who will actually visit the different towns and villages and will hold prenatal clinics for expectant mothers who may attend free of charge. These clinics are designed to help the doctors and midwives who actually deliver the baby. Where necessary, the mother's health will be built up by giving free vitamins. The chief aim of this scheme will be to teach mothercraft which will be done by the trained nurses and health visitors whose co-operation is so essential.

LADY MOUNTBATTEN: The magnificent response of so many doctors who are eager and willing to help in this scheme is most encouraging, and we hope as time goes on to form more teams and to enlarge the scope of our work so that every mother in Malta and Gozo may find free help and advice, and be cared for at our clinics. We have been fortunate in acquiring the services of Dr. Rene Eminyan and our nurse in the first class team is Miss Sylvia Parnis, both of whom have had considerable experience in this type of work abroad and in Malta.

MRS. DEBONO: We have also in mind the setting up of Day Nurseries to

help mothers with their children between the ages of two and five.

LADY MOUNTBATTEN: That is an excellent plan as these children do not appear to be included in any scheme at present, and from the time they leave the infant clinics to the time that they come under the care of the school medical officers, they often experience difficulties and ill-health. In many cases the mother has to go out to work and it is a vital necessity that there should be a well organised day nursery where she will know that her child is being well cared for while she is away from the home. It is also hoped to promote a scheme to help the unmarried mother, and her child, the crippled child or the child who is incapacitated in any other way, as soon as the first part of our programme is in motion.

MRS. DEBONO: The possibilities and aid to unfortunate children are boundless and even the needs of emigrant children can be met through the co-operation of our branches overseas.

LADY MOUNTBATTEN: When one is part of a big family where goodwill exists no child is looked upon as one too many, and no child is regarded as being outside the scope or range of The Save the Children Fund. There is no distinction of race, creed or nationality.

MRS. DEBONO: Yes, and our main purpose is to encourage the parents of Malta to bring up their children to be healthy and useful citizens of the future.

LADY MOUNTBATTEN: The motto of the Fund is SALVATE PARVULOS and that I know appeals to the heart of every parent in these Islands, where their devotion to their children is the dominant characteristic.

MRS. DEBONO: The principle aim of the Fund is to help parents to help themselves, thus ensuring that our children are healthy and happy from birth right up to the time they can stand on their own feet.

We have received most generous help from abroad to start our work, but we must naturally look to the people in our Islands to help us to continue and fulfil our aims.

The Importance of Bone Marrow Examination in Haematology

Dr. H. M. Micallef B.Sc., M.D., D.C.P.

Marrow biopsy was performed in 1903 by Pianese who punctured the epiphysis of the femur by a trocar. In 1908 Ghedini trephined the tibia in its upper third. Ghedini's method was employed for several years but it became evident that the tibia is one of the later bones to react to haemopoietic stresses. In 1923 Seyfarth trephined the sternum. The material obtained by this method can be used for preparing smears, wet preparations for supravital staining and blocks for sectioning. Sternal puncture which is simpler to perform than trephining was first proposed in 1927 by Arinkin. This method can be repeated at frequent intervals and is the method most widely used. In children the iliac crest is used.

Bone marrow biopsy is of great help in haematological work. It is of particular value in those disorders of the haemopoietic system in which no demonstrable changes are found in the peripheral blood and in those cases in which the peripheral blood changes are so slight that only very tentative conclusions can be drawn. In many disturbances of haemopoiesis marrow biopsy aids in prognosis and in the evaluation of therapeutic methods and it has contributed to elucidiation of pathogenesis and classification of certain diseases.

The value of bone marrow examination in different haematological disorders will be considered.

DEFICIENCY ANAEMIAS.

The diagnosis of the different types of deficiency anaemias can usually be made from the peripheral blood changes i.e. blood count and picture, red cell diameter Mean corpusclar volume, Mean Corpuscular Haemoglobin, Packed cell volume etc. Marrow biopsy helps to confirm the impressions gained from the peripheral blood investigations and acts as an index to effective therapy.

a) Macrocytic Anaemia. Pernicious Anaemia and other allied macrocytic anaemias are characterised by megaloblastic hyperplasia. Cells of the red cell series make up 30 to 50% of all nucleated cells instead of 20% or less. Most of the cells consist of promegaloblasts and different megaloblasts (basophilic polychromatophilic and orthochromic). These cells are of large size with delicate nuclear chromatin and deeply basophilic cytoplasm. Normoblasts are few in comparison to the megaloblasts. There is also abnormal leukopoiesis. Bizarre forms of metamyelocytes are frequent and these are associated with multisegmented polymorphs (macropolycytes).

