JOURNAL OF THE COLOMBO GENERAL HOSPITAL

Vol. 2 OCTOBER 1971 No. 4

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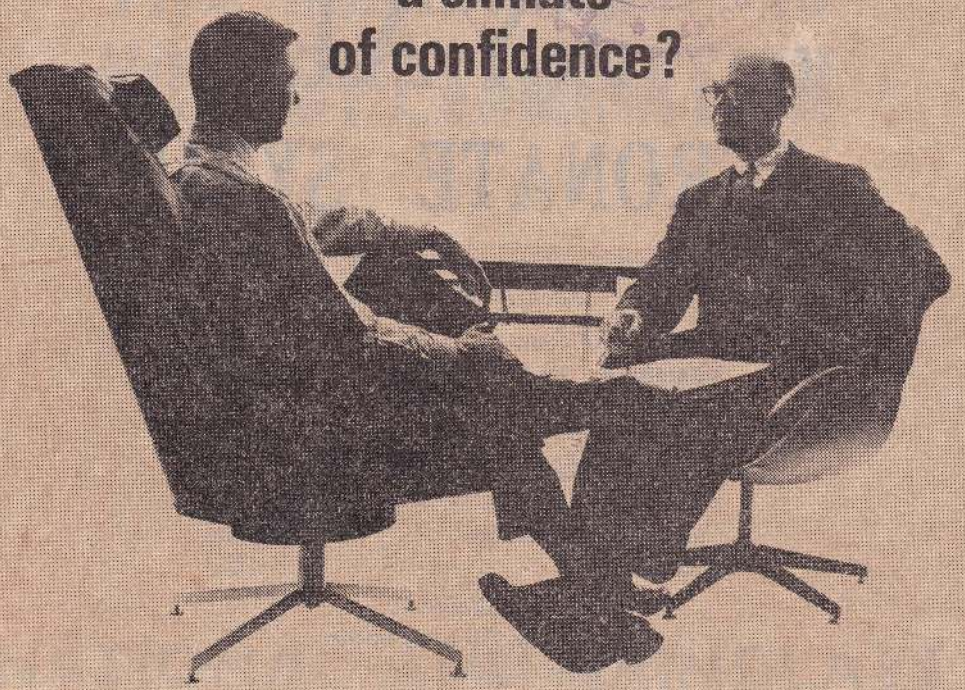

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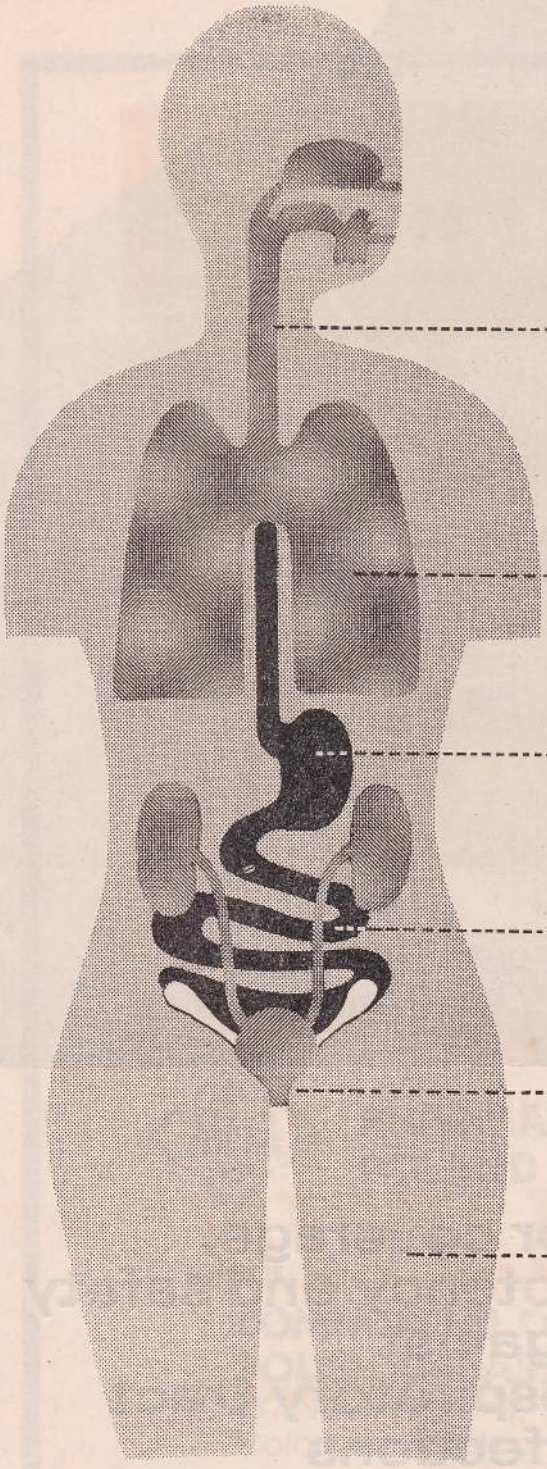

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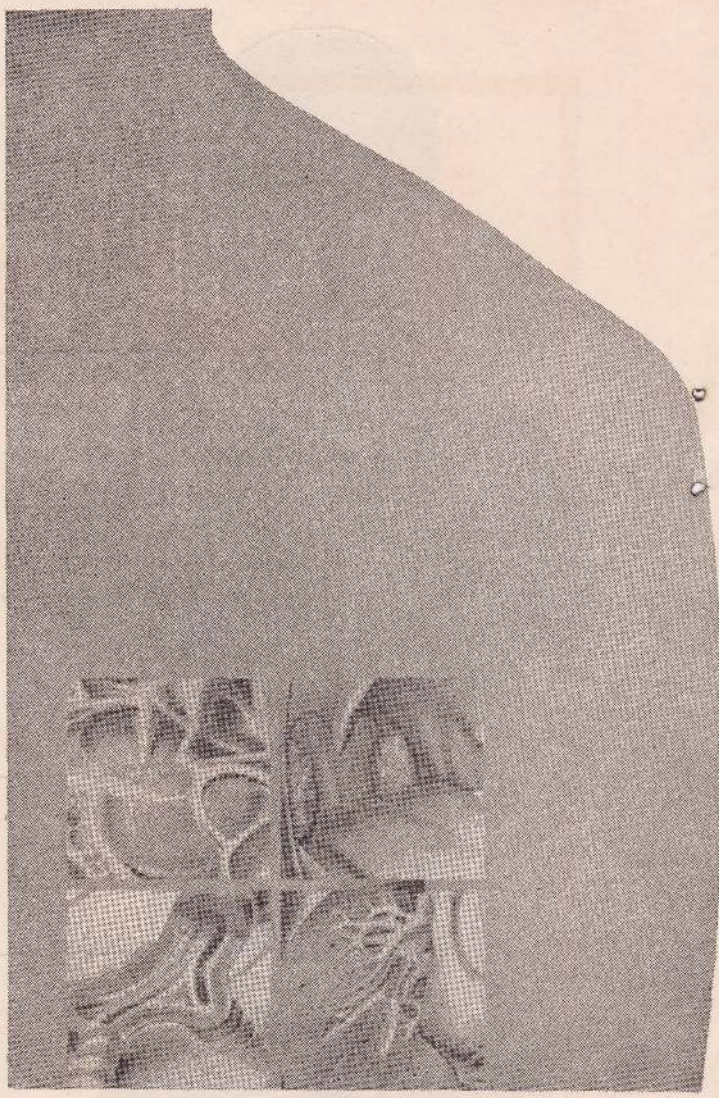

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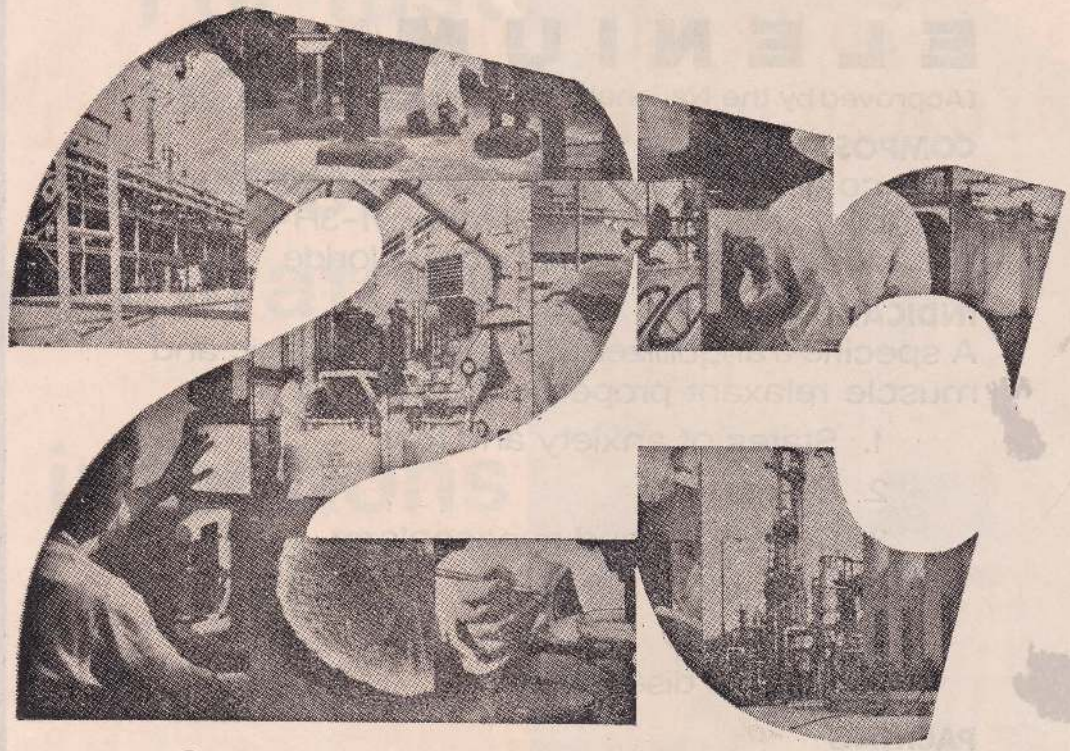

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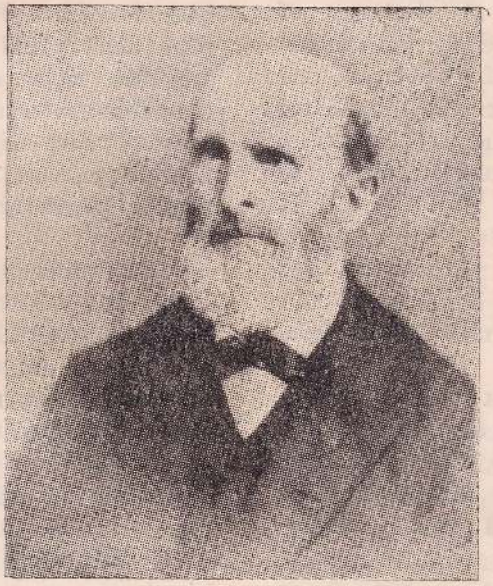

Dr. SAMUEL F. GREEN, M.D.
1822 - 1884

B. Amirthanayagam Mills M. R. C. O. G., F. I. C. S.
Obstetrician - Gynaecologist General Hospital Jaffna.

Dr. Samuel Fiske Green was one of the most outstanding men of the last century who worked in our country. His whole life was characterized by untiring selfless work with a sense of devotion, dedication and purpose. He was a pioneer in every sense of the word. He not only founded hospitals, but also initiated scientific medical training in this country, and established the first Medical School in Ceylon. What is more remarkable was that he left to the Tamils, access to western medical science in their own language as a lasting and permanent contribution.

Samuel Green, son of William E. Green and Julia Plimpton was born at Greenhill, Worcester, Massachusetts on 10th October, 1822. He was the eighth in a family of eleven children and was educated at public schools. Early in life, under the wise guidance of his father, he acquired good habits of study and discipline which were to fit him so admirably for his later career.

In October 1841, at the age of nineteen, he enrolled himself for professional studies at the College of Physicians and Surgeons of New York. He graduated on 13th March 1845 and set himself up in practice at his native town of Worcester.

While practising at Worcester, Dr. Green was moved by the heroic adventures narrated by two saintly missionaries from Ceylon, one of whom was Dr. John Scudder, the world's first medical missionary. This experience overwhelmed Dr. Green and he immediately decided to accept the challenge to come out to the East and throw in his lot with Jaffna.

Dr. Green sailed from Boston on April 20th 1847, arrived in Madras on September 4th and in Jaffna on October 6th, having ridden 205 miles on horseback to cross the Palks trait. Soon after his arrival, the following incident occured and writing about it in 1884, Dr. E. Waitilingam, one of Dr. Green's first batch of students and later an Assistant Colonial Surgeon at Mullaitivu, records : " In the year 1847, there were very few English doctors and none among the Tamils of Jaffna who had any idea of European practice. The Jaffnese would not dare to gainsay their own physicians. Mr. Muthuthamby, a Tamil and Sanskrit Pandit (my uncle) became seriously ill. The native physicians, including my father, who had been treating him gave up his case as hopeless. After much hesitation and long consultation it was decided to call in Dr. Green. Dr. Green diagnosed the case as abscess in the abdomen and advised immediate operation. I bravely responded to it and the patient was also willing. Dr. Green cut open the abscess and cured him." The doctor's fame spread throughout the peninsula. 'The doctor had removed the bowels out, adjusted them and refixed them'. Ignorance and prejudice were overcome. Dr. Green's reputation as a surgeon was quickly established. "Five days later Dr. Green had a dozen patients, then a few, then enough, then a swarm and then a rush."

It is difficult now to imagine the conditions that obtained in the country at the time that Dr. Green commenced his work here. Communication between the various parts of the country was extremely difficult. Proper roads had not yet come into existence. Access to the north was along the west coast of the island and it was a mere track through jungle from Chilaw northwards In fact the north of the island was practically unknown to the people of the south. Regular steam boat communication by sea commenced only in 1859.

The only hospitals in existence at that time were the Military and Prison Hospitals. Cadjan sheds served as Quarantine Cholera and Small Pox hospitals. Hardly any civil medical work was done by the government. The Civil Medical Department was founded only in 1858.

Prior to Dr. Green's arrival, Rev. Dr. John Scudder had practised medicine at Pandateruppu for 16 years from 1820 to 1836.

His successor Dr. Nathan Ward had practised at Vaddukoddai from 1833 to 1847. They also trained a few young men to help them, but the medical teaching initiated by them had not been on any organized basis.

Dr. Green soon after his arrival surveyed the field and assessed his opportunities. There was neither a medical school in the country nor a civil medical department. The Government had very few doctors of its own. In Jaffna, there was no hospital or dispensary of any kind except the Military Hospital inside the Fort. It was also a time when ignorance and superstition was rife and the people were generally in the hands of untrained physicians for medical relief. Dr. Green was appalled at the suffering people underwent under the native system of medicine. Therefore, he decided that for his work to be of any lasting benefit to the people whom he chose to serve, he should "stud the province with well educated physicians" to carry on the work among their own people after he left. With this aim in view, he embarked on his mission of healing, teaching and preaching.

In February 1848, he shifted his place of work to Manipay, which he considered a more central place. Having set up his dispensary there, he organised the Mission Medical School giving instruction in western medical science. He hand picked his students from the Batticotta Seminary. The medium of instruction was English. He organised a regular course of studies in medicine and surgery to small consecutive 3 year classes. The medical curriculum was based on the same lines as those followed by the medical faculties of the American Universities of that time. The students had to use standard text books on each branch of medicine and pass an examination at the end of their course. In 1861 - 64, the following books were in use:

1. Anatomy by Wilson.
2. Physiology by Carpenter.
3. Chemistry by Constock.
4. Dispensatory by Christison and Griffith.
5. Physician's Vade Mecum by Hooper.
6. Surgery by Druitt.
7. Dublin Practice of Midwifery by Mansell.
8. Diseases of Children by West.
9. Diseases of Women by Churchill.
10. Medical Jurisprudence by Taylor.

The students had to attend the Mission Dispensary regularly and twice weekly clinics at the Friend - in - Need Society (F. I. N. S.) Hospital at Jaffna. After they were successful at the examination, the students had to gain practical experience of one or two years under supervision before the certificate of qualification was issued. The first batch of students graduated in 1850.

Soon after his arrival, Dr. Green struck up an intimate friendship with Mr. Ackland Dyke, then Government Agent of Northern Province and was largely instrumental in helping Mr. Dyke to found a General Hospital in collaboration with the Friend - in - Need Society of Jaffna. The hospital became a reality in 1850 when Dr. Green's first batch of students passed out. Dr. Green functioned as its Visiting Surgeon almost throughout his stay in Jaffna.

From its inception in 1850 till 1900, for a period of 50 years, the F. I. N. S. Hospital was worked by doctors educated by Dr. Green in the Mission Medical School. They were doctors Gould, Town, Evarts, Danforth, Mills and Paul. The F. I. N. S. Hospital went under the Civil Medical Department in May 1907 and is now the Government General Hospital, Jaffna.