Following effective liver or Vit B12 therapy the marrow picture alters with extraordinary rapidity. Within a few hours the typical megaloblasts are greatly reduced in number and their place is taken by normoblasts.

b) Microcytic Anaemias. In this type of anaemia the Bone Marrow differs fundamentally from that of Pernicious Anaemia. The Bone Marrow shows hyperplasia which is normoblastic in type. All stages of erythropoiesis are more numerous particularly polychromatophilic normoblasts with scanty irregular grey rim of cytoplasm. As the blood is restored to normal by iron therapy the cellularity of the marrow likewise becomes normal.

LEUKAEMIAS.

In leukaemias associated with a high leucocyte count marrow puncture is not of diagnostic importance as the peripheral blood changes are quite typical. It is in the diagnosis of aleukaemic and subleukaemic cases that sternal puncture is

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of great importance. These terms are generally used to refer to those cases in which the white count is normal or subnormal. The white count may be as low as 400 per c.mm. Persistent leucopoenia together with anaemia and thrombocytopoenia should always arouse suspicion of leukaemia. Immature white cells may be abundant or they may form only a small proportion of the circulating peripheral blood cells. Yet in the bone marrow these immature white cells are predominant and hence marrow puncture clinches the diagnosis. The increasing number of reports of aleukaemic leukaemias is probably due to more frequent resort to marrow puncture. This is fully confirmed by the increased number of aleukaemic leukaemias seen at St. Luke's Hospital Clinical Laboratory during the last 3 years.

LEUKAEMOID BLOOD PICTURES.

Certain diseases are sometimes accompanied by blood changes which if taken apart from the clinical picture may be suggestive of leukaemia. In difficult cases bone marrow examination at once settles the problem.

a) Glandular Fever may be confused with acute leukaemia especially if throat infection is also marked. In glandular fever there is no anaemia and no thrombocytopoenia. Although many of the leucocytes are abnormal very few of them contain nucleoli. Marrow puncture is chiefly of value to exclude leukaemia.

b) Tuberculosis. The marked leukocytosis which may occur consists chiefly of adult cells. The regenerative hyperplasis of the marrow is distinguishable from the disorderly proliferation of the leukaemoid marrow.

c) Sepsis. In sepsis most of the cells are adult granulocytes and the % of myelocytes is small.

d) Acute Infectious Lymphocytosis may simulate lymphatic leukaemia. The bone marrow does not show the great increase of lymphocytes seen in lymphatic leukaemia. The same applies to whooping cough.

e) Lymphadenoma may rarely show a very high white count. The marrow shows activity but no immaturity.

f) Intoxications. Myeloid blood pictures may sometimes occur in mercury poisoning mustard gas poisoning, in eclampsia and following serves burns.

g) Lymphosarcoma may be accompanied by leukaemic blood picture. This condition is termed leukosarcoma. There is no doubt that lymphosarcoma and lymphatic leukaemia are closely allied and Willis draws no sharp distinction between these two conditions.

LEUCO ERYTHROBLASTIC ANAEMIAS.

In this group there is anaemia with large numbers of nucleated red cells and few or many myelocytes in the peripheral blood. This condition may be found:

a) Secondary tumour marrow deposits. Sternal puncture may make the diagnosis of malignant disease but this is not an early diagnosis as such cases must have skeletal metastases. The tumour cells are foreign to the marrow and mostly recognisable but groups of cells are necessary to make the diagnosis. Histological examination of the marrow increases the reliabilit of the diagnosis.

b) Myeloma. In a number of instances marrow puncture decides the diagnosis and clarifies an otherwise obscure clinical picture if typical myeloma cells are found. These cells may or may not be found in the peripheral blood.

c) Myelosclerosis. Sternal puncture is valuable as a diagnostic measure. If the puncture is successful the picture is different from that of leukaemia. In the hyperplastic cases the florid picture of leukaemia is lacking. As the disease progresses the hyperplasia will lead to hypoplasia, aplasia and fibrosis. During the latter stages marrow puncture is characteristically unsuccessful and usually very little blood is all that is withdrawn.

APLASTIC ANAEMIA.

Sternal puncture is of great value in the

diagnosis and assessment of prognosis in this condition. In fact it is in the differentiation between aleukaemic leukaemia, aplastic anaemia and thrombocytopoenic purpura that marrow examination during life achieves its greatest usefulness.

The marrow may show the following pictures.—

a) Aplasia. The material obtained consists chiefly of red cells. 60 to 100% of the nucleated cells are lymmphocytes. Such a finding makes it desirable to obtain a larger specimen of marrow (by trephening) in order to be sure that one has obtained actual marrow and also to see how fatty the marrow is.

b) Maturation arrest with primitive marrow. The cells seem to be arrested at the myeloblast and myelocyte stages.

c) Hyperplastic Marrow the cells seem to be destroyed as soon as they enter in the peripheral blood.

PURPURA HAEMORRHAGICA.

A number of studies have shown that in this condition the megakaryocytes are plentiful but show various morphological changes. Platelet production appears to be greatly reduced. Dameshek and Miller (1946) found platelet production in only 8 to 19% of the megakaryocytes instead of 68.6%. Following splenectomy platelet production was found in 69 to 85% of the megakaryocytes. In acute Leukaemias and other diseases invading or destroying the bone marrow the megakaryocytes were greatly reduced although those remaining were of normal morphology.

HAEMOLYTIC ANAEMIAS.

Mylogram shows extreme hyperplasia of erythropoietic tissue with marked increase in proerythroblasts and basophilic normoblasts. 75% of the marrow cells may be nucleated red cells. Reticulocytes are very abundant. Relative granulocytopoenia is usual. Following splenectomy in Familial Haemolytic anaemia the marrow usually returns to normal.

In the infective and toxic groups of Haemolytic Anaemia the marrow changes are usually milder.

Di Gugliemo's disease is a disorder of the red cell series analogous to leukaemia. It is characterised by enormous erythroblastic hyperplasia.

GAUCHER'S DISEASE.

This rare disease of lipoid storage is characterised by splenomegaly, anaemia, leucopoenia, and thrombocytopoenia. This disease may frequently be diagnosed at an early stage by marrow puncture, where the typical Gaucher cells are seen.

Likewise the diagosis of *Niemann-Pick's disease* can be made by the finding of 'foam cells' in the marrow smears.

Hand-Schuller-Christian's disease. Fat storing reticulum cells may be found in the marrow and peripheral blood. Differential diagnosis on the basis of marrow findings only is not possible owing to the similarity of the cells. Diabetes insipidus exophthalmos and irregular bony defects form the three cardinal points.

KALA-AZAR.

Marrow puncture is of great help in establishing the diagnosis of Kala-Azar by finding the typical Leishmann-Donovan bodies in marrow smears.

Likewise marrow puncture may help in the diagnosis of malaria and in some cases of filariasis.

LUPUS ERYTHEMATOSUS.

In acute lupus enthumatesus the finding of L.E. cells in the blood or marrow establishes the diagnosis. The typical L.E. cell is a mature neutrophil leucrcyte which contains within its all membrane one or more masses of nuclear material called L.E. bodies.

Investigations into the metabolism of blood and marrow cells and into their defensive mechanisms and also tissue culture of marrow cells have produced results important in both clinical and academic fields. Though many problems still await investigation and solution, marrow biopsy has proved its value in diagnosis, prognosis and even in therapeutics and has given invaluable help in the elucidiation of many haematological problems.

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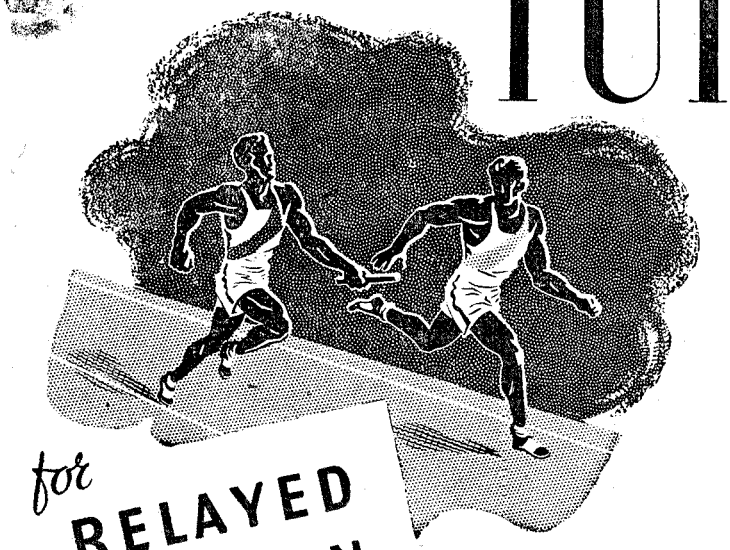