In 1852, on Mr. Dyke's recommendation, the Government voted a grant of £ 50 to the Mission Medical School. The Committee which went from Colombo to examine the educational institutions supported by the government referred to Dr. Gould, the first Resident Surgeon of F. I. N. S. hospital, as possessing acquirements quite equal to those of the majority of young men who enter the medical profession in England. The grant was raised to £ 100/- in 1867 and to £ 200 in 1873.

Dr. Green was in constant touch with Mr. Dyke and collaborated with the government in all matters connected with the F. I. N .S. hospital and affording medical aid to the people in general. In 1851 to 1855, there were epidemics of cholera and small pox in Jaffna. With the sanction of the government, Mr. Dyke used the services of Dr. Green and his students to combat the epidemic. Dr. Green contracted cholera himself and barely survived it. Thereafter, Dr. Green devoted himself to the prevention and cure of cholera in Jaffna and when another epidemic broke out in 1866, the government distributed Dr. Green's tracts by the thousands and adopted his methods to combat the disease.

Dr. Green always considered himself a missionary first and being a physician was secondary to him. Regarding his decision to be a missionary, he wrote to one of his sisters soon after his arrival here "I have experienced no regret for my decision and no doubt of its wisdom". In January 1849, he wrote to his brother John "You say in your letter 'come home'. Now I can give you more reasons why I should not come home. I feel more and more convinced the longer I stay here, that here I ought to stay ; that God has shown me that it is both my duty and privilege to remain here so long as I have health to be useful". In one of his letters to his father, Dr. Green wrote : "Your letters are pleasant to me and I am thankful to you for them. But there is one feature in them which painfully affects me - they speak almost of this world. They do not speak with joy of the world to come as a place of rest after your hard life is over. What theme than this is more appropriate for one whose head is silvered by age and whose cheek and form declare that he will soon be launched in that unseen eternal world ..... Excuse me if over earnest and put it down to the love of your affectionate son.". Those who came in contact with Dr. Green had no doubts as to his spiritual fitness to be a missionary.

The extensive correspondence that Dr. Green left behind (Cutter 1891) gives much information regarding his early experiences and impressions in Jaffna and throws very valuable light on the medical, social and educational environment of that time.

Writing to his brother John in January 1849 describing the work he was doing here, Dr. Green states : "Let me tell you a little of what I am doing. I came out here to take medical care of, first the missionaries and secondly of whoever of the natives who applied to me for aid .....

the number on the register today is 2544 (in 13 months). Many of these are surgical cases, one-third of them or more. I have removed lots of tumours, have operated for cataract several times, for strangulated hernia once, amputated the arm once,.... removed several cancers, amputated fingers toes and portions of hands several times, treated a good many fractures and severe burns, attended some very bad cases of childbirth ..... Last Monday, I removed the left upper jaw and cheek bones for a cancerous fungus in the Antrum filling the whole mouth and left nostril. Yesterday couched a cataract, today after attending the most necessary cases, have been dissecting a fine subject with my students".

There is no reference to whether any form of anaesthesia was used by Dr. Green. Since anaesthesia was first used in 1846 at Boston, Dr. Green must have been aware of it before he came to Ceylon. It is possible that Dr. Green used some form of anaesthesia for his extensive surgical work, at least, later on in his career here and might have even been the first to use anaesthesia in this country.

Dr. Green records an experience with a Brahmin thus: "A Brahmin wished me to examine his wife's case when no crowd was present and to avoid touching her or putting any instruments in her mouth. I told him that I should not touch her more than was requisite and he need not fear pollution, for I should wash my hands immediately before, and she would not pollute me as I should wash them just afterwards."

Regarding an encounter with a native physician, Dr. Green writes: "A famous practitioner in Manipay brought me one of his patients. I showed him some anatomical plates. He had been in practice for 42 years and said that he had never noticed two kinds of blood - blue and red; that he never saw any of the vital organs of the body. I explained the heart and blood vessels and their connection with the pulse. He had the old notion that pulse is the motion of air within the body." In this connection, Dr. Green described his attitude towards the native system of medicine thus: "The medical missionary should investigate the native systems of medicine, know the native doctors, fraternize with them as far as possible, consult with them when desired, communicate information freely, assuming no appearances of superiority and drawing out their views and experiences." It is surprising that this attitude to the Ayurvedic system of medicine was adopted by a foreigner in our country over a hundred years ago. One is not sure whether the Ceylon Medical Council would approve of it even now.

Dr. Green commenced his study of Tamil even before he left Boston and diligently pursued it. Within 18 months of his arrival here, he was able to preach in Tamil and at the end of three years he wrote" I have now got so far that I can begin to enjoy the language and see the ludicrous usage of the uneducated natives as it differs from the pure classic speech of the refined. A vast amount of labour has been expended in polishing the language of this people. Having naturally acute minds, fond of metaphysics and knowing no true science upon which to expend their powers, they have lavished thought and ingenuity on their vernacular tongue. It is said that a man may be a diligent scholar in Tamil for 50 years and yet meet with works in the language which he cannot read !!

Dr. Green conducted a census on literacy among his patients and worked out that of the 422,000 inhabitants in the province, there were about 132,000 who could read, of whom 2600 were women. Comparing this with the observation of Rev. Meigs that in 1816 there were only two women who could read, Dr. Green comments: "The number of female readers in 1852 is prophetic of a period, not far in the future, when the education of women would be as nearly universal in the province as it is now in the Western countries."

Dr. Green deprecated the pride and self importance, consequent upon Western education and the adoption of the habits of the foreigner, so far as it tended to destroy the usefulness of the educated nationals among their own people. Observing the change that was occuring in Jaffna among the educated nationals. Dr. Green wrote "I begin to think that the change here will be from waist cloth to pants, from a scarf to a coat, from a turban to a hat, from vegetarianism to carnivorism, from a hut to a house and so on till many get denationalised. I would rather see here Christian Hindus than Hindus Europeanised.....I hope by going into vernacular education to get some doctors, who will in native dress start off afoot in response to calls and not demand a horse and carriage to be sent. and a heavy fee also in addition. This aping European habits is very well in moderation, but young Jaffna overdoes it!"

Dr. Green had discovered early that the nationals desired to be taught in English in order to be eligible for lucrative positions under the government. He felt that the only way to get them to settle down as physicians in their own villages, to be of maximum use to their own people was to educate them in the vernacular alone, as far as it was possible. Dr. Green's policy was disliked by his fellow missionaries as well as by the government. When he applied for government aid to publish medical literature in Tamil, his request was refused because "the non-English policy pursued by the mission was, in the Governor's view, disastrous and suicidal. Similar views were expressed by some of Dr. Green's friends in India who felt that a physician educated in Tamil would be at least ten years behind those educated in English. Dr. Green's contention was that they would still be a thousand years ahead of the native physicians. Because he decided to teach in the vernacular, Dr. Green quickly mastered the Tamil langauge and added to his linguistic list of Latin, Greek, German and French. Because he taught in Tamil, he had to provide books in Tamil. Therefore he initiated a new service and set himself the tremendous task, with the help of his students, of translating the standard medical works of his day into Tamil.

Since Dr. Green was left largely to his own devices to raise funds for his medical literary work without the help of either the Government or the Mission, he adopted a self sufficiency plan as a practical solution which incidentally gives us an idea as to how he intended deploying his doctors to work in the province. Dr. Green writes: "I am anticipating before long to make an effort to put the dispensary on a paying basis getting people to pay for their medicines first, and eventually for the physician's skill and trouble and surgical operations. I think of putting Reid and McIntyre into partnership and letting them get out of the profits of the Surgery and Dispensary their salaries without any expenses to the Mission. After 3 years or so, I hope to set off one in his own village and associate one of the younger doctors with the other; and then,

after a while, set off the second one in his village and bring in another student into partnership; and thus two juniors will carry on the business and hand it down to their successors. I intend to send all patients from the regions of these set off practitioners to the one in their neighbourhood with prescriptions and notes of advice and let the patients put themselves under the doctor's care. So step by step, I hope to get true scientific medicine planted in the land which being done, I have no fear as to the result."

At about this time Dr. Green wrote to his sister Mary thus: "I hope to have my doctors stationed through the country, well read, practical men. I hope they will feel bound to do what they can to promote medical practice on true principles. I hope to rout the superstitious practice of the native doctors or at least to begin that rout in the belief that, ere many generations, it will be completed. I want in my day to give an impulse to change for the better in all things medical in the land, to be a reformer in my department here, to practise, to write, to teach, to encourage truth in medical men and things. The Lord prospers me much and I cannot but feel greatful to him."

In a greatly weakened state of health, Dr. Green left on furlough for America on 5th October 1857, almost ten years to a day after he set foot on this Island. During his four years of stay in America, while recuperating his health, Dr. Green kept himself extremely busy in the interest of his mission work. He spent time selecting the best editions of books for translations, obtaining blocks for illustrations and favours from publishers. He conferred with theological students and lectured to medical students. He improved himself professionally by visiting hospitals, attending lectures and witnessing advances in operative techniques. He appealed for funds for his work from the leading physicians and clergymen of New York in which he stated: "It is the definite aim of this enterprise to displace a false, by a sound medical practice; to supercede cruel superstitions by kindly truth; to root among the millions speaking the Tamil Language a system of physic and surgery, correct in its literature and practice, that being self sustained may long endure".

On 22nd May 1862, Dr. Green married Miss Margaret Phelps Williams and sailed for Ceylon 4 days later, arriving in Manipay on 19th October.

After his return from furlough, Dr. Green continued his mission medical work at Manipay, his visiting post at the F. I. N. S. hospital and the medical classes. In addition, he assumed the Superintendentship of the F. I. N. S. hospital as this position put the hospital directly under his control and afforded a better opportunity of instruction in practical anatomy and demonstration of surgical operations to his students. On 7th August 1863, Dr. Green records: "Dr. Danforth (Resident Surgeon of F. I. N. S. hospital) sent me a note saying two chank gatherers had been severely bitten by a huge shark. I saw them this morning. One has 4 bad deep large bites in his left thigh and the other has his right thigh bitten off leaving as stump the upper third. We sawed off a bit of the bone which projected for about 3 inches; performed Sim's operation on an unhappy woman; and tapped a moorman making out a pretty good surgical clinique for the 13 students and 3 doctors present". At about this time, Dr. Green had about 8000 cases annually at the F. I. N. S. hospital.

During the second term of service, Dr. Green concentrated on the task of Tamilizing western medical science. With

the help of his students, he pursued with vigour, the work of translating standard medical text books into Tamil. By 1864, Dr. Green felt confident that he had sufficient medical literature in Tamil to start a class of 11 students who were to receive their entire medical instruction in Tamil.

Dr. Green made many observations on the technique of putting medical science into the vernacular, which are of special interest to us today. He stated: "Mere translations are comparatively useless. It is better to devise one's own plan and compile freely from many authors, taking their ideas only. But sometimes, it may be best to select a well planned elementary treatise and use this as the basis of the Vernacular issue, which may prove to be a compilation, translation and original work combined - interleave it, add, erase, transpose matter, remodel sentences, phrases and figures so as to adapt the work to the language of the people. Every book should be in simple clear style and freely illustrated by cuts".

Once on being dissatisfied with a translation, he wrote: "The translation, requires so much alteration that it amounts to ploughing one's way rather than a walk of survey over the whole field..... this translation is generally the English words in grammatical Tamil. What is wanted is the idea in idiomatic Tamil. Through this translation, one can see only the Englishman; one should see only the Tamilian. Experience demonstrates that both languages must be represented, each by its native, in order to achieve a satisfactory result. My expectation that western ideas can be transplanted in their integrity by even the most accomplished Tamilian is illusory. I have to do over nine - tenths of all the translations prepared for my revision".

On another occasion, writing to Dr. Chapman, he said: "Allow me to express my gratification at the excellence of your translation. I hope that with growing experience and pains, your style and accuracy may still further improve. As we have repeatedly talked, simplicity is the chief characteristic of good style. In works of Science, we want as little technicality as possible but should not prefer cirumlocution to the use of a technical".

In 1866, Dr. J. Periayathamby Danforth, one of Dr. Green's brilliant students, completed his translation of a large work on surgery which was published in 1867 under the title 'Science and Art of Surgery'. Dr. Green, in recommending Dr. Danforth to the College of Physicians and Surgeons of New York (Columbia) for an honorary degree of Doctor of Medicine, wrote: "..... I do not intend to apply for those unworthy nor for those who would not earn it by doing a bona fide service in the cause of Tamilizing Western Medical Science. Their service must be gratuitous and valuable, and they must stand repeated examinations at the hands of educated foreign physicians and show certificates for their proficiency and ability aside from any I could give". Dr. Danforth was conferred the M. D. degree and Dr. Green while thanking the Trusties of the College wrote: "I believe this recognition of merit will have a happy influence upon the many practitioners trained in Medicine by the American Mission".

As the years rolled by, Dr. Green reached the end of his second term of service. In failing health and with great reluctance to leave the scene of his labours, Dr. Green with his wife and four children left Jaffna on 7th March 1873 and sailed from Colombo 3 weeks later. The day before his departure from Jaffna, in a letter to his family, he

declared his intention of founding a Medical Professorship at Jaffna College: "I have thought I would like all our property and whatever may have been willed to us, given in whole or in part to found a medical professorship in Jaffna College, provided such a disposal commends itself to the judgement of my brothers and sisters. I am writing this now in case we should all pass from this Earth while on our way to you".

Two days before he sailed from Colombo, Dr. Green received a letter from Dr. James Loos, the first Principal of the Ceylon Medical College in which Dr. Loos states: "Dear Dr. Green..... I am grieved that sickness has prevented me from seeing you. I should have been happy to take you round our hospital and show you the work we are carrying on - a work in which we are humbly immitating you. Medical education in Ceylon is deeply indebted to you and your predecessors. You have loosened the foundations of quackery and I trust it may please God to bless us also in our efforts to place the Medical practice among the natives of this island on a more rational and scientific basis. Your Tamil works in Medicine will remain a memorial to you after you are gone and you will not be soon forgotten. We, as natives of this island, are much indebted to the American Mission for their efforts in the cause of Christianity, civilization and science although these have been confined to a part of the island.....".

At Dr. Green's departure, it is recorded that "His hope of studding the province with well educated physicians has begun to be realised. The people have lost confidence in their native doctors to an encouraging extent; the F. I. N. S. hospital, now manned by his graduates, had more patients than all the hospitals in the other provinces".

Having recuperated his health, Dr. Green repeatedly offered himself to come back, but the American Board considered it to be unwise to risk his health in the tropics for a third term. However, Dr. Green maintained a constant contact with Manipay and buried himself in completing the unfinished task of translating, proof reading and editing. He carried on an endless correspondence with his students here especially Dr. Chapman. Thus he completed the monumental task of publishing 8 medical tomes and glossaries in Tamil, the translations running into nearly 5000 printed pages.

The following is a complete record of Dr. Green's contribution to medical literature :

1. "ANATOMY, PHYSIOLOGY AND HYGIENE" by Calvin Cutter M.D., Translated into Tamil by Dr. S. F. Green. M. D., 1852 -First Edition. Manipay Press, Jaffna. 1857 - Second Edition. Madras - 204 pages.
2. "DUBLIN PRACTICE OF MIDWIFERY" by Mansell. Translated into Tamil by Dr. S. F. Green M. D., 1857. Manipay Press, Jaffna - 258 pages.
3. "THE SCIENCE AND ART OF SURGERY". Compiled from Erichsen and Druitt. Translated by Dr. J. Periyathamby Danforth. Edited by S. F. Green M. D. 1867. Manipay Press. - 504 pages.
4. THE PRINCIPLES AND PRACTICE OF PHYSIC" - Modified Tamil Version of Hoopers' Physicians Vade Mecum by Dr. William Paul-Supervised and amended by Samuel F. Green M.D.,

1872. London Mission Press. Nagarcoil. 917 pages.

5. "HUMAN ANATOMY" Compiled from Gray's natomy, Wilson's Vade Mecum, Smith and Horner's Atlas. Translated by Dr. D. Waitilingam Chapman. Supervised by Dr. S. F. Green M. D., 1872. Press of Strong and Asbury. Manipay - 838 pages.
6. "INTRODUCTION TO HUMAN PHYSIOLOGY" by Samuel F. Green M.D., 1872 - 134 pages.
7. "CHEMISTRY PRACTICAL AND THEORETICAL" by David A. Wells. Rendered into Tamil by Dr. S. F. Green M. D., with the assistance of Dr. D. W. Chapman and Dr. S. Swaminathan, 1875. London Mission Press. Nagarcoil - 516 pages.
8. "VOCABULARY OF MATERIA MEDICA AND PHARMACY; OF MIDWIFERY AND DISEASES OF WOMEN AND CHILDREN, AND OF MEDICAL JURISPRUDENCE by Dr. S. F. Green M.D., 1875. London Mission Press. Nagarcoil. - 161 pages.
9. "HUMAN PHYSIOLOGY" BY Professor J. C. Dalton M. D., Translated by Dr. D. W. Chapman. Revised and edited by Dr. S. F. Green M. D., 1883. Press of Strong and Asbury. Manipay. Jaffna - 590 pages.
10. "WARING'S PHARMACOPOEA OF INDIA" by Dr. S. F. Green. M.D., 1884 - 574 pages.