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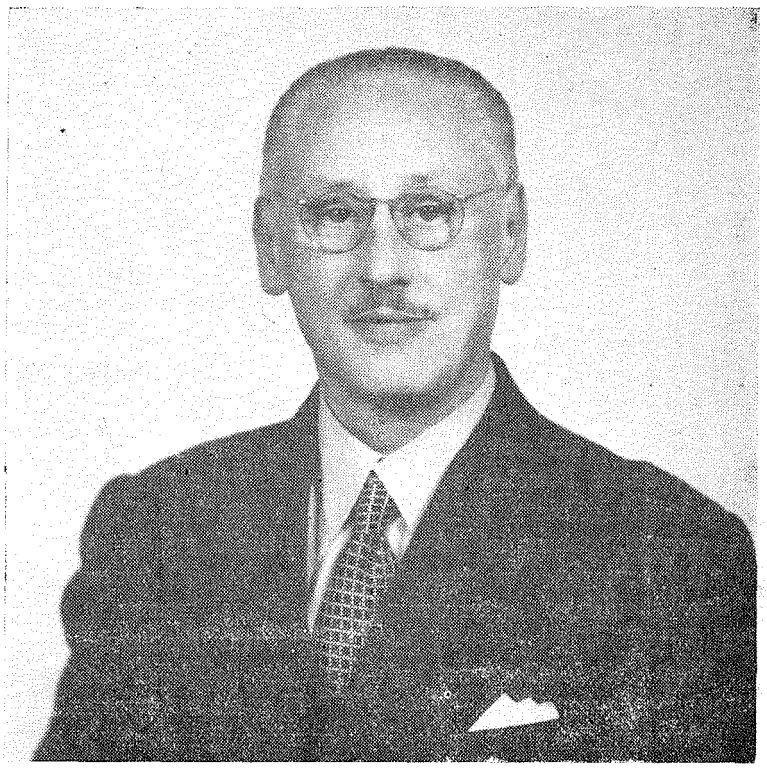
BIOGRAPHICAL SKETCH

PROF. VICTOR STILON.

Prof. V. Stilon was born at Valletta on the 11th. November 1898. After receiving his early education in the elementary school, he entered the Lyceum in 1909. He matriculated in 1915 and he graduated as Doctor of Medicine in 1922.

After graduating at the Malta University, he proceeded to Rome; and he was admitted as Honorary Assistant in the Medical Clinic of the Royal University under the direction of Prof. Ascoli. On his return to Malta, he was appointed A.R.M.O. at the Central Hospital.



From 1925 onwards, Prof. V. Stilon took up as a speciality Obstetric and Gynaecology. He went again to Rome, and he was admitted as Volntary Assistant in the Royal Institute of Obstetrics and Gynaecology under the direction of Prof. E. Pestalozza. He took part in scientific researches under the direction of Prof. R. Bompiani; and at the XXVI Congress of the Society of Obstetrics and Gynaecology which was held in Rome, he read a paper in conjunction with Prof. R. Bompiani on the "Premature Detachment of Placenta in the Rabbit". In 1929, he was appointed assistant to Prof. G. Debono who was the Professor of Midwifery and Gynaecology. And since 1930, he filled the post of Junior Accoucheur and Gynaecologist. As in 1951, Prof. J. Ellul relinquished the post of Professor in the University due to the age limit, Prof. V. Stilon became Senior Accoucheur and he was given the Chair of Midwifery and Gynaecology.

Besides Prof. V. Stilon was a thorough gentleman and his excellent manners made of him a good friend. His premature death which occured on the 25th. September 1952 at the relative young age of 54 distressed everybody who knew him especially members of the medical profession. With his death, Malta has lost a good Obstetrician and Gynaecologist and also a fine citizen.