ORIGINAL TREATISES

1.	The Eye -	11	pages
2.	The Ear -	11	pages
3.	The Hand -	11	pages
4.	The Foot -	12	pages
5.	The Skin -	16	pages
6.	The Mouth -	12	pages
7.	The Body -	15	pages
8.	Be Clean -	4	pages
9.	Hints for Cholera Times -	20	pages
10.	Government Tract on Cholera	11	pages
11.	Way of health	4	pages

OTHER TREATISES

1.	Secret Vice -	24	pages
2.	Soul's Abode -	44	pages
3.	The Mother and child	44	pages

Articles to New York Medical Journal

1. Tamil Obstetrics
2. Tamil Surgery

Most of Dr. Green's books are still available at the Jaffna College Library, the British Museum Library in London and at the Harvard University Library in America.

The last of the volumes was published in 1884 shortly before his death. It is ironical that by this time, the Government grant had been terminated and Dr. Green's Medical School at Manipay had ceased to function. It is possible that the dominance of English in the subsequent years and the attitude of the British Colonial administration had to a large extent obscured the efforts of Dr. Green. But the significance and the magnitude of his achievement can now be fully appreciated a century later, with the introduction of swabhasa in the medical faculties of our universities.

When Dr. Green left, he had already trained 66 doctors, the first 33 of whom had their full course of instruction in English and the balance were taught in Tamil. Dr. Green's men were very much in demand for employment not only in Ceylon. but even in India and Malaya. These doctors

eventually manned and pioneered the Government Medical Service at a time when it had few men. Dr. Green helped the Government to open up a large number of hospitals and dispensaries in various parts of the country. His men served with distinction in the various posts they held and many of them were highly commended by the Government for outstanding work. For further details, the reader is refferred to an article 'Modern Medicine and the American Ceylon Mission in the North' by the author (Mills 1966)

When Dr. Green left for America in 1873, he left a class of 18 students. Dr. C. T. Ethirnayagam Mills, a distinguished student of Dr. Green, shouldered the burden and responsibi ity of teaching the med cal classes. While Dr. Green was still exp.cted back, Dr. Mills taught two medic l classes, the second being graduated in 1879. The Government continued to recognise the medical school and its graduates.

However, when the Government became aware of Dr. Green's impending departure and realising that it could no longer ignore its responsibility for providing medical education and adequate medical facilities to the nationals of this country, took steps to establish a Medical School in Colombo in 1870. Later, as the doctors from the Colombo Medical School became available for employment, they gradually began to replace Dr. Green's men in the public service. At the turn of this century, there was hardly anyone of Dr. Green's men left in active service.

Though there was no possibility of Dr. Green returning, Dr. Green continued to show great concern and interest in the continuance of the Medical School at Manipay. In writing to Rev. Howland in 1879, Dr. Green states: "I hope and pray that Dr. Mills, Dr. Paul and Dr. Clives may be so practical in their teaching as to encourage the continuance of the medical Government grant. It would be well to invite Dr. Kynsey (then Principal Civil Medical Officer) and his representative in loco to occasionally examine the class and be present also at regular examinations..."

Although Dr. Green had been away in America during the last 11 years of his life, his heart was in Jaffna. This is indicated in one of the last letters he wrote, just before his death, to one of the missionaries in Jaffna in which he states: "It seems incumbent on you and your confreres to maintain the Medical Mission in Jaffna. Get what help you can from the Government and from the Mission and combine among yourselves to peretuate the practice and propagation of a system of medicine so much needed in that community in a sanitary, hygienic and curative way. My daily prayer for long has been, 'O' Lord, stir and constrain Chapman, Mills and Paul to do all they may and all they should for the maintenance and perpetuation of Medical Mission work in Jaffna and to enable them each, and each of the medical graduates to walk, in purity, in honesty and in kindness. Please inform this to friends Mills and Paul with my Christian fraternal love".

Dr. Green passed away on 28th May 1884 at Greenhill, Worcester in the presence of his brothers and sisters. In his will he wrote: " I wish that my funeral may be conducted as inexpensively as may consist with decency and order. Let the exercises be simply to edification; and of the dead speak neither blame nor praise. Should I ever have a gravestone, let it be plain and simple."

Somewhere in Worcester, Massachusetts, there lies a gravestone with the following inscription: "Samuel Fiske Green. 1822 - 1884. Medical Evangelist to the Tamils. Jesus my all."

Dr. Green's contribution to us in Medicine in the last century is effectively summed up in the following acknowledgement from the pen of Sir William Twynam, a veteran administrator of the North and a reliable contemporary witness. He states: " I venture to say without fear of contradiction that it would have been simply impossible for Mr. Dyke or the Government to have carried out what has been done in affording medical and surgical relief to the people of Northern Province and even in the Central Province from 1848 to 1890, but for the fact that men educated in the American Mission Medical School were ready to take up work under the Government when it had few men of its own."

There is no doubt that Dr. Green was a missionary of outstanding qualities and rare talent. As a Physician, he was eminently skilful. As a Surgeon, in the words of Dr. William Paul, he was 'par excellence and none to equal him in the island.' As a man and missionary, he was saintly. He sacrificed a whole life-time in the service of an alien people. He was a pioneer in the creation of science in the Tamil language. His contribution to medical education in this country and his efforts in the field of medical scholarship were monumental achievements. Wrote Dr. Green "I must have the satisfaction at the close of my work of leaviug behind this useful study to the Tamil Nation in their own tongue, as an abiding thing, and not in a foreign language which may in the lapse of time depart from the land." This prophesy has now come to be fulfilled.

In reviewing Dr. Green's career, one is struck and impressed by the marked difference in his attitude and outlook towards our country and people, as compared to that of the British Colonial Administrator. It is all the more significant when one realizes that Dr. Green was a foreigner in our country, a hundred years ago, at a time when the Colonial Empire was at it's height. Indeed, it will not be an exaggeration to acclaim Dr. Green as one of the greatest nationalists and socialists that this country ever produced. The Green Memorial Hospital at Manipay and the Government General Hospital at Jaffna are monuments to his memory.

Acknowledgement

The author wishes to acknowledge and express his indebtedness to the book Life and Letters of Samuel Fiske Green M. D., complied by Dr. Ebenezer Cutter D. D. and published in New York in 1891. All the correspondence of Dr. Green quoted in this article have been taken from this source.

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JOHANNES JACOBUS (JAMES) LOOS

M. D. (ST. ANDREWS,) M. R. C. P. (EDIN),

1822 — 1904

R. L. Brohier, D. LITT.,

Rummaging some family papers the other day, I came upon a document which would have delighted the eye of any anti-quarian. It was a copy of a letter, dated 9th February 1841, written by a forbear of mine to a relative who had repatriated himself and his family to Batavia 34 years earlier, when Ceylon passed over to the British.

Casting my eye over the meticulous copperplate writing of those times which covered the pages of the letter, I read: "It is to be wished you can come and have a glance of Colombo now. The changes in the City would indeed be a surprise to you ....Bridge-of-Boats laid, a Savings Bank established, Mail Coaches plying to and fro, Government Land selling off and very promising estates arising, Schools Commission appointed, Friend-in-Need Society and Academy (Royal College) established..... Ceylon youth sent to Medical School at Calcutta for education at the expense of Government".

There can surely be no more fitting back-drop than this excerpt on which to focus the story of the life and times, of James Loos (to use his short name). Apart from promoting atmosphere and showing us a Colombo of the sluggish past, it is important for the particular reference to his start in life. He was one of those Ceylon youths in the first batch of students selected to leave for Calcutta to graduate in the Bengal Medical College.

James Loos, was born at Colombo on the 17th of July 1822. It is almost a certainty that he spent his boy-hood living with his parents, in the Pettah - which then was a residential zone, and together with the Fort then hedged in by its blackened and time-worn ramparts, constituted what was the City of Colombo. With equal measure of certainty it might be assumed that he received his early education at the Central School - the reputed scholastic institution before the establishment of the Academy His father Peiter Adriaan Loos, held office as Registrar of the Supreme Court, and nurtured a family of 19 children. James was eighth in line, He was eighteen years of age when he left home. He had grown up in comfortable circumstances.

On his return to Ceylon after graduating, Dr. James Loos was appointed Medical sub-Assistant. His first posting appears to have been to Puttalam. Sir William Twynam in his reminiscences says that when he arrived at Puttalam in 1845 to take up his first appointment, Dr. Loos "who had not long since come from Medical College at Calcutta, was there". Sir William goes on to say that Dr. Loos was relieved by Dr. Charsley (who was one of three Medical Officers sent out from England in 1847), sometime before Dr. Loos left the station.

It merits mention that originally the medical service in Ceylon was a Military Institution. It was only in 1857 that the Civil, and Military Departments were separated by the Legislative Council, and a Principal Civil Medical Officer was appointed to head the former.

When this administrative distinction was effected Dr. Loos was assigned the substantive rank of Assistant Colonial Surgeon in the Civil establishment - but was appointed to act, as Colonial Surgeon of the Southern Province. He was confirmed in the higher office in 1862. After a sojourn of eight years in South Ceylon he proceeded in 1866 on leave to Great Britain to better his professional position. He received the degree M. D. of St. Andrews University, and both Fellowship and Membership in the Royal College of Physicians of Edinburgh.

It so happened that in 1867 the then Governor, Sir Hercules Robinson, alarmed by reports of serious deterioration and depopulation of the Vanni Districts of the Northern Province ordered a comprehensive enquiry. Dr. Charsley, who had succeeded Dr. Eliot as Principal Civil Medical Officer, recommended to Governor Robinson that Dr. Loos, who at the time was Colonial Surgeon of the Northern Province, should head the enquiry. Dr. Loos was accordingly appointed to do so.

The enormity of Dr. Loos' task can hardly be appreciated or assessed from our modern stand-point. The Vanni was an unroaded hinterland. The people lived segregated in villages miles apart from one another linked by foot-paths which trailed for miles through wild jungle and scrub. The country was notoriously unhealthy, and that scourge of Ceylon's lowcountry: malaria, was rife. Most of his travelling and field inspections had to be done on foot.

The noble work done by Dr. Loos entitles him to a place in Ceylons' medical history Despite serious injury to his own health through the privations and discomforts he was called on to undergo, he carried out his investigations, and submitted his conclusions that depopulation was due to: "Malarious fever and to the prevalence of an invetera te skin affection, possibly associated with an hereditary specific taint, aggravated by insanitary conditions, and known in that district as the **"Parangi-disease"**.

Dr. Loos suggestion that new hospitals for the treatment of cases of this disease be established at Mullaitivu, Anuradhapura and Vavuniya, were immediately acted upon. Factually although much was done to study the disease and afford medical aid to those suffering from Parangi, it extended to only affording relief by treatment with "alterative tonics, cleansing of the skin and good food". In the memory of the writer, Parangi was one of the greatest scourges, which, with wave upon wave of Malaria, was noticable to anybody who had contact with the village population in the Vanni to even so recently a time as 1920

Dr. Loos was thanked by the Governor in Council for the efficient manner he had performed the duties entrusted to him. In recognition thereof he was appointed the first Principal of the Medical School established in Colombo in 1870, by Governor Robinson. "There is no question that Dr. Loos should be regarded as the pioneer of medical education in Ceylon" (L. E. Blaze, D. B. U. Journal of July 1925).

There were 25 students in the first enrolment, and at the end of the 3rd year, the first examination for the Licence was held - 12 succeeded in passing. The period of study was thereafter raised to four years. Originally the students had to pay an annual fee of Rs. 25/- each (a big sum of money in those times) This was increased subsequently to Rs. 50/-, and after the School was raised to the status of a College (which gave recognition to the certificate in the United

Johannes Jacobus (James) Loos 1822—1904

JAMES LOOS,

M.D. St. Andrews, L.R.C.S.Ed., M.R.C.P.Ed.

Born 17th July, 1822, at Colombo.

Graduated at the Bengal Medical College and Appointed Medical Sub. Asst. 1843—58.

Asst. Col. Surg. 1858—Act. Col. Surg. S.P. 1862—66.

Colonial Surgeon, N.P. 1867, Actg. C.S., C.P. 1869.

Colonial Surg., W. P. and Principal Ceylon Medical School 1870.

Colonial Surg., C.P. 1875. Retired 1st Jan. 1883.

Acted as P.C.M.O. and I.G.H. 1881—82.

Visited the Hospitals in Great Britain 1866—67 and 1879—80.

Re-visited Calcutta 1886, and 1890.

Reported on the Depopulation of the Wanni Districts N.P. by Parangi Disease in 1867. Thanked by the Governor in Council, and appointed First Principal, to Establish Medical School in 1870.—

Was Ex-Officio Member of Municipalities Kandy and Colombo, 1876—82.

Now Resides at Laurel Lodge, Ward Place, Colombo.

Kingdom) and the course was extended to 5 years, the fee was increased to Rs. 180/-. There were scholarships of course; but the moral - few there are who appreciate anything they get, unless they have made some sacrifice towards getting it!

But those days have gone away, and I have digressed, Retiring from the Medical School in 1875, Dr. Loos took up the appointment of Colonial Surgeon Kandy. He held this office until retirement, with an interruption to make a second visit to Great Britain in 1879, and another to officiate as Principal Civil Medical Officer and Inspector General of Hospitals in 1881-1882. He retired from the service, on the 1st of January 1883.

As was the custom in those by-gone times, in his capacity as Colonial Surgeon of the Western and Central Provinces, he was Ex-Officio, a member of the Municipal Councils of Colombo and Kandy.

Dr. James Loos lived in retirement for 21 years in Colombo, residing at "Laurel Lodge" Ward Place, which alas! knows its setting no longer in the nest of concrete cages which have erupted on every razor-grown grass lawn that afforded elegancy to the old mansions of the Cinnamon Gardens of Colombo. In addition to being one of the most distinguished of Ceylon's physicians, Dr. Loos was a literary scholar, and a popular public lecturer. Yet greater than all, religion was to Dr. Loos a living experience and a motive power.

The following concluding words of the article by L. E. Blaze, in the Journal already quoted are an index to his character; "No reference to Dr. Loos' life can be complete without mention of his convinced belief in the main principles of Christian truth and his constant practice of them. He was a friend of the poor, and his charity was unostentatious. Intimate associations with suffering and death neither blunted his human feelings nor deprived him of the faith that death is but the doorway to immortality. It is characteristic of him that in 1887, he published a little "Manual of Prayers for Medical Men" - compiled and arranged from manuscript books kept from 1842. In his Preface he writes; 'Having now in great measure retired from active life I desire greatfully to ascribe any success I may have had in life to the fountain of all blessing and the Giver of all good'.

With this glimpse of a great and good man's inner mind, this sketch may fittingly close. He died on May 4th 1904, having lived to the age of eighty two years. His wife, and his two sons predeceased him, and Laura - an only daughter, died unmarried in 1919.

SURGICAL EXPOSURE AND LIGATION OF THE ANTERIOR DIVISION OF THE INTERNAL ILIAC ARTERY AND ITS IMPORTANCE IN RECTAL EXCISIONS

Anthony Gabriel F. R. C. S., F. R. C. S. (Edin.)
Consultant Surgeon Cancer Institute, Colombo

One of the basic principles in operative surgery is haemostasis. This gives the surgeon a clear field, quicker, cleaner and more accurate dissection, and also minimal effects of shock during and after surgery,

To this purpose, the internal iliac artery bears an important role in excisions of the rectum; such as in an Abdomino-perineal resection or similar procedures.

The artery supplies a large portion of the pelvic contents, such as the rectum, bladder, prostrate, lower end of the ureter, and the male and female genitalia. One would expect that a cessation of the blood supply to any of these organs would lead to either non-function or death of tissue.

But, in practice, it has been found that bilateral ligation of the internal iliac artery leads to either no or only temporary impairment of function of the bladder. Sloughing of the lower end of the ureters has never been encountered. This observation is important in an abdomino-perineal resection or a pelvic excentration, when the technique of bilateral ligation of the internal iliacs is practised.

This procedure is not original, but however, is practised by few surgeons, though the advantages are quite remarkable. The usage of artery forceps does not arise, during the operation, as there is no haemorrhage.

The fear of a non-functional bladder, prevents surgeons from adopting this technique. It is also, not widely known, and there is a natural prejudice in performing such a definitive and irrevocable step.

The surgical exposure of any organ is principled on quick and easy access and avoidance of bleeding; quite unlike an anatomical dissection where the problem of haemorrhage and masking of the field with blood does not arise.

The blood supply of the rectum comes from :

1. the superior rectal artery which arises from the inferior mesenteric.
2. the two middle rectal arteries coming off the internal iliac or the internal pudenal artery, which is a branch of the internal iliac.
3. the inferior rectal artery arising from the internal pudenal.
4. the median sacral artery.

The bladder is supplied by the superior and inferior vesical arteries which arise from anterior division of the internal iliac.

The pelvic portion of the ureter is supplied by vesical and middle rectal arteries.

Anatomically the internal iliac is about an inch and a half long arising from the common iliac opposite to the sacro iliac joint, at the lumbo-sacral disc, running slightly inwards, downwards and backwards to the upper border of the greater sciatic notch where it divides into an anterior and a posterior branch.

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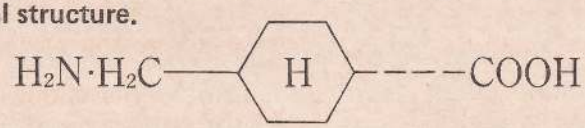

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Antero Medially - It is covered by peritoneum under cover of which along its anterior surface runs the ureter, which is adherent to the peritoneum by fine strands of cellular fibrous tissue. This is an important point in the surgical exposure of the internal iliac. Lying over the artery, with the peritoneum interposing is the pelvic colon on the left, and the terminal ileum on the right. In the female, the ovary and the infundibulum of the uterine tube will also be anterior.

Posteriorly - The commencement of the common iliac vein and the internal iliac vein are posterior to the arteries. Behind these veins are the lumbo sacral trunk and the sacro iliac joint.

Laterally - The external iliac vein separates the artery from the Psoas major above and laterally. Sometimes at operations a thin sheet of fine musculo-fibrous strands stretch over the artery from the Psoas making its identification difficult.

In some cases, in fact the external iliac vein and the internal iliac artery are partially embedded in the muscle.

Lower down the obturator nerve separates the artery from the side wall of the pelvis.

An important factor one must remember in visualising the anatomical complex of this area, is that retro-peritoneally all the structures lie in a mesh work of fibrocellular bands. Hence blood seeping into this enveloping "sponge", leads immediately to obscuring the anatomy of the region, which in turn can lead to some inconvenience in identifying the internal iliac artery.

In the actual approach to the artery, the important step is the point of incision in the peritoneum overlying it.

This is better understood when it is realised that the pelvic mesocolon merges on to the pelvic peritoneum on both sides. The mesocolon contains the arterial and venous arcades to the pelvic colon, while behind the pelvic peritoneum there is no such meshwork of vessels.

It is at this point of juncture between the pelvic mesocolon and the parietal peritoneum - "the floor of the valley" - that the incision should be made.

An incision too medially means, entering the mesocolon and into a morass of blood vessels, and bleeding. Also, once the wrong point of incision is made, one has a tendency to keep on "burrowing" more medially into the pelvic mesocolon and further away from the internal iliac, and this leads to further bleeding and confusion.

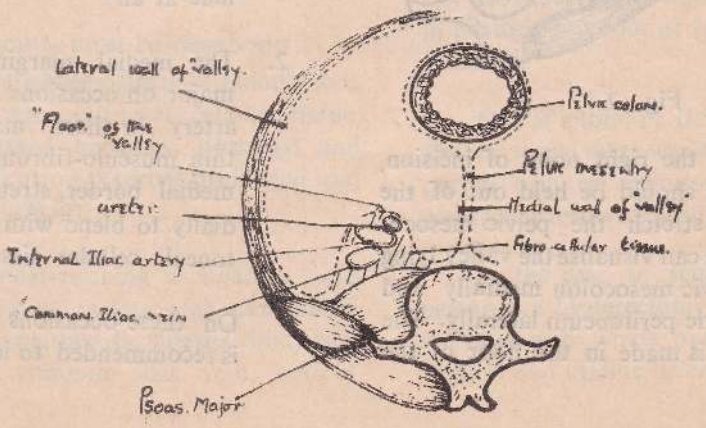

Fig 1

On the other hand, an incision made too far laterally from the bottom of the "valley" - can lead to the ureter being reflected laterally with the lateral portion of the divided peritoneum, before one realises what is happening. Also on application of tissue forceps to the cut margin of the lateral fold, can enclose or damage the ureter if it lies on the margin of this incised peritoneum.

This is not uncommon in one's early days of surgery whether it be doing an abdomino-peritoneal resection or an uretero lithomy.

Hence placing the point of incision at the very floor of the peritoneal "valley" is most important for a tidy, neat exposure of the artery. Otherwise quite some time or frustration can result looking for the ureter or trying to stem a bloody ooze from injured vessels in the pelvic mesentery.

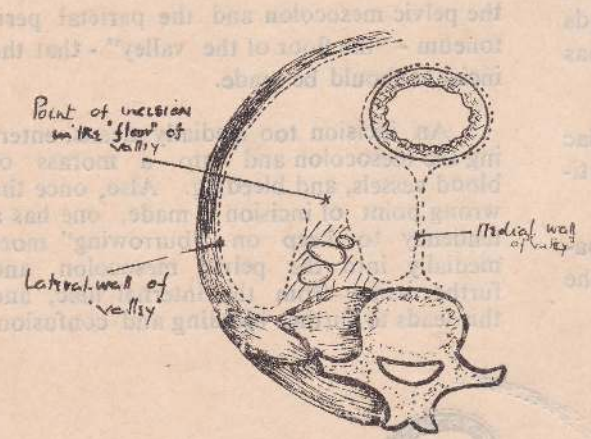

Fig 2

To obtain the right point of incision, the pelvic colon should be held out of the wound, and so stretch the pelvic mesocolon and thus one can visualise the valley lying between the pelvic mesocolon medially and the parietal pelvic peritoneum laterally. The incision either is made in tne floor of the valley or 1/2" up the lateral slope (which is the pelvic peritoneum). On incising the peritoneum one immediately encounters the internal iliac artery surrounded by the retro peritoneal fibro cellular tissue and about 1/2" to 1" from the lateral edge of the peritoneal incision one usually finds the ureter closely adherent to the peritoneum and quite easily recognisable.

Also, if the correct point of incision is not made the ureter may be immediately behind the lateral peritoneal margin, and may be damaged when a tissue forceps is placed on the peritoneal edge for retraction. So that when one begins to search for the ureter by reflecting the lateral sheet of peritoneum the ureter is reflected laterally and upwards fixed by the tissue forceps and the surgeon has a tendency to keep on burrowing retro-peritoneally in exasperation, while all the time the ureter is being held by the tissue forceps away from h.m !

The identification of the internal iliac artery is not always as easy as it seems because :-

1. It sometimes "bends" backwards when entering the true pelvis, lying close to the sacral contour. So. unless one is aware of this, one may wonder whether there is an internal iliac at all !

2. The medial margin of the psoas major on occasions may overlie the artery or there may actually be a thin musculo-fibrous sheet from the medial border, stretching across medially to blend with pelvic retro-peritoneal cellular tissue.

   On these occasions blunt dissection is recommended to identify the artery.

One is advised to go upwards, to identify the common iliac at its bifurcation and then trace the artery down into the pelvis.

3. It has been noticed that the right iliac artery sometimes seems "deeper" in the pelvis and may cause a little difficulty in its identification.

4. On several occasions one or the other of the internal iliac have been quite a bit smaller than its opposite number, and one may wonder whether the internal iliac artery or some other vessel has been isolated.

The writer has not come across any congenital abnormalities of the internal iliac, although it can arise direct from the aorta.

Once the internal iliac artery has been identified, the question of isolation of the anterior division for ligation in continuity arises. This in reality is not difficult because the posterior division is given off at the upper margin of the greater sciatic notch, and it runs posteriorly immediately and disappears.

So the vessel that is in practice mobilised and ligated is in the anterior division. Hence there is no necessity to identify to the posterior division.

Several points must be observed:-

1. Complete haemostasis - if blood floods the retroperitoneal cellular tissue, the artery becomes obscured and identification becomes prolonged and quite difficult.

2. On under-running a ligature and isolating the artery one can easily puncture either the internal iliac vein or the common iliac vein, both of which lie behind it. If this occurs, as mentioned before, flooding of the cellular tissues occurs.

3. Sometimes an arterio sclerotic vessel is encountered which can be quite brittle. If it is tied too tight it can "crack" or actually tear.

The artery should be ligated in continuity and there is no necessity to divide it.

The easiest point of ligation is at the bifurcation of the common iliac artery. Once the isolation and ligation of the internal iliac (anterior division) has been secured, the rest of the resection of the rectum is quite simple as no artery forceps need be applied at any stage either in the abdominal or the perineal stage.

Occasionally if one has to shave off a bit of the prostrate with the adherent rectum, the ooze that occurs, is normally controlled by diathermy coagulation.

The problem of bladder dysfunction, has never been a problem. Some lack of tone may occur for 4 or 5 days after the operation whether it be due to cutting off the blood supply or damage to the Nervi Erigentes is difficult to say.

However, an indwelling catherter is kept in position for, four or five days and then removed.

Out of a total of 183 cases over the last sixteen years, there was only one case where partial urinary retention occurred for two weeks but resolved itself later.

In the case of females one normally performs a hysterectomy as well, and here the brisk ooze which one expects from the vaginal and uterine arteries hardly occurs.

Some (Morgan 1955) advocate the temporary occlusion of the common iliac arteries. But here, one still has to apply forceps and ligate the potential bleeding points, for when the arterial clamps are removed from the common iliac, the cut vessels will surely bleed again, if they have not been clamped. But Morgan does stress the great value in temporarily occluding the common iliacs, in the pelvic dissection.

The advantage of ligating the internal iliac are several, and in the writer's opinion well worthwhile.

1. Complete haemostasis throughout the operation - use of artery forceps hardly arises. Hence a neat clean dissection can be obtain d. The slight venous ooze that may occur in the perineal wound is very easily stopped by the perineal pack.
2. This technique cuts down operating time considerably.
3. The need for more than one assistant hardly ever arises as excessive exposure and vessel ligation does not occur.
4. With shortening of operating time, the problem of shock is reduced, should it occur at all.

This technique is not new, but is not popular as there is the bogey of bladder complications which really never arises. To the writer's mind, the magnitude of these types of resections no longer really exist as this is certainly a step that cuts out the bug bear of haemorrhage, a longish procedure, and a pelvis full of forceps. However, a knowledge of the practical approach to the internal iliac artery as described, is essential, for the fluency of the operation.

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CIRCUMCISION

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M. R. C. O. G. (Gt. Brit), F. R. C. S. (Edin), F. R. C. S. (Eng)

Surgical operations can be classified in many ways. One fascinating classification is where, these are grouped under the headings - special, major, intermediate and minor, though their definitions are most vague and sometimes ambiguous. One specialist defined a major operation as one that is done on a **major** person not meaning a person of over 21 years of age, but a V. I. P.

Another classification is as follows. Firstly, operations that are socially acceptable and freely talked about. Secondly, those that are discussed only in whispers lest it may cause some embarrassment and thirdly, those that are supposed to add to the social status. There are many operations that can be grouped under this third category - though these may vary from country to country and from time to time. But it seems to me that in Ceylon today, more and more people mostly in the capital city, appear to believe that getting their infant sons circumcised adds to their social status. This is rather unfortunate. Some of these parents I observed had been abroad and they try to bring forward the argument that "In such and such a country the infants are circumcised before they leave the hospital." But they do not seem to have any further knowledge as to whether those infants were born to Jews or people of Islamic faith.

Some have friends (unfortunately) with a B. T. A. certificate - meaning been to America - who advise the natives about how the babies are circumcised in the States. Further some members of the nursing staff (a few having had their training in a remote district hospital in the U.K. or the U.S.) seem to have an irresistable urge to remove the foreskin of the newborn. Thus, the innocent mother who hasn't still recovered from the effects of labour gets a continuous bombardment of unnecessary remarks and unwanted advice.

In the U. S., circumcision no longer adds to the social status. I quote William Keith C. Morgan of the University of Maryland School of Medicine in Baltimore. He says, "This ritual however has become so widespread in the United States that it is no longer much of a status symbol."

Male circumcision has been practised by all Semitic races Arabs and the Jews alike. It may be surprising to note that circumcision is practised by one sixth of the world's population. It seems that aborgines of Australia and the natives of America before Columbus, had practised circumcision for as long as we can tell. Many reasons have been given for this practice. -Firstly to assess the ability of the young boy to endure pain before he is accepted as a fully developed man into the respective tribes; secondly, as a religious belief by people belonging to certain faiths; (many of them now believe that this is mainly for hygenic reasons) and thirdly with a view to reduce libido.

The age at which circumcision is performed varies widely in different races, from the eighth day of birth to near the age of puberty. In spite of all these available information we are still profoundly ignorant of the origins and significance of this presumably sacrificial rite.

From a medical point of view the variety of reasons given for circumscising an infant are-

1 Phimosis

Most of the infant circumcisions are done for this condition. Phimosis implies a pathological constriction of the prepuce and this cannot be properly applied to the infant. What most people mean when they talk about "congenital phimosis" is the nonretractability of the foreskin. The prepuce in the new born is nearly always nonretractable and this state remains so for a variable period upto about four years. The nonretractability is not by any means due to the tightness of the prepuce relative to the glans but to the incomplete separation of the two structures. Douglas Gairdner from Cambridge who studied carefully the development of the prepuce describes that, by the sixteenth week, the epidermis of the deep surface of the prepuce is continuous with the epidermis covering the glans, both consisting of squamous epithelium. Later by a process of desquamation the preputial space is gradually formed. This desquamation occurs in patches forming a series of spaces. These spaces increase in size and join up ultimately to form a continuous preputial space. The prepuce is still in the course of development at the time of birth. The process of desquamation is not complete and this renders the normal prepuce of the new born nonretractable. It may be said that there is still a physiological union between the prepuce and the glans. The age at which a complete preputial space is formed with full retractability varies up to five years. At birth only about 4% of infants have fully retractable prepuce. In 50% the prepuce becomes retractable by one year and by the second year 80% become retractable. By three years about 10% of boys still have a nonretractable prepuce.

The nonretractability at these ages is due to the incomplete separation of the prepuce from the glans I am sure that most of you would have had the experience of performing a circumcision on an infant with an "alleged Phimosis". After running a probe round the preputial space completing the continuity by gently breaking the physiological union - the prepuce becomes retractable without any difficulty. Surely this infant did not have Phimosis, nor was the non-retractability due to a narrow preputial orifice.

It is true that the preputial orifice may appear minute, but as long as a good stream of urine flows out at the time of micturition the opening is without any doubt adequate. Sometimes the preputial orifice is imperfectly related to the external urethral meatus so that the urinary stream balloons out the subpreputial space. This can be easily remedied by gently separating the prepuce from the glans in the region of external meatus by a probe. Pin hole external urethral meatus should not be confused with the narrow preputial orifice.

Through ignorance of the anatomy of the prepuce in infancy, mothers and nurses (and sometimes even doctors) often try to draw the infant's foreskin back regularly, in the belief that stretching is necessary This is not only inadvisable but traumatising and this will almost certainly lead to Phimosis when healing takes place.

So, the diagnosis of Phimosis in an infant should be carefully reviewed before subjecting the poor child to this mutilating operat on.

II. Balanitis and Posthitis.

The prepuce, because ofthe physiological union with the glans, protects the glans and balanitis in infancy and early childhood is rare. Posthitis meaning inflammation of the prepuce may occur in two forms.

(i) As a part of ammonia Dermatitis affecting the napkin areas and
(ii) as cellulitis of the prepuce.

Ammonia dermititis can be easily treated by impregnating the napkin with a mild antiseptic inhibiting the growth of urea splitting organisms. Ammonia dermatitis is in fact a contra - indication to circumcision because the glans will lose its protective covering and ammonia dermatitis can now affect the glans giving rise to a meatal ulcer which is not easy to cure. It is well known that metal ulcer is almost unknown in the uncircumcised.

Cellulitis of the prepuce responds well to chemotherapy but perhaps recurrent cellulitis is an indication for circumcision.

III. Some people performed circumcision in the belief that this prevented venereal diseases and paraphimosis. It is crystal clear that this argument does not hold water anymore and so can be dispensed with.

IV. There is evidence to show that penile cancer occurs mostly in the uncircumcised- *if they do not keep their glans and prepuce clean.* It can be reasonably argued that if the prepuce can be retracted, and this and the glans kept clean he will enjoy the same immunity from penile cancer as his circumcised brother. What he really needs is soap and water and not an operation.

V. **Cancer of the Cervix.**

There is extensive documentation about the relative freedom of the Jewish cervix from carcinoma and about the low incidence of this condition in muslim women. But with the same degree of authority and conviction Eser from Istanbul reported that 99% of women In Turkey are Muslims and 96% of the males are fully circumcised, and that even though circumcision performed by the sixth year of the life reduces the incidence of penile cancer it has very little effect on the incidence of carcinoma of cervix. The age at marriage again he said cannot be brought in as an argument because Turkish women are usually younger than Jewesses when they marry and bear children. Wynder (1955) studied this aspect of the problem among all types of people in India and concluded that the high standard of personal hygiene of Parsee men (who by the way are uncircumcised) is responsible for the Parsee women seldom developing cervical cancer. There is absolutely no doubt that cleanliness is the main factor related to the incidence of penile and cervical cancer and not the presence of the poor foreskin.

VI. Mothers may give their own reasons for requesting circumcision of their infant. One very interesting, incident is worth mentioning here. A thirty year old lady had an easy vaginal delivery of her first child. As longed for by her, she was blessed with a son. On the third day she asked me " Doctor, don't you think that it is better for my son to be circumcised?" I was a little surprised but wanted to know if she had any special reasons. She said ,'No special reasons, doctor, but it looks nice when it is circumcised." Pretending to agree with her I enquired whether her husband was circumcised. Her answer was "Yes". I interviewed the husband seperately on the same day and to my astonishment found that he was not circumcised. Without allowing my imagination to run riot I remarked to her "Madam - you are very lucky. You have the benefits of an uncircumcised and a circumcised organ. Why do you want to deprive your future daughter-in-law of the same benefits?" Anyway the baby went home with his foreskin intact.