DIARRHOEA

Dr. V. Captur M.D., B.Sc., Assistant Physician St. Luke Hospital.

The term diarrhoea translated from the Greek means flowing through. It implies, therefore, elimination of a non-solid i.e. liquid or semi-solid stool. Confronted with a patient complaining of diarrhoea, we want to know whether it is *acute* or *chronic*, in the latter case whether *continuous* or *intermittent*, furthermore, whether or not it is accompanied by *pain* and what kind of pain, by *fever*, and by *nausea* or *vomiting*. This first information from the history considerably restricts the larger number of possible morbid conditions that could account for the diarrhoea of the patient.

Acute Diarrhoea.

Acute diarrhoea in adults without fever and at first painless is most commonly due to *dietary indiscretion* (unripe fruit, spoiled food, poisonous mushrooms) or specific *food allergy*. In the case of alimentary origin, nausea and vomiting may accompany the diarrhoea. Colicky pain and tenesmus set in if very frequent bowel movement occur for some length of time. *Poisoning*, chiefly with arsenic, mercurial derivatives, carbon tetrachloride or excessive dose of laxatives should be kept in mind as possible aetiology.

Acute diarrhoea with febrile onset indicates an infectious cause. If the history suggests alimentary origin, acute enteritis, or gastro-enteritis, or enterocolitis due to food infection will be presumed (*Salmonella group*).

A typhoid-like clinical picture and course, especially enlargement of the spleen and leucopenia are highly suggestive of infection with *Salmonella paratyphosa*.

Bacillary dysentery (Shigella Flexner or Sonne) is another frequent type of food infection. It shows leucocytosis. Only bacteriological examination of the stool and blood at the beginning of the disease, and agglutination tests with the blood serum not before the second week of the illness can yield definite aetiological diagnosis.

Staphylococcic toxins will be suspected particularly if milk or milk products are apparently involved in mass outbreaks of food poisoning, and if the incubation period had been not more than 2-3 hours. Inadequately sterilised or contaminated canned vegetables are the most frequent source of *Botulism* which may begin as acute gastro-enteritis before the severe cerebral manifestations, usually first visual disturbances, become apparent.

Acute diarrhoea may be the main or initial symptom of a great many infectious diseases — bacterial, viral, protosoan or metasoan. Besides the previously mentionel bacterial infections, *typhoid fever*, *bacillary dysentery* of the Shiga type and *cholera* are those epidemiologically most important.

Not only the clinical symptomatology but also the gross appearance of the diarrheic stool is of diagnostic importance. The high yellow appearance in typhoid fever, the pink, watery elimination without any faecal masses in dysentery, and the rice-water like stool containing mucus and cellular debris in cholera are characteristic.

The most important protosoan disease causing diarrhoea is *amoebic dysentery*. *Ballantidium coli*, may in some persons produce the symptoms of true dysentery. Whether *Giardia intestinalis* is actually pathogenic and capable of producing severe diarrhoea is still a matter of debate.

Diarrhoea may occur as one of the symptoms of a localised or otherwise welldeprived acute abdominal disease other than enterocolitis. It may occur in *acute appendicitis, in mesenteric thrombosis* or *embolism*, or in *intussusception*, or *pneumococcic peritonitis*. Diarrhoea stool con-

taining blood and mucus and accompanied by violent colic may also occur in *Henoch's purpura*.

Causes of Acute Diarrhoea.

(a) *Food indiscretion* e.g. unripe or over-ripe fruit and poisonous mushrooms.
(b) *Poisoning* Arsenic, Mercury, Zinc, Lead, Carbon tetrachloride
(c) *Purgatives* Overdosage.
(d) *Allergy*
(e) *Infections* Acute fever of childhood
Infective Salmonella
Staphylococcus
C. Botilinus
Typhoid and paratyphoid
Cholera
Bacillary dysentery
Amoebic dysentery
Lambliasis
Balantidium Coli.

Investigations in cases of Acute Diarrhoea.

(a) *History* — Duration; pain; nausea and vomiting; fever; occupation; kind of food ate; whether other persons affected.
(b) *Physical examination*
(c) *Laboratory Tests* — White cell count.
Examination of the faeces for parasites.
Culture of faeces.
Blood culture.
B.S.R. .
Examination of gastric contents.
Urine for nephritis and mercury.