It appears to me that in almost every case this innocent and useful appendage is lopped off due to ignorance of the anatomy and physiology of the prepuce by all concerned. As mentioned earlier, about 10% of boys fail to attain normal retractability by the age of three years and even in them - the prepuce can be separated and made retractable in many, by gentle manipulation. The main indication for circumcision would therefore be the inability to retract the foreskin after the age of four years, and one should bear in mind that this situation usually results from early forcible retraction of the prepuce.

I do not wish to wage a lone war against circumcision. I very well realize that traditions, mistaken beliefs of many of the medical profession, false sense of aesthetic values of women, consciousness of status symbols, teachings of the Holy books and even grandmother's tales are all against me. Nevertheless, there is no doubt that 98 times out of 100 there is no valid indication for this mutilating procedure other than religion. It is very disheartening to find that a situation has arisen where any recently delivered mother who is eccentric enough to wish her child to retain his prepuce would be well advised to maintain a permanent guard over it until such time as they both leave the hospital. **My sincere plea is that this rape of the phallus should be stopped.**

At this juncture I think it is most appropriate to mention the advantages of the prepuce, as great many of the people do not really appreciate these. This appendage protects the glans which is not very sensitive to ordinary stimuli. It has special receptors for other pleasurable sensations. Continuous exposure of the glans after circumcision leads to dullness of the special receptors with obvious results. The pistol should be taken out of its holster only when you want to clean it or when you are ready for action. The similarity is clear in this context of the prepuce. This is the natural law that governs all species.

There is still another advantage of the prepuce. During coitus it helps the penis to penetrate smoothly and without friction by retracting as the organ advances. William Osler seems to have aptly compared penetration in the circumcised man to the thrusting of the foot into the sock held open at the top which in the intact counterpart it has been likened to slipping the foot into a sock that has been previously rolled up - you have a right to your own choice.

Types of Circumcision

There are four variations of circumcision as described by Wynder and Licklider (1960) resulting in complete exposure of the coronal sulcus at one extreme and a covered glans at the other. It is obligatory on the part of the surgeon to know that in Muslims it is a requirement that the sulcus should be exposed after circumcision.

Methods of Circumcision

The ways in which circumcision can be performed are —

(1) Using a general surgical set - by the free hand method
(2) Using bone forceps
(3) Using Gomco clamp and
(4) Using the Hollister disposable plastibell

All methods are subject to the following errors

(1) Removing too much skin
(2) Removing too little mucosa

(3) Accidental damage to the glans and
(4) Incomplete haemostasis

Care should be taken to prevent these.

I would like to say a few words about the plastibell - as this is a fairly recent device. This is made of plastic and available in five sizes - very small, small, regular, large and very large - measuring 1. 1, 1. 2, 1. 3, 1. 5, and 1. 7 cm respectively. In the great majority of infants the regular size is most suitable. The device and the piece of twine are prepacked and presterilized and ready for use. The hollow cone truncated to permit micturition is placed within the prepuce and over the glants. The redundant tissue is infarcted by the application of a tight ligature around the prepuce and the cone, in the groove of the cone.

It is important to remember that the plastibell should hang free without pressure on the frenulum. Pressure may be caused by removing too much foreskin or using too small a bell. If the ligature is not applied tightly enough the prepuce distal to it becomes enormously oedematous and this will require an emergency circumcision by the free hand method. Needless for me to say that this method is quite simple. time saving and gives good results. This can be performed by anyone - from the intern to the specialist, irrespective of whether he belongs to the obstetric department, orthopaedic department or even the ophthalmology department.

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PARIETAL LOBE SYNDROME

Lalini Seebert, M.B.B.S. (Cey.) *

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Summary:-

A case of parietal lobe lesion of the non dominant hemisphere due to vascular insufficiency is documented in view of the interesting signs and symptoms exhibited.

Case Report:-

W. S., a 50 year old male, was admitted to the Neurosurgical Unit, Colombo for investigation of increasing weakness of the left upper limb.

Inquiry revealed that 10 months ago he had noticed a numbness of his left upper limb but had not taken much notice of it. About a month prior to admission the patient started continuously dropping objects carried in his left hand. He had difficulty in wearing his sarong and buttoning his shirt.

He gave no history of headache, vomiting or fits.

On examination the patient was conscious, euphoric, fidgety and inattentive. He had a right homonymous hemianopia (Fig. 1) and on forcibly closing the eyes there was conjugate deviation of both eyes upwards and to the left. A left upper motor neurone facial weakness was noticed. He had weakness and wasting of the left upper limb and spontaneous twisting

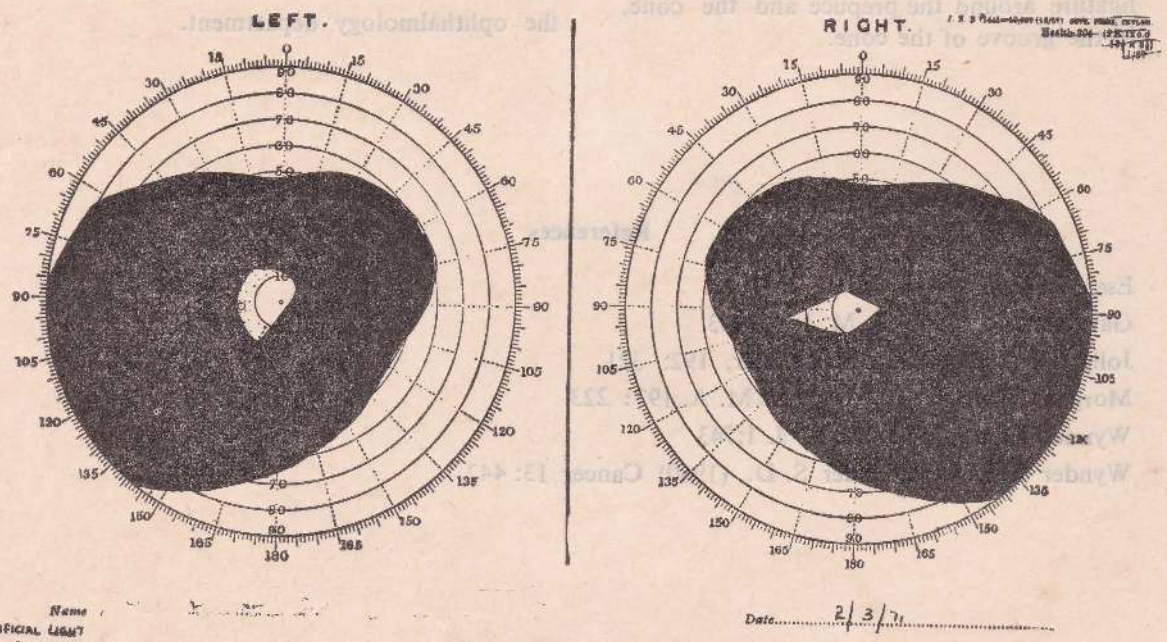

Figure 1 - Field Charts showing homonymous hemianopia

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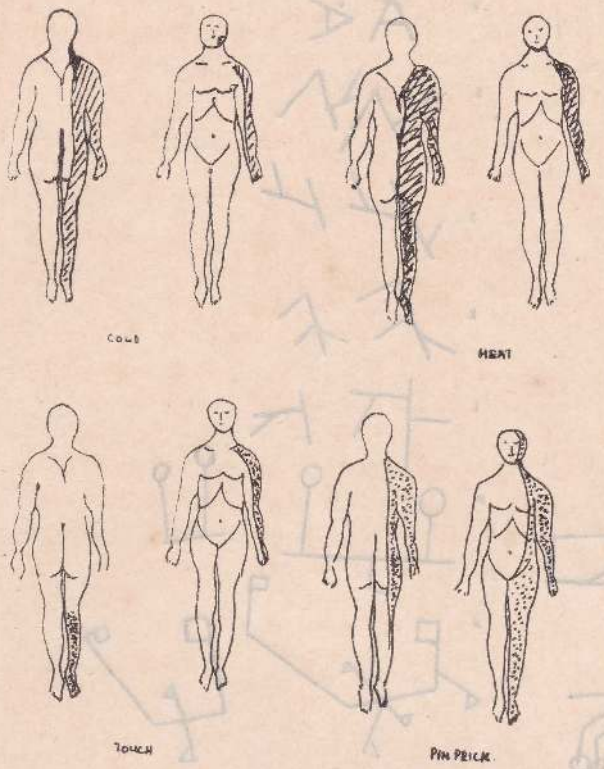
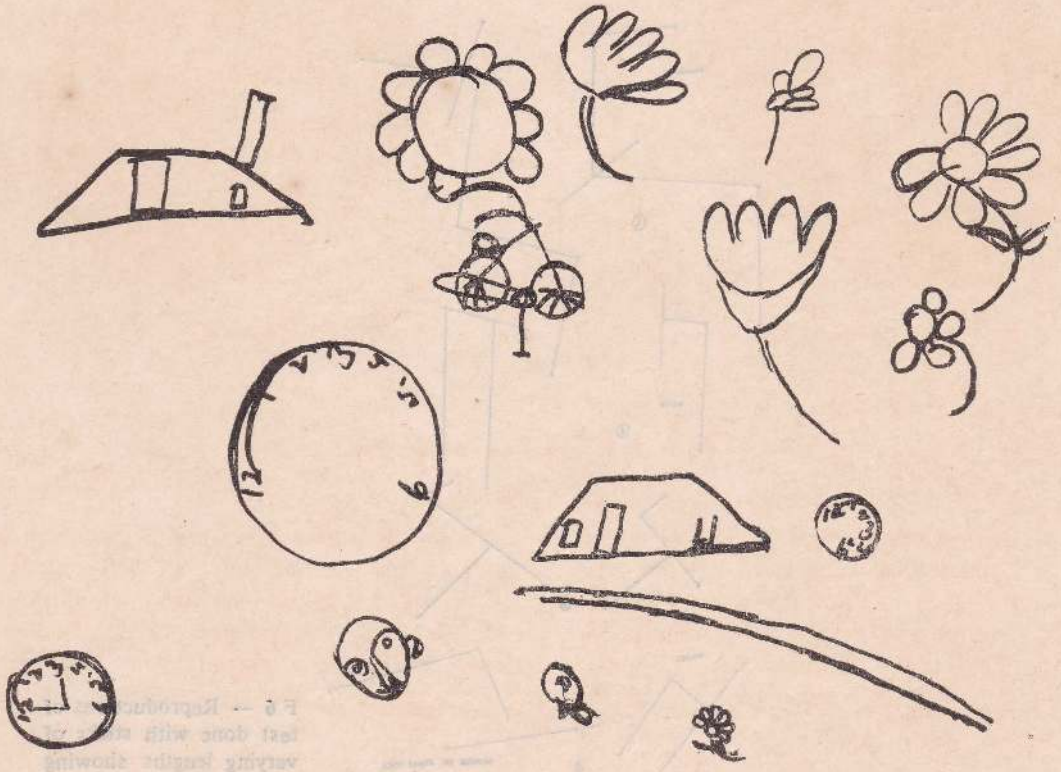


Figure 2 - Distribution of sensory loss.

movements of the left hand. Pain and temperature sensation in the left half of the body were diminished. (Fig. 2) There was loss of postural sense in the left upper limb. Two point discrimination and stereognosis were lost on the left side. He had exaggerated reflexes in the left upper and lower limbs with an extensor plantar response on that side.

The patient was aware of the left side of the body. He had no difficulty in pointing to various parts of his anatomy, and naming his fingers and the examiner's fingers; but he tended to ignore the left half of external space. He showed a tendency to crowd his drawings into the right half of the paper, had ignored the left half of some of the drawings (Fig. 3) The lines drawn were not bold and single. In copying the model diagrams the patient's diagrams were unusually close to the models. He had omitted details on the left half of his drawings. (Fig. 4 & 5 - D G.J.L.M.N.)

Figure 3 — Drawings made by patient neglect of left half of space.



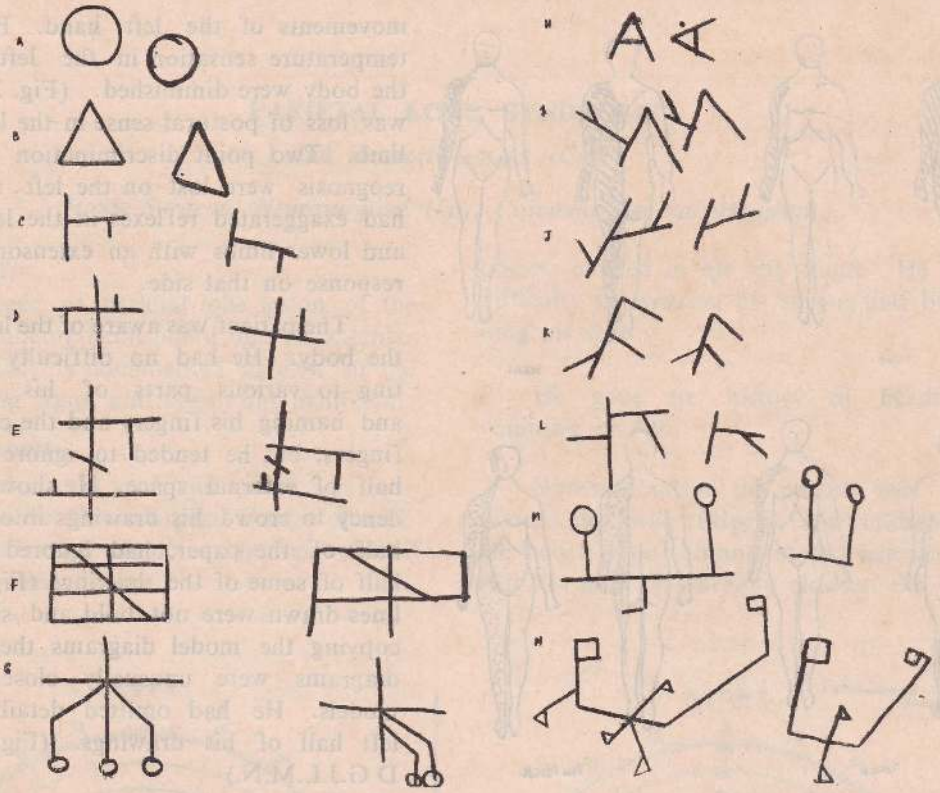
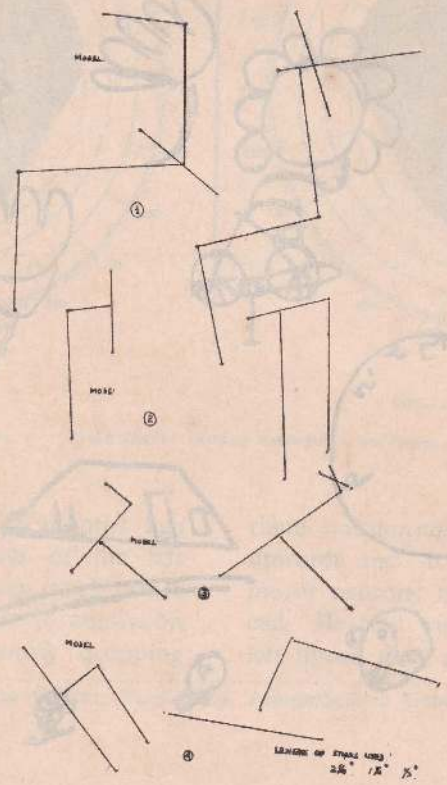


Figure 4 & 5 — Model drawings and patient's copy showing Constructional Apraxia and neglect of left half of space.



F 6 — Reproductions of test done with sticks of varying lengths showing constructional apraxia.

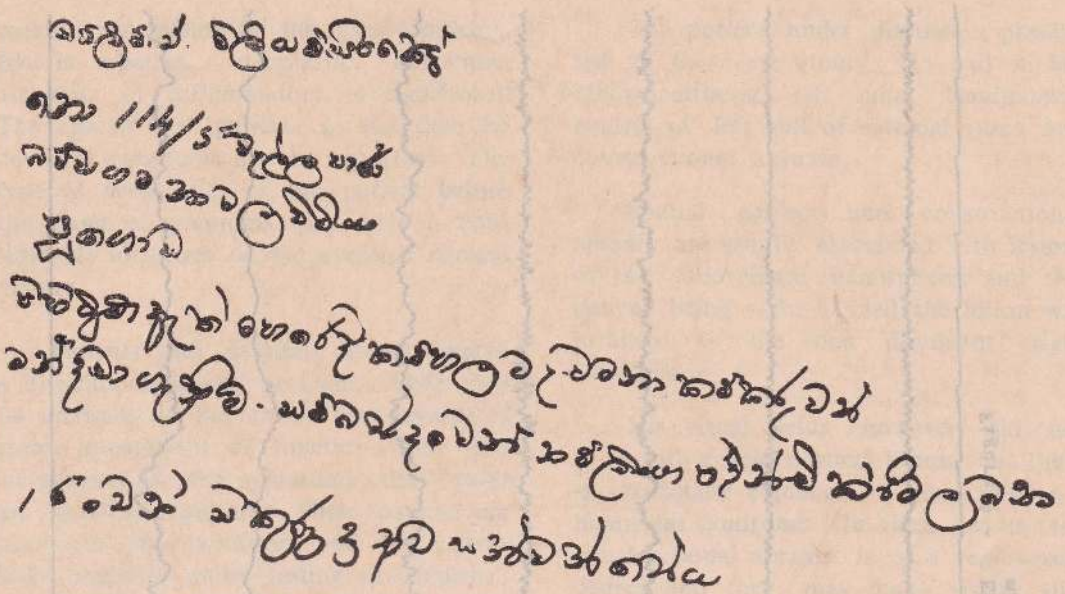


Figure 7 - Copy of patient's handwriting.

Tested with sticks of varying lengths the following features were noticed. (Fig 6) The sticks were not neatly placed in apposition. (IV) There was mirror reversal of parts of the patterns. (I) Sticks of incorrect length were selected which did not match the model and there was inaccurate alignment. (IV) Handwriting showed no abnormality (Fig. 7). One of the four simple calculations given was wrong. (Fig. 8) He could read a paragraph from the paper and understand and could also copy correctly.

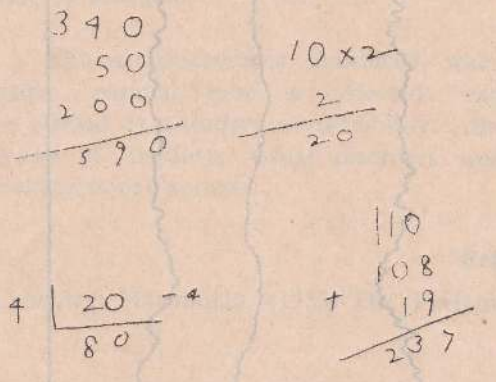


Figure 8 - Basic Arithmetic Test done by patient.

His blood preassure was 150 m. mi of mercury systolic and 80 m. m. of mercury diastolic. The cardiovascular and respiratory systems were clinically normal. The E. C. G. and Teleradiogram of chest were normal. Blood urea 25 m.g% Serum cholesterol 275 m.g.%. Blood V.D.R.L was non reactive. Blood sugar 75 m.g.%

The E. E. G. showed an asymmetry of right sided slow wave activity mainly temporal, suggestive of a destructive lesion Infarct. (Fig. 8) Echo-encephalography and right carotid angiogram were normal.

Discussion:-

The clinical manifestations of disease of the parietal lobes are diverse. Some patients show few abnormal signs while others display intricate clinical pictures. Reasons for this diversity is not yet fully understood.

The actual size of the lesion naturally plays a part, though it is less important than might be expected. The

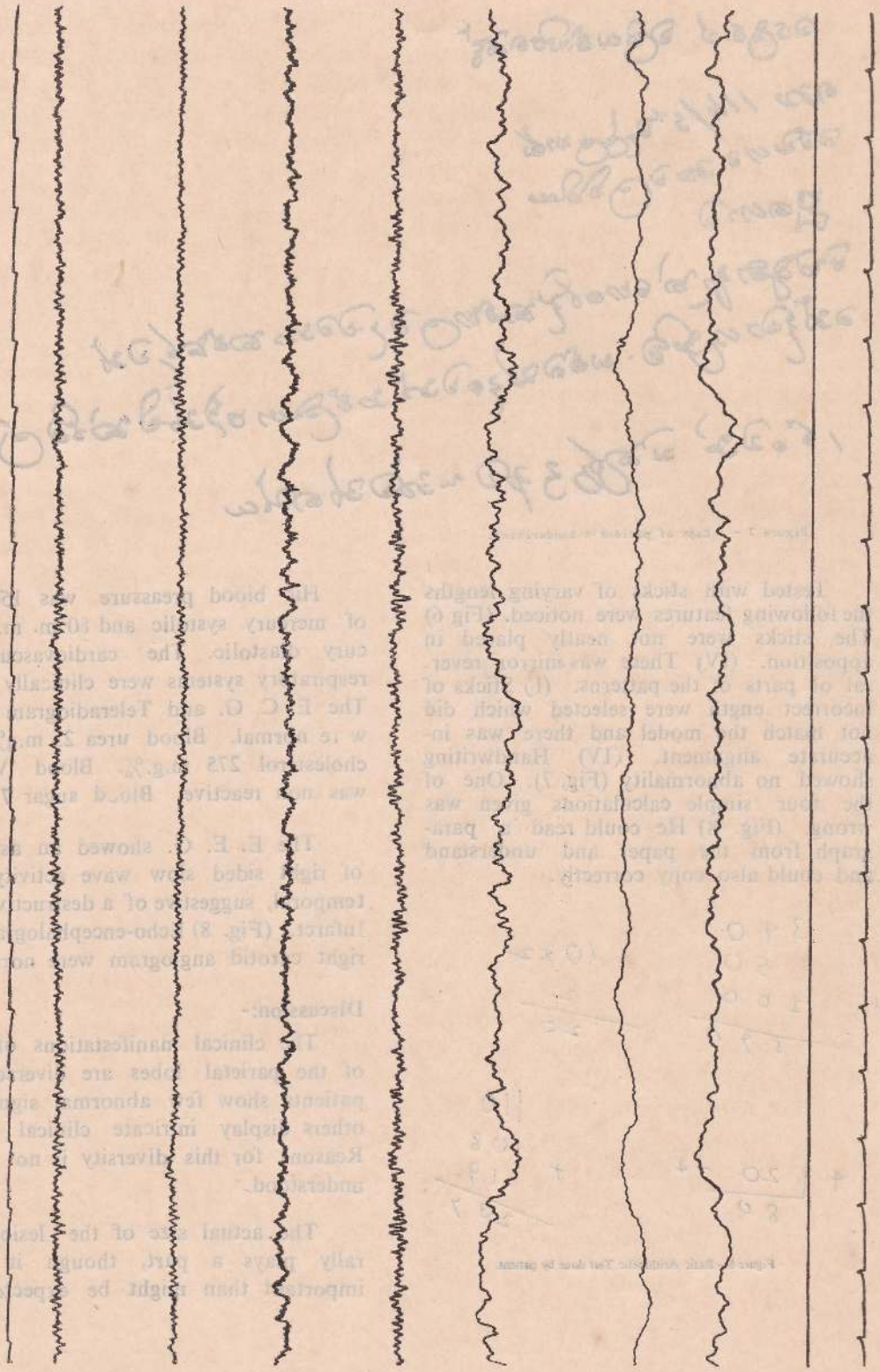


Figure 9 - EEG - showing right sided slow wave activity mainly in the temporal leads.

pathological nature of the disease process, that is whether neoplastic, ischaemic, atrophic, or inflammatory, is significant. The age of the patient at the time he develops symptoms may be important. The type of personality of the patient before the onset of symptoms may have a considerable influence on the eventual clinical picture.

Patients with parietal disease present a difficult diagnostic problem. They may be unaware of the extent and severity of their impairment of function and give an account of the symptoms that paint an inadequate picture. These patients are also very poor witnesses and very unreliable subjects under testing procedures.

In the case presented it is a shortcoming that the history could be obtained only from the patient. We were unable to supplement his story with that from a close associate as no such person visited him during his entire stay in hospital.

The two parietal lobes though morphologically identical are clinically anything but equipotential. In a right handed person the left parietal lobe, when the seat of disease, shows clinical defects which do not occur when the non dominant right lobe is affected.

Clinical phenomena produced when either parietal lobe is affected can be classed as disorders of sensibility, disorders of motility, visual disorders and constructional apraxia.

The patient under discussion presented all these symptoms. He had a left hemianaesthesia, left mild hemiparesis, neglect of left half of external space and constructional apraxia.

Spatial neglect and constructional apraxia are usually associated with lesions of the subordinate hemisphere, and this patient being right handed, the lesion was localised to the non dominant right hemisphere.

His visual fields however did not fit in with a right cortical lesion, but there is inadequate evidence to label this as a biparietal syndrome. In these cases the constructional apraxia is of a very severe degree and they may have visual disorientation, visual object agnosia, stupor etc. which this patient did not exhibit. He also showed no other disorders of his dominant hemisphere like bimanual astereognosis loss of topographical memory finger agnosia, right left disorientation, agraphia, and acalculia

The visual field disorder could therefore be explained as an isolated vascular lesion of the left cortex. The laboratory and special investigations also.point to a vascular aetiology for the right sided lesion.

Acknowledgements:-

The author is indebted to Dr. S. A. Cabraal for permission to publish this case and for all the assistance given. Our thanks are also due to Drs. G. S. Ratnavale and P. I. Wirasinha for advice.

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AN UNUSUAL CASE OF OBSTRUCTIVE JAUNDICE

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Summary.

Obstructive jaundice that follows recent removal of the gall bladder signifies either the development of a stricture of the common bile duct or stone within it unremoved or undiscovered at the time of cholecystectomy. When in the latter situation one finds evidence that the gall bladder has apparently reappeared, the circumstances become unusual indeed. Such a case is reported and its implications discussed.

Case Report.

B. M., a 38 year - old farmer was referred from a distant Provincial Hospital to the University Surgical Professorial Unit in the General Hospital, Colombo for 'specialised treatment' and was admitted on August 2, 1970. The transfer form meagrely stated that cholecystectomy had been performed about 4 months earlier and that this had been followed by a recurrent biliary fistula for which he was being referred to Colombo.

The patient's story was that he had been in quite good health until March 22 when he developed sudden severe pain in the right upper abdomen radiating to the back together with vomiting. There were no other prominent symptoms. Episodes of pain and vomiting occurred several times daily and after two days of unsuccessful home treatment he sought advice at his provincial hospital where he was admitted and treated with injections and operated upon 3 days later since he had developed fever in addition to his original symptoms which had become worse despite treatment. His postoperative course was uneventful and he was discharged home practically symptom - free on April 1.

Ten days after his return home he noticed a dirty yellow discharge from the upper part of his wound which he found was swollen. He went back to hospital and was readmitted. A second operation was carried out - the upper part of his wound was opened up - and he discharged further yellowish material from his abdomen intermittently for about 25 days at the end of which he was sent home once more with the wound healed.

On July 7 he noticed a lump in his abdomen in relation to his operation wound because his attention was directed to it by a dull ache. The lump increased gradually in size and some days later he developed backache and noticed that his eyes were yellow. At this stage he also developed loss of appetite and itching of the whole body and noticed that his urine was dark in colour, but had no fever or change in his stools. He sought treatment once more at his hospital some 10 days after he noticed the lump in his abdomen. He was readmitted and investigated and then transferred to Colombo by ambulance.

EXAMINATION. The patient was found to be of average nutrition and build, not acutely ill, afebrile, not anaemic and obviously jaundiced. The cardiovascular and respiratory systems were without clinical abnormality. The abdomen showed no evidence of any form of sinus or

fistula. There was a linear healed right upper paramedian scar extending well below the umbilicus. At the upper end of the scar there was felt a smooth spherical lump of about 6 cm. in diameter. The lump was intra-abdominal and had all the features that could be expected of a palpable distended gall bladder. The liver was not enlarged and no other significant findings were elicited in the abdomen.

INVESTIGATIONS. The patient's serum bilirubin stood at 19 mg. % with the urine loaded with bile and containing normal amounts of urobilin. Serum alkaline phosphatase was at 60.0 KA units, prothrombin time at 100% and other liver function tests were within normal ranges. Blood urea stood at 37 mg%, WBC and DC were within normal limits and ESR was at 108 mm. in the first hour.

In view of the note on the transfer form that cholecystectomy had been carried out and the presence on examination now of a right sided lump with gall bladder features, contact was established with the patient's hospital and precise information as to his past surgical history requested. The only data that were forthcoming indicated that cholecystectomy had definitely been carried out for acute cholecystitis and that the specimem had been forwarded to the Colombo Unversity Department of Pathology for report. Inquiry at this Department revealed that the specimem had been reported on as one of acute cholecystitis - the specimen had unfortunately been discarded - but the pathologist who reported on the specimen remembered it well enough to confirm that the gall bladder was of about average size and configuration and that it was grossly inflamed.

As such, the case gathered more than ordinary interest and a percutance cholangiogram was considered the best procedure for elucidation of the situation. It was carried out on July 9 and was successful as well as surprising in the pictures that it produced. The films showed that the intrahepatic biliary tree was dilated as was the common bile duct - to a moderate degree - and the cause of the obstruction was a stone of about 1 cm. in diameter at the lowermost portion of the common bile duct. There was a second stone of about the same size a little higher up causing apparently partial obstruction and a similar third calculus in the middle of the common hepatic duct. The piece de resistance of the cholangiogram was a cystic duct of normal size and location expanding out into a pyriform shape typical of an intact and dilated gall bladder (Fig. 1).

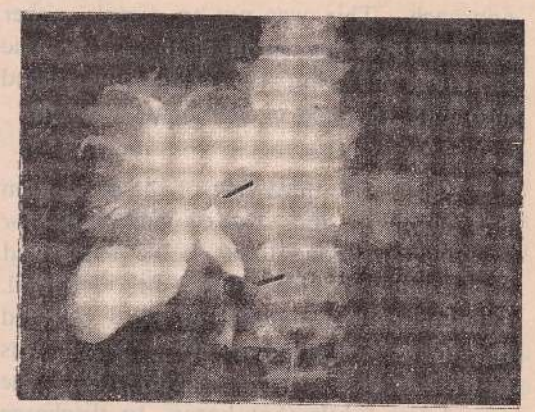

Fig. 1. Percutaneous cholangiogram showing the dilatation of the biliary tree, the dilated gall bladder and the obstructing stones (black arrows).

OPERATION. Laparotomy was carried out on July 12 under general anaesthesia after intensive preparation with parenteral vitamin K and a high carbohydrate diet.

An intravenous infusion of Mannitol of 250 ml. was commenced immediately before surgery.

The abdomen was opened with excision of the old right paramedian scar. The tissues were unusually vascular right down to the peritoneum. The peritoneal cavity was found with some difficulty as it too was partly sealed off by vascular adhesions. The greatest of care employed in separating adhesions failed to prevent an accidental opening into what appeared to be the fundus of the gall bladder which was adherent to the pyloric portion of the stomach which suffered a tear of about 7 cm. in length down to the submucosa. This was closed with fine silk. The supraduodenal area was also a mass of vascular adhesions and hence exploration of the common duct was resorted to by the easier way of 'Kocherisation' of the duodenum for a transduodenal approach. This was not so simple either and in mobilising the duodenum the hepatic flexure of the colon was accidentally opened into and required closure with fine silk.

Finally the third part of the duodenum was mobilised and exposed sufficiently for an oblique duodenotomy to be made and the papilla of Vater to be identified. Division of the sphincter of Oddi revealed the lowest obstructing stone which was easily extracted. Whilst suction kept the area free of bile that began to discharge from the common duct, the other two calculi were removed by a Desjardin's forceps advanced cephalad as well as several pin head - sized calculi and biliary sand and mud. The biliary tree was flushed out with sterile saline, a wide sphincteroplasty was done and a short polythene tube of about 1 cm. internal diameter sutured with catgut into the open ampulla of Vater before the duodenum was closed.

Attempts at cholecystectomy only resulted in tearing of the oedematous and vascular fundus and this procedure was abandoned. The lumen of the gall bladder was cleared of debris, a stone of about 1 cm. in diameter of the pigment type (as were all others) removed and an 18F Foley catheter introduced through a separate stab wound used to fashion a cholecystostomy.

After closure of the gall bladder fundus around the catheter a corrugated rubber drain was introduced through another stab wound to drain the paraduodenal area. The sutured tear in the hepatic flexure was mobilised and brought to the surface of the skin lower down and anchored there to a small skin incision as a prophylactic measure against intraperitoneal leakage before the main operative wound was closed.

One pint of blood was transfused during the operation to cover losses and nasogastric suction and intravenous fluid therapy continued into the postoperative phase until intestinal activity returned - about 48 hours later - when the patient was graduated from fluid to solids orally in stages and mobilised to full ambulation. The cholecystostomy drained well and the discharging bile was returned to the patient by the nasogastric tube from which there was very little aspirate after 24 hours. After removal of the tube the patient swallowed most of the bile without demur.

The patient's convalescence was marred by only one factor - a persistent fever around 101° F which failed to respond to the ampicillin given on the antibiotic sensitivity of the **streptococcus faecalis** cultured from his bile. Seven days after surgery the cause of his fever became obvious as a wound infection. In addition to a seropurulent discharge from the site of the corrugated

rubber drain removed much earlier there was a bulge at the upper end of the wound. Following incision and drainage of the abscess in the wound, the fever subsided rapidly and wound healing progressed steadily.

Eleven days after operation the Foley catheter was removed after prior clamping of it for 24 hours was without ill effect and a retrograde cholangiogram through it had demonstrated good patency and easy emptying into the duodenum of the common bile duct.