Causes of Chronic Diarrhoea.

(a) *Accompanying chronic intestinal disease* :—
i. Ulcerative colitis
ii. Regional ileitis
iii. T.B. enteritis
iv. Actinomycosis
v. N.G. colon
vi. N.G. rectum
vii. Papilloma rectum
viii. Granuloma venereum (Frei test)
ix. Proctitis (gonococcic, T.B., syphilitic, dysenteric)
x. Faecal impaction.
(b) *Due to deficient gastric digestion* :
i. Hypochloridia and Achloridia
ii. Pernicious anaemia
iii. Addison's disease
iv. Chronic alcoholism
v. Gastro-enterostomy
(c) *Due to defecient Carbohydrate metabolism*.
i. Fermentation diarrhoea
(d) *Due to defective fat absorption* :
i. Biliary and pancreatic disease
ii. Coeliac disease
iii. Sprue
(e) *Due to nutritional deficiency* :-
i. Pellagra
ii. Sprue
iii. Hill Diarrhoea
iv. Avitaminosis
v. Tropical macrocytic anaemia.
(f) *Due to neurogenic defects* (paraysmpathetic overstimulation)
i. Anxiety neurosis
vii. Post — prandial
iii. Thyrotoxicosis
iv. Irritable spastic colon
v. Mucous colitis

Diagnosis of Chronic Diarrhoea.

1. *Chronic enterocolitis.* This can be caused by various infections and is often the aftermath of acute dysentery. Diarrhoea often alternates with constipation. Sensation of fullness and floating, tenderness and anorexia are frequent symptoms.

2. *Catarrhal colitis.* Here there is no evidence of poorly digested food but grossly visible mucus is usually found in the liquid or semi-solid stool. The differentiation of a chronic catarrhal colitis from an allergic or neurogenic type of an irritable colon is not always easy. An anatomical lesion of the colon can be substantiated only by a visible catarrhal condition of the pelvic colon by sigmoidoscopy or by signs of mucosal defects on good X-Ray pictures.

3. *Allergic mucous colitis.* Large amount of glairy mucus frequently covering hard stools and white membranes floating in the stool, often with numerous eosinophilia both in the stool and in the blood, and the general clinical picture of the nervous patient will clear the diagnosis.

4. *Catarrhal ileitis and jejunitis.* This can be suspected if there is evidence of insufficient digestion and absorption of food. The rapid passage through the small intestine does not permit a normal utilisation of the food, and striated muscle fibres, fat and undigested remnants of carbohydrate may be found in the diarrhoeic stool after a standard test meal. X-Ray gives valuable information. The barium meal frequently reaches the colon within 1-2 hours instead of at least double that time. Fluid levels in the small intestine may indicate exudation in the lumen or abnormal fermentation.

5. *Fermentation diarrhoea.* The stool has an acid reaction, smells sour, and gas bubbles give it a frothy apearance. Restriction of carbohydrates in the food may produce a change from fermentation into a putrefactive stool, restriction of protiens may do the opposite.

6. *Sprue Syndrome.* This consists of an impairment of the intestinal absorption of fat, fat-soluble vitamins, and some carbohydrates. The stools, therefore, are liquid or semi-solid, frothy, of light colour, rancid odour, acid reaction, and contain large amount of fatty acids and soaps as well as small quantities of neutral fat. Contrasting with the much less marked steatorrhea of chronic enteritis there is no blood or pus in the stools. The considerable nutritional defeciency caused by the impaired intestinal absorption results in weight loss, general weakness, anaemia usually of the hyperchromic macrocytic variety, hypoproteinaemia and painful lesions of the mouth and tongue. Deficient absorption accounts for hypocalcaemia and consequently for the frequent association of sprue with tetany and decalcification of bones. Serum phosphorus is usually low, too. Dextrose tolerance test shows flow curves if dextrose is administered orally; the curves are, as a rule, normal if the dextrose is given i.v.i. In some instances of the sprue syndrome, the liver is enlarged and its function impaired. On X-Ray examination, distrubed motility, segmentation and flocculation of barium, and alternation of the mucosal pattern of the small intestine are to be found (so called 'deficiency pattern'). Aetiologically different varieties of sprue syndrome may be encountered. Distinction between tropical and non-tropical sprue is not justified in any way. Idiopathic steatorrhea and coeliac disease of early childhood are clinically identical sprue syndromes. In these cases of idiopathic or primary sprue no specific or significant anatomical alterations have been found at necropsy.