The patient's obstructive jaundice subsided rapidly after operation and two weeks postoperative serum bilirubin was at 1.0 mg.%, alkaline phosphatase was at 10 KA units and the urine free of bile. When he was discharged home on August 8, a little less than a month after surgery, he was symptom free, had clear sclerae and healed wounds and was gaining weight. He was requested to report for follow up in six months (or earlier if he had any untoward symptoms) but did not turn up until about 9 months had passed. He stated that he had no symptoms, was feeling well and was back at his normal work. Since he was not very enamoured of subjecting himself to surgery for the removal of his gall bladder due to various domestic reasons and since we had had considerable difficulty earlier with his vascular adhesions, which could possibly diminish with the passage of time, it was agreed that he come back again in about six months for review.

Discussion

The only explanations which can be offered for the finding of a gall bladder on cholangiography and confirmed at surgery after previous cholecystectomy in this case includes (a) reformation of the viscus through dilatation of a cystic duct stump, (b) removal of only the distal part of an hour-glass gall bladder with subsequent enlargement of the remainder and (c) removal of one 'half' of a double gall bladder.

Dilatation of a cystic duct stump rarely gives rise to anything other than a miniature gall bladder (Le Quesne, 1969). The cholangiogram in this case showed a gall bladder of about normal size and the interval between cholecystectomy and reformation of the gall bladder appears far too short (about 3 months) and symptomless to make cystic duct stump dilatation from obstruction the answer to the findings of this case.

Perhaps the same reasons could be held valid for dismissing an hour-glass gall bladder whose proximal portion had dilated to reform the gall bladder found subsequently.

The third possibility that only one twin of a double gall bladder was removed at cholecystectomy which may have been done as an emergency under difficult conditions of access and visualisation which prevented a true assessment of the situation ranks highest in probability in the explanation of the facts of this puzzling situation.

On this assumption one could perhaps site the calculi in the common duct as originating from this second gall bladder since the patient had no features pointing to their presence except during the last episode of illness which brought him to Colombo.

Exploration of the common bile duct for stone at a second operation by the orthodox method of opening it between stay sutures in its supraduodenal part is beset with the hazards provided by inflammatory

adhesions of the first operation, quite apart from those provided by anatomical anomalies. Hardy and Davenport (1969) stress the simplicity and advantages of the transduodenal approach. By using this method stones are less likely to be left behind and if they are, there is more chance of their being passed spontaneously through the ampulla now widely open from the sphincteroplasty. The technical difficulty of this operation is little affected by previous biliary disease or surgery. This statement probably holds true when such disease or surgery has not been recent and the disease not acutely inflammatory as witnessed by the more than ordinary difficulty provided by the vascular adhesions of our case through recent acute disease followed by surgery. T-tubes are unnecessary and permanent free drainage of the common bile duct is assured.

If there is any lesson to be extracted from the situation provided by this case - apart from the one of consideration of the transduodenal approach to the common bile duct more frequently and favourably in dealing with common duct stone- it is that under difficult conditions and lack of suitable facilities for exploration and/or radiographic visualisation of the biliary tree, discretion is better than valour and cholecystostomy safer than cholecystectomy. Cholangiography that may reveal the exact state of affairs in the biliary tree is later often possible via the cholecystostomy tube to prevent blundering into the unknown at subsequent surgery.

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A CASE OF PRIMARY AMYLOIDOSIS.

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The widespread deposition of homogenous material throughout many organs of the body was first described in 1842 by Rokitansky. Virchow in 1854 noted that like starch this material stained with iodine and sulphuric acid and termed it Amyloid. Actually it has no relation to starch but is of protein of variable composition usually associated with a sulphate bearing polysaccharide similar to, if not identical with chondroitin sulphuric acid. Election microscopy has demonstrated the fibrillar nature of Amyloid. The deposition may occur as a result of chronic suppurative and inflammatory processes such as tuberculosis, bronchiectasis, Lung Abscess, osteomyelitis, rheumatoid arthritis, regional ileitis, Ulcerative Colitis, chronic pyelonephritis and reticulosis, when it is Secondary Amyloidosis, or it may occur without any of the above diseases as a primary condition. The primary disease may occur as a familial or sporadic form. In the pre antibiotic era the former was commoner but with decreasing incidence of chronic suppurative disease since the advent of antibiotics the relative frequency of primary amyloidosis is being increasingly recognised

Case Report

Mr. A. D. R. aged 48 years, trader by profession was admitted to General Hospital Colombo on 4.7.70, with swelling of both feet and oliguria of ten days duration of insidious onset. Till then the patient had been in good health. He had no headaches, giddiness, exertional dyspnoea, puffiness of face, distension of abdomen or haematuria. He had no previous history of sore throat, hypertension, diabetes or rash in any part of body or ingestion of any drugs of note. The patient did not give a history of alcohol or infective hepatitis. On examination he had an enlarged 2 finger breadth liver and oedema of both feet.

Investigations Serum Proteins Total 5.6. gms.% Albumin - 2.4. gms.% Globulin - 3.2. gms.% S.G.P.T. - 8 units Urine occasional pus cells Blood Urea 20 mg% Liver function test - Serum bilirubin .5 mg Zinc sulphate turbidity 4 units Thymol turbidity 1 unit

The patient left against medical advice before investigations were completed but his oedema had subsided. He was provisionally diagnosed as a case of Nephrotic syndrome. Two weeks later, the oedema reappeared with oliguria and abdominal distension. He was readmitted and on examination in addition to the oedema of both legs he had ascites and the liver was enlarged four fingers, its consistency was hard and surface was coarsely nodular.

Investigations Urine - free of albumin no pus or red cells Prothrombin time 21 secs =62% of normal. Bleeding time 1 min. Clotting time 13 minutes. Serum proteins 6.2. gms% Albumin 2.6. gms% Globulin 3.6. gms% Serum alkaline phosphatase 69 K.A. units L.F.T. - Serum bilirubin .3 mg. Zinc sulphate 24 units. Blood Urea 32 mg% L.F.T. (Repeated) Serum bilirubin .4 mg% Zinc sulphate turbidity 10 units Thymol turbidity 2 units.

He responded to aldactone, Lasix Vitamin K, Calcium Lactate and slow K. He was discharged as having had cirrhosis of liver. Four days later the patient deve

loped oedema and distension of abdomen, and was readmitted for the third time. His oedema had increased, both his lower limbs were swollen and his ascites was more, the size and consistency of the liver remaining the same. In addition he also had numbness of both feet and loss of postural sense. His liver function tests were now as follows. Prothrombin time 17 sec - 100% Serum bilirubin .5 mg% Bleeding time 1½ mins. Clotting time 6 mins. Alkaline phosphatase 20 K.A. units. **L.F.T.**-Zinc sulphate turbidity 9 units Thymol turbidity 1 unit Electrophoretic strip showed raised beta globulin. Albuminuria Serum cholesterol 350 mg%. X'ray chest - N.A.D. Blood Urea 25 mg% Urine - Pus cells 5-6 a field, Epithelial cells 2-5 a field, E.C.G. - low voltage curves otherwise N.A.D. X'ray chest - N.A.D.

This prompted us to investigate the cause of his hard nodular enlarged liver. Liver biopsy was done and the section of the aspirated liver tissue showed diffuse deposition of Amyloid between the hepatic parenchymal cells and in the walls of sinusoids with associated atrophy of the liver cells. Congo red stain was positive for Amyloid. Gum biopsy, rectal biopsy and intravenous Congo red test were not done on this patient. Having established that the patient had Amyloidosis we investigated for the presence of diseases like pulmonary tuberculosis, bronchiectasis, lung abscess, leprosy, osteomyelitis, rheumatoid arthritis, regional ileitis, ulcerative colitis, chronic pyelonephritis reticulosis or myelomatosis. But we could not substantiate any of these. Since we could not find a cause for his Amyloidosis it is reasonable to assume that it is of primary type.

Discussion:—

The deposition of Amyloid in organs in the primary and secondary types varies. The localisation of Amyloid in primary and secondary is given in table I. In multiple myeloma Amyloid deposition occurs but it is primary in distribution. Amyloid deposition initially occurs in the blood vessels, small arteries and capillaries. Pressure and interference with the blood supply leads to secondary changes. When Amyloid deposition occurs in the spleen, intestines and adrenals it is called typical and when it occurs in tongue, heart, skin and nerves it is termed atypical. In typical the deposition is perireticular, and deposited along reticular fibres particularly in the intima and the inner portion of the media of blood vessels. In contrast in the atypical form the distribution is pericollagenous, the amyloid is deposited along Collagen fibres in the adventitia and the outer media. Only one fibre system is affected in a given case of Amyloid whether primary or secondary in origin (Table II, Heller et al 1964.)

The whole course of the disease in patient ADR is less than one year's duration and showed evidence of liver and kidney dysfunction. He had no macroglossia, and the heart except for low voltage curve in electrocardiogram was normal: he had peripheral sensory impairment but had no obvious peripheral nerve thickening. His father died at the age of 70 years but had no similar ailment, mother, one brother and three sisters are all in good health. His involvement of liver was confirmed but the Nephrotic syndrome picture may be produced by the compression of the inferior vena cava by the hard nodular liver or renal vein thrombosis which is common in amyloidosis or by pure amyloid deposition in kidney itself. We were unable to confirm these as the oedema and ascites rapidly progressed and did not respond to diuretic therapy. Only repeated plasma transfusion relieved the oedema and ascites to some extent. The management is symptomatic as there is no specific treatment available which will cure any form of amyloidosis.

TABLE I.

	Primary*	Secondary +
Heart	85 %	1 %
Tongue	57 %	1 %
Gastro intestinal tract	52 %	4 %
Skeletal muscle	41 %	
Kidney	26 %	72 %
Spleen	24 %	89 %
Adrenal gland	22 %	41 %
Liver	17 %	63 %
Bone and joints	11 %	63 %

* Data from Eisen Am. J. Med. L: 144 (46 cases)

+ Data from Rosenblat. Am. J. Med. Science 186:558 1933 (110 cases)

TABLE II.

	Peri-reticulin amyloidosis	Peri-collagen amyloidosis
Hereditary	Familial Mediterranean Fever Urticaria and deafness	Neuropathic Cardiopathic
Acquired	Associated with chronic infection, chronic inflammation of unknown origin or malignant neoplasm	Associated with multiple myeloma
Idiopathic	Primary with typical distribution ("nephropathic")	"Classical" primary neuropathic or cardiopathic Localised

Classification of the Amyloidoses (from Heller, Missmahl et al (1964)

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MYXOMA OF THE VULVA — CASE REPORT

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Case Report

A case of Myxoma of the vulva is presented. S. M. A., a 38 year old married woman was admitted on 20-2-70 to the Gynaecological Unit of my ward at the De Soysa Hospital for Women. She had been married for 5 years and had one child 2 years after marriage but this child died 3 days after birth. Regarding this neonatal death she was not certain about the cause of death. Since then she had not conceived. Her present complaint dates back to about 5 months when she noticed a small swelling in the right labial region. She carried on with it till it reached the present size and became ulcerated giving rise to a discharge.

On examination, she was of average build and her general condition was satisfactory. There was no evidence of filarial manifestation anywhere else in the body. The heart and lungs were clinically normal. The blood pressure recorded was 110/80 mm Hg. The abdomen showed no ascites. The liver and spleen were not palpable. There were no lumps in the abdomen. The inguinal and femoral lymph nodes were not palpable. The external genitalia was now examined with the patient in the dorsal position (Fig. 1). There was an oval lump 7 inches by 4 inches arising from the Right labium majus with signs of ulceration over the left and anterior aspect of the lump. The lump had a peculiar rubbery feel on palpation. It had a broad base which was seen to extend from the anterior end of the labium majus to the ischio-rectal fossa. This was well illustrated when the lump was lifted up and towards the left with the patient lying flat. Considering the size and consistency a provisional diagnosis of Elephantiasis of the vulva was made. The patient was given bed rest till the ulceration healed.

Investigations

Blood - Hb. 65%, Blood urea 35 mgms %, Microfilaria nil. Urine - No abnormalities detected.

Operative Technique

The patient was placed in the lithotomy position. An elliptical incision was made round the base of the lump. The incision was made deeper into the tissue, cutting into normal tissue deep to the tumour mass. The base was very vascular with large blood vessels arising more from the ischio rectal region. Anteriorly the ischio-pubic ramus had to be exposed to remove the entire tumour. Cut section of the tumour were sent for histology. A self retaining catheter was maintained in situ for 48 hours. The post operative period was uneventful. She was seen at the Gynaecological Clinic in July 1971 and there was no evidence of recurrence. She is still being kept under supervision.

Pathologist's Report

The histological appearances are compatible with a Myxoma.

Discussion

This case illustrates a rare tumour of the vulva. Benign connective tumours of the vula are extremely rare, only 34 cases having been seen at the Mayo Clinic in 34 years. Compared to epidermal lesion, con-

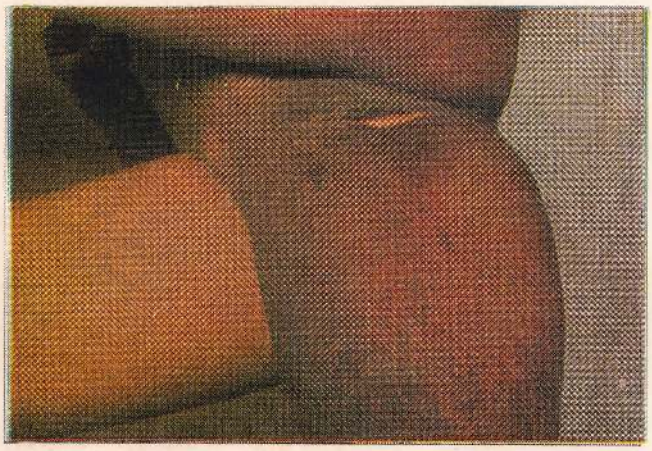

Fig 1:—Myxoma of the Vulva.
Appearance of the tumour with the patient in the dorsal Position.

RADIOLOGICAL QUIZ.

Compiled by **Dr. S. N. B. Talwatte**
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Text on Page 185, Answers on Page 188

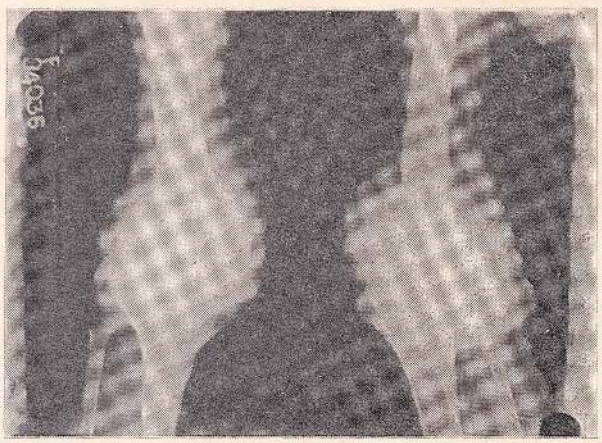
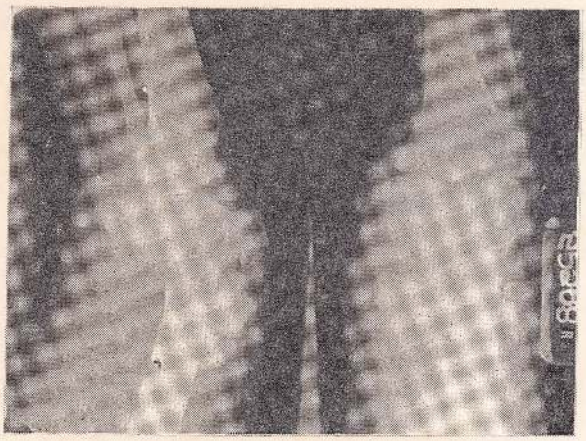


Fig 1.



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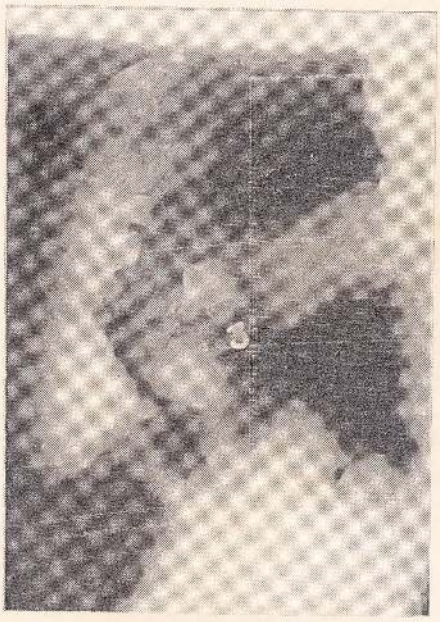

Fig 3.

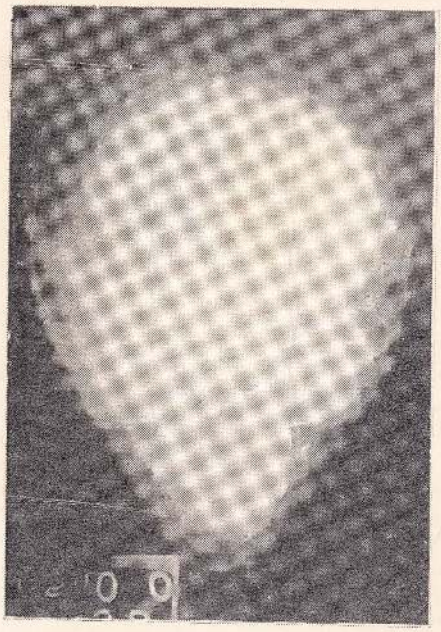

Fig 4.