7. *Pancreatic disease.* Here also we get bulky stools but we find chiefly unsplit neutral fat (as compared with fatty acids and soaps in sprue) and striated muscle fibres. Pancreatic ferments are present in the duodenal content in sprue as constrasted with pancreatic insufficiency.

8. *Pernicious anaemia.* The blood picture and the findings of the test meal are diagnostic.

9. *Achylia gastrica.* It is questionable whether achlorhydria, per se, causes diarrhoea.

10. *Pellagra.* The deep red colour of the tongue and the association with dermatological and neurological manifestations of pellagra are of diagnostic importance.

11. *Hyperthyroidism.* This causes diarrhoea by increasing nervous stimulation of intestinal motility. The signs and symptoms of thyrotoxicosis usually clinch the diagnosis.

12. *Addison's disease.* Repeated severe attacks of diarrhoea, after alternating with periods of obstructive constipation, and accompanied with colicky pain and vomitus are a typical occurrence in Addison's disease.

13. *Anxiety neurosis.* Diarrhoea is a common expression of fear and anxiety. It is usually associated with other features of the anxiety state.

14. *Ulcerative colitis.* The patients may have up to 15 or more bowel movements per day. The stools contain mucus, pus and blood. Cramps, borborygoni, and tenesmus are quite comon. There are usually moderate fever, tachycardia, leucocytosis and increased E.S.R. The diagnosis will be ascertained by procto-sigmoidoscopy and X-Ray. The former shows haemorrhagic spots and ulceration of the mucosa, the latter reveals a tight, ribbon-like spastic colon without haustration and a frizzy, irregular marmorisation of the mucosal pattern.

15. *Regional ileitis.* Diarrhoea, colicky pain, low grade fever, anaemia, and in some cases an ill-defined palpable mass are the clinical manifestations. X-Rays show a 'string-sign' deformity of the terminal ileum which appears as narrow irregular cord, devoid of its normal mucosal markings. Irregularly constricted and dilated loops with localised barium residues may be seen if higher intestinal segments are involved. It may be confused with appendicitis, T.B., or actinomycosis of the ileocaecal region, neoplasms of lymphomatous processes.

16. *Intestinal tuberculosis.* This can cause persistent diarrhoea. It will be suspected in persons with pulmonary or other localisations of T.B. Occasionally it may appear as a palpable, chronic inflammatory mass in the right lower abdominal quadrant. Diarrhoea in tuberculous patients, however, is no proof of intestinal localisation of the process, not even if Koch's bacilli are found in the stools. They may be eliminated with the stool if infective sputum is being swallowed. Occult blood in the stools of such patients, however, may be an important sign.

17. *Actinomycosis.* This has a predilection for the ileo-caecal valve region. It has a particular tendency to form sinuses and fistulate penetrating the skin. Microscopic examination of the purulent discharge will reveal the characteristic fungi.

18. *N. G. colon.* Clinical and X-Ray diagnosis.

19. *N. G. rectum.* Rectal examination. Procto-sigmoidoscopy examination. If high up, X-Ray.

20. *Granuloma venereum.* Frei test diagnostic.

Laboratory examinations of value in chronic diarrhoea.

1. *Recto-sigmoidoscopy—*
   (a) Culture the material directly from involved colon.
   (b) Examination for amoeba and bacilli of dysentery.
2. *Examination for ocult blood.*
3. *Carmini test.* The use of the carmini capsule may be of value in estimating gastro-intestinal motor function. The patient is asked to note the time interval between taking the capsule and first staining of the faeces.
4. *Gastric content.* Test meal.
5. *X-Ray chest and sputum for T.B.*
6. *Urine.* To exclude chronic nephritis.
7. *Blood.* To exclude pernicious anaemia, leukemia and lead poisoning.
8. *B.S.R.* Against B. Shiga (at least 1 : 50)
   ,, B. Flexner (at least 1 : 300)
   ,, B. Sonne (at least 1 : 100)
9. *Frei test.* Should be done in all cases with a history of venereal disease.
10. *X-Ray examination.*

References.—

1. Meakins J.C. "The Practice of Medicine" C.V. Mosby Company St. Louis.

2. Hurt, Sir A. in Portis' "Diseases of the Digestive System" Lea and Febiger Philadelphia (1946).

3. Bauer J. "Differential diagnosis of Internal Diseases" Greene and Stratton N.J. (1950).

THE TIME HAS COME....

By THE WALRUS

As I was remarking to the Carpenter the other day the time has indeed come to talk of many things. However, it would be tedious to discuss the usual topics of cabbages and kings. We might for instance talk of oyster beds, or rather students quarters as I understand they are called. They are a sad and sorry sight, quite out of harmony with the rest of St. Luke's. When I enquired who was responsible for the maintainence of these quarters the old Chesire cat just grinned and disappeared. It seems that the hospital authorities provide the rooms and the University is supposed to do the rest. Whatever the arrangement is, it does not work. The matter calls for a closer liaison between the two bodies. The whole root of the trouble is that neither appreciate the position of a senior Medical Student. They tend to regard them as schoolboys or as necessary evils to be tolerated with the barest amount of recognition. This is quite absurd. It is bound to have a very bad effect on the finished product, the Doctor. In no country in the world, let alone one with a civilisation as old as ours, with a medical tradition stretching back to the dim days when people flocked to the ancient temples, which adorn our shores, for treatment, are medical students so shabbily treated. In other medical schools and teaching hospitals the students are regarded as an important and welcome part of the organisation and no effort is spared to turn out as fine a doctor as possible. It is essential that besides adequately furnished quarters for the students sleeping at Hospital, there should be rooms where they could study, if not in comfort, at least in quietude and also arrangements for students to have a decent meal if they have to stay in hospital. The rooms require someone to look after them. The present arrangement is most unsatisfactory. A large sum of money was allotted to the University for the building of Science Laboratories and a Students Union. Where and how is the money being spent? I have full confidence in the ability of the University to spend the money honestly if not wisely. I suggest that if it is not feasible to build a new club for the students some of the money should be spent on improving the Quarters of senior medical students at St. Luke's. I believe a tennis court was included in the plans of the Hospital. It is almost too much to hope that the hard worked staff should ever enjoy the benefit of a few minutes relaxation on this bit of concrete which must ever exist "in my minds eye, Horatio".

There are of course several other things I must talk to Alice about, but I hear the Black Queen coming along the corridor muttering "Off with his head, off with his head."

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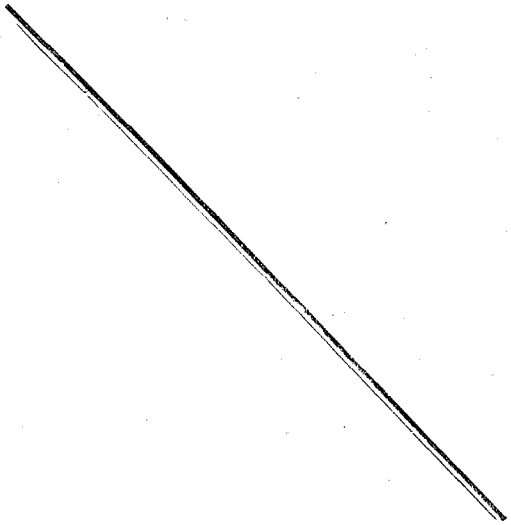

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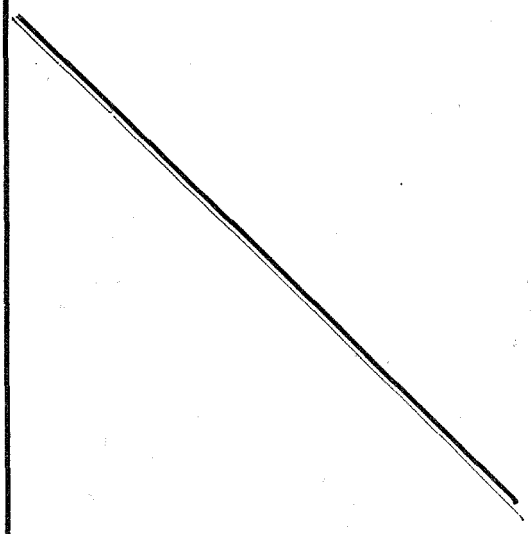

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