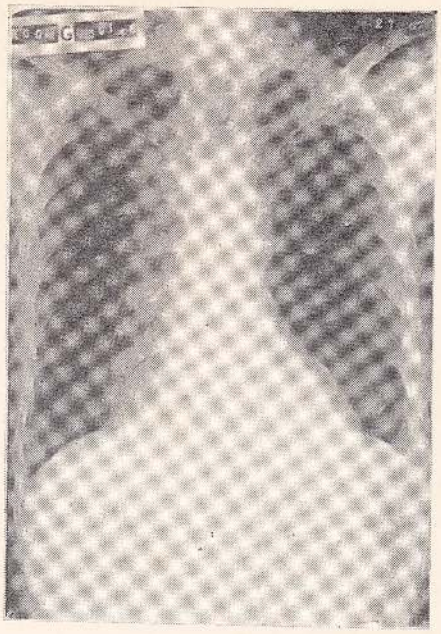

Fig 5.

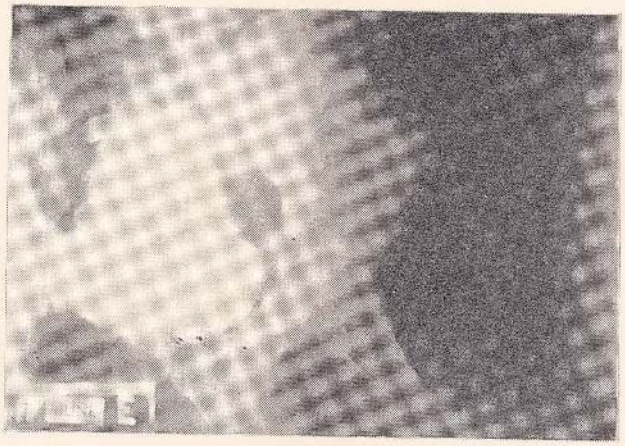

Fig 6.

nective tissue tumours are relatively uncommon. Of these, Myxoma is so rare, that in describing solid benign tumours of the vulva Novak goes on to say "though still others like the Myxoma and Lymphangioma have been observed in rare instances.

It is not surprising tumours situated in the vulva produce so few symptoms. The vulva is a region not seen by the patient and swellings in this region do not in themselves produce symptoms of pressure. Subjective symptoms occur only when tumour reaches a large size or when ulceration takes place as in this case.

Jeffcoate also makes a passing mention of Myxoma as a tumour of the vulva. He considers the common sites as the ischiorectal fossa and subcutaneous tissue of the buttocks. It is also seen arising or extending to the paracolpos. Being soft and poorly encapsulated it is usually difficult to excise. It is likely to recur and sooner or later to become frankly sarcomatous. Jaffcoate describes recurrence of the tumours 3 years after excision.

RADIOLOGY QUIZ

(see plates facing pages 184 + 185)

Compiled by **Dr. S. N. B. Talwatte,**

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Fig I. X'ray of the R knee joint of a 52 year old male with swelling of the Right knee joint and limitation of movements of 6 months duration.

Fig II. X'ray of the R knee joint of a 60 year old male with pain and swelling of the Right knee joint of 2½ years duration.

Fig III. Barium enema study of a 53 year old woman with diarrhoea, loss of weight and anorexia of 3 months duration.

Fig IV. X'ray of skull of a 18 year old girl with proptosis of the Left eye and a "pinched" face.

Fig V. Chest X'Ray of a 59 year old man with dysphagia of 3 years duration and bouts of Coughing.

Fig VI. Cystogram of a 28 year old male with difficulty in passing urine following an accidental fall 4 years ago.

ANTI-CHOLINESTERASES IN THE CONTROL OF THE NEUROLOGICAL MANIFESTATIONS OF RUSSELL'S VIPER BITE

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Introduction

Poisoning due to Russell's viper bite causes haemotological, neurological and renal manifestations. This report deals with a case of Russell's viper bite whose neurological manifestations were controlled by the administration of anti-cholinesterases.

Case Report

W.S.A. a 20 year old male was admitted to the University Medical Unit at 4 p.m. on 3-6-71 with a history of a Russell's viper bite 21 hours before admission. He had developed local pain and swelling at the site of the bite a few hours after the bite and later developed diplopia, slurring of speech and finally complete dysphagia with generalised muscular weakness. He had passed only a small amount of red coloured urine since the bite.

On admission the patient looked ill. His blood pressure was 110/80 mm of Mercury, his pulse was 100 per minute. He was anaemic and there were two fang marks just above the left medial malleolus, the area round it being swollen and tender.

He had bilateral ptosis, complete opthalmoplegia and bulbar paralysis with slurred speech, total dysphagia and nasal regurgitation. There was generalized flaccid paresis of his muscles with absent deep reflexes.

Treatment

He was given 100 millilitres of polyvalent antivenin on admission. Penicillin one mega unit six hourly and hydrocortisone

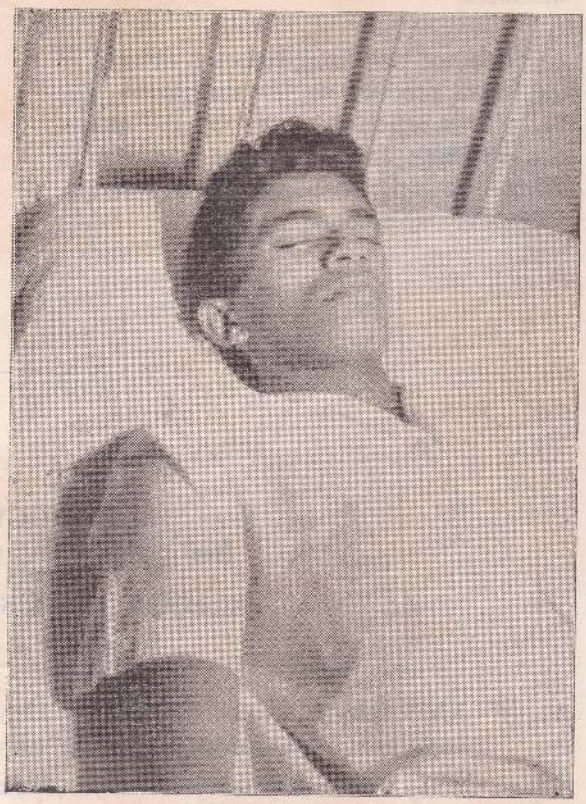

Fig. I. Complete ptosis of the eyes seen on the second day after the snake bite.

100 mg. six hourly was commenced. ATS 3000 units and 1 ml. of tetanus toxoid were given. A diuresis was obtained with 250 ml. of 20 per cent mannitol and continued with a slow infusion of mannitol, 80 mg. of frusemide and 5 per cent dextrose intravenously.

Next day (4-6-71) the patient continued to have ptosis complete ophthalmoplegia

and dysphagia (Fig. 1). He was given 10 mg. edrophonium ('Tensilon') intravenously. There was an immediate dramatic response. The ophthalmoplegia and ptosis completely disappeared, and he drank a glass of water without any difficulty. These effects lasted for a few minutes.

Anti-cholinesterases were continued with neostigmine 30 mg. t.i.d. with complete relief of the neurological manifestations.

He made an uneventful recovery. The neostigmine was tailed off in a few days.

Comment

Russell's viper venom usually causes death by massive haemolysis, in the acute phase, or by the acute renal failure which supervenes, in the later stages. The neurotoxicity in Viper bite though rarely leading to acute respiratory failure, usually does not cause death directly unlike in Elapidae (which includes cobras and kraits) poisoning. However the respiratory depression together with the dysphagia often leads to aspiration, and the diplopia and generalised muscular weakness is frightening and incapacitating to the patient.

The specific treatment of Russell's viper bite is the use of anti venom in large doses (over 100 ml) given soon after the bite (Reid 1968). Exchange transfusion has been shown to be of some value in severe cases (Peiris et al 1969).

Anti-cholinesterases were tried in this case, since it was observed that the neurotoxicity of the Russell's viper bite resembled very closely, tubo-curarine poisoning and myasthenia gravis. In Russell's viper poisoning ptosis and ophthalmoplegia are the first to appear followed by dysphagia and generalised muscular paralysis, and it disappears in the opposite order, the ptosis and opthalmoplegia being the last to disappear. This pattern suggested that there was a reversible neuromuscular block as seen in tubocurarine poisoning. The dramatic relief of the neurotoxicity observed during exchange transfusion (Peiris et al 1969) also suggested a circulating reversible neuromuscular blocking action of the neurotoxin. The anti-cholinesterases, it was presumed may antagonise the neuromuscular blocking action of the Russell's viper bite.

The pharmacolgy and biochemistry of snake venoms are extremely complex, and though 'neurotoxins' 'haemotoxins' 'vasculotoxins' etc. are often described these relate more to the clinical manifestations rather than distinct biochemical products, The neurotoxicity of snake venoms have been extensively studied. Elapidae and hydrophidae (which consist of water snakes) have been shown to have specific polypeptide neurotoxins while in the viperidae too, these have been demonstrated but are pharmacologically somewhat different from the former. The mode of action of the cobra neurotoxin seems to be a curare like effect, while in the viperidae it seems to be by blocking peripheral nerve conduction (Juimenez, Porras, 1970). However the polypeptides are not the only substances leading to neurotoxicity. Cholinesterases and acetyl - cholinesterases have been described in snake venom. Phospholipases have also been incriminated and are supposed to act by increasing the permeability of the nerves and the neuro muscular junction and permitting the pharmacologically active toxins to penetrate the nerve (Russell & Puffer 1970).

Anti-cholinesterases cannot be expected to reverse completely the neurotoxicity of snake venom on theoretical grounds. However this case demonstrated that it may be useful in neutralising the neurotoxicity in certain cases of snake bite. While its role in the routine treatment of the neurotoxicity of snake bite remains to be established, it does seem to be a promising technique of preventing the morbidity and mortality of the neurotoxicity at least in certain types of snake bite poisoning.

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Answers to Radiological Quiz

(Compiled by Dr. S. N. B. Talwatte, Department of Radiology, Colombo General Hospital)

Fig. 1 There is disorganization of the Right knee joint with a combination of destructive changes and gross new bone formation. Neuropathic (Charcot's) joint.

Fig. 2 There are densely calcified opacities especially in the supra patellar compartment of the Right knee joint with secondary osteo-arthritic changes mainly in the medial compartment of the knee and the patello-femoral articulation. Osteochondromatosis

Fig. 3 There is a filling defect in the lower pole of the caecum and narrowing of the terminal ileum. Ileo-caecal tuberculosis (The chest film showed pulmonary disease as well)

Fig. 4 There are map like bone defects in the skull with destruction of the roof of the left orbit (hence the proptosis) The "floating" teeth are due to destruction of the maxillae and mandible.
Hand - Schuller - Christian disease

Fig. 5 There is a right paramediastinal shadow extending from the diaphragm to the root of the neck. Soft granular opacities and translucencies can be seen within the limits of the shadow (food residue and trapped air) Achalasia cardia with a grossly dilated oesophagus.

Fig. 6 This is a neurogenic bladder with a grossly trabeculated "pine tree" appearance (The patient had a cord injury)

Retirement

Dr. J. R. RICHARDS

L. M. S. (Cey.), D. A. (Lond.), F. F. A. R. C. S. (Eng.)

Dr. J. R. Richards retired as consultant Anaesthetist, Colombo Group of Hospitals on 26th July 1971 having served the Department of Health for almost thirty years of which he spent twenty two years as an Anaesthetist. In 1966 he became the Senior Anaesthetist and in 1967 he was elected the first President of the Association of Anaesthetists of Ceylon.

He took to anaesthesia in the "bad old chloroform" days when the Silk mask, the Junker bottle and the Shipway apparatus were familiar sights in the operating theatre. In 1950 he went on postgraduate study leave to Liverpool where he learnt modern Anaesthetic techniques from men such as Cecil Gray and Jackson Rees. He was a very popular "Liverpudlian" and in one of their parties he stole the show by dressing as a Sinhalese country gentleman with coat and sarong, buttoned shirt and no tie and wearing a 'konde' with a comb.

On his return to Ceylon in December 1952 he introduced modern anaesthetic techniques and with the return of others these techniques became fully established here with disappearance of the "rag and bottle". Here again he was very popular with the surgeons be worked with and was much sought after in hospital and out side.

In 1966 when he succeeded Dr. C. Umagiliya F.F.A.R.C.S. (Eng.) as Senior Anaesthetist he got on well with most of his colleagues and was kind and under standing to the Junior staff. In his administrative capacity he may not have been able to please every body but that is the lot of all administrators. He resigned from this post shortly before he retired.

His colleagues and junior staff bade him farewell in the usual tradition with a theatre party to which the hospital staff were invited and presented him with an engraved silver plate.

In his retirement he appears to be a busy as ever and we wish him well and many more years of service in the private sector.

T. W. V.

JOURNAL OF THE COLOMBO GENERAL HOSPITAL, ESSAY PRIZE

The Journal of the Colombo General Hospital will award two prizes of Rs. 100/- each for essays pertaining to clinical observations made in any hospital or other medical institution in Ceylon, Credit will be given particularly for originality.

One prize will be restricted to persons who have not completed two years since commencing their internship, while the second will be open to those within five years of commencement of internship. Entries for the 1972 awards must be received by the Editors not later than 1st February 1972. All communications should be addressed to Dr. D. Chanmugam, Editor, Journal of the Colombo General Hospital, Department of Medicine, Faculty of Medicine, Kynsey Road, Colombo 8.

The panel of judges will comprise Professor R. A. Navaratne, Dr. T. Visvanathan, Dr. N. J. Wallooppillai, Dr. H. A. D. Weerasooriya and the Editors of this journal, All essays submitted become the property of this journal, and may be published in the journal. The decision of the panel of judges will be final.

UNIVERSITY OF CEYLON, COLOMBO

Final Examination for Medical Degrees — Aug. 1971

(Provisional results subject to confirmation by the Senate)

Second Class (Upper)

Chandrasoma, P.T. (Distinction in Obst & Gyn) Fernando, U.D.S. (Distinction in Obst & Gyn) Gunawardene, K.A. (Distinction in Medicine) Kreltszheim, M.A. Mihindukulasuriya, J.C.L. (Distinction in Medicine) Seneviratna, Miss D.R. (Distinction in Obst & Gyn) Sheriff, M.H.R. (Distinctions in Medicine and Obst & Gyn)

Second Class (Lower)

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(Provisional results subject to confirmation by the Senate)

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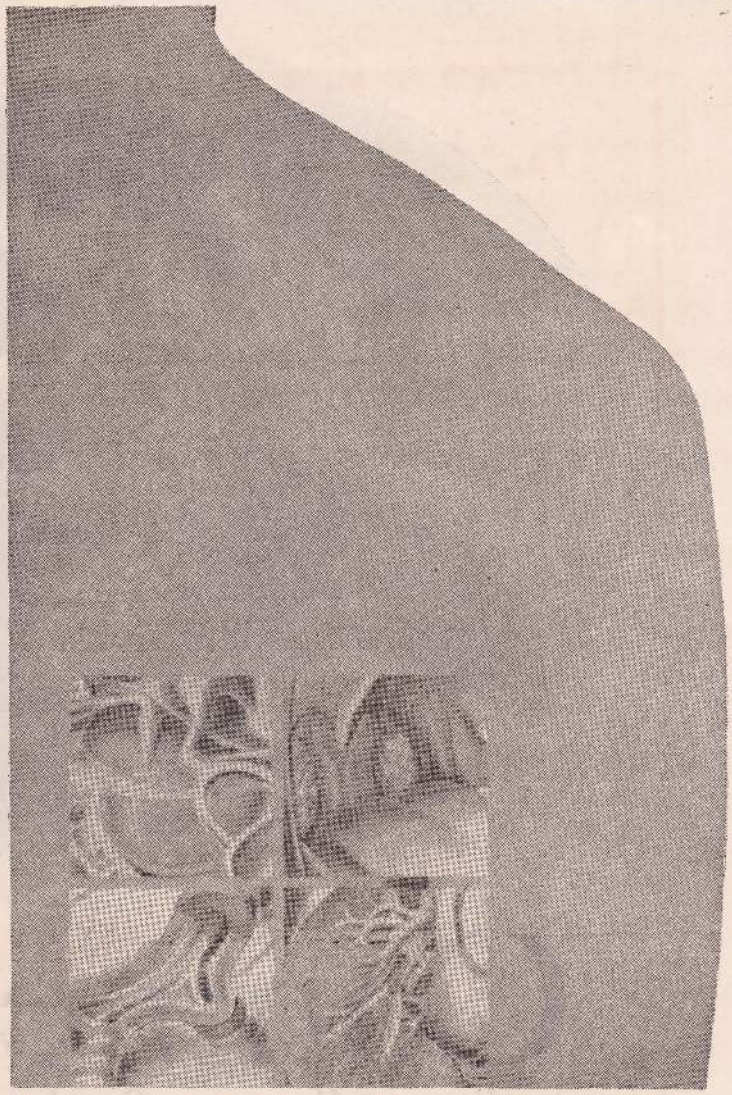

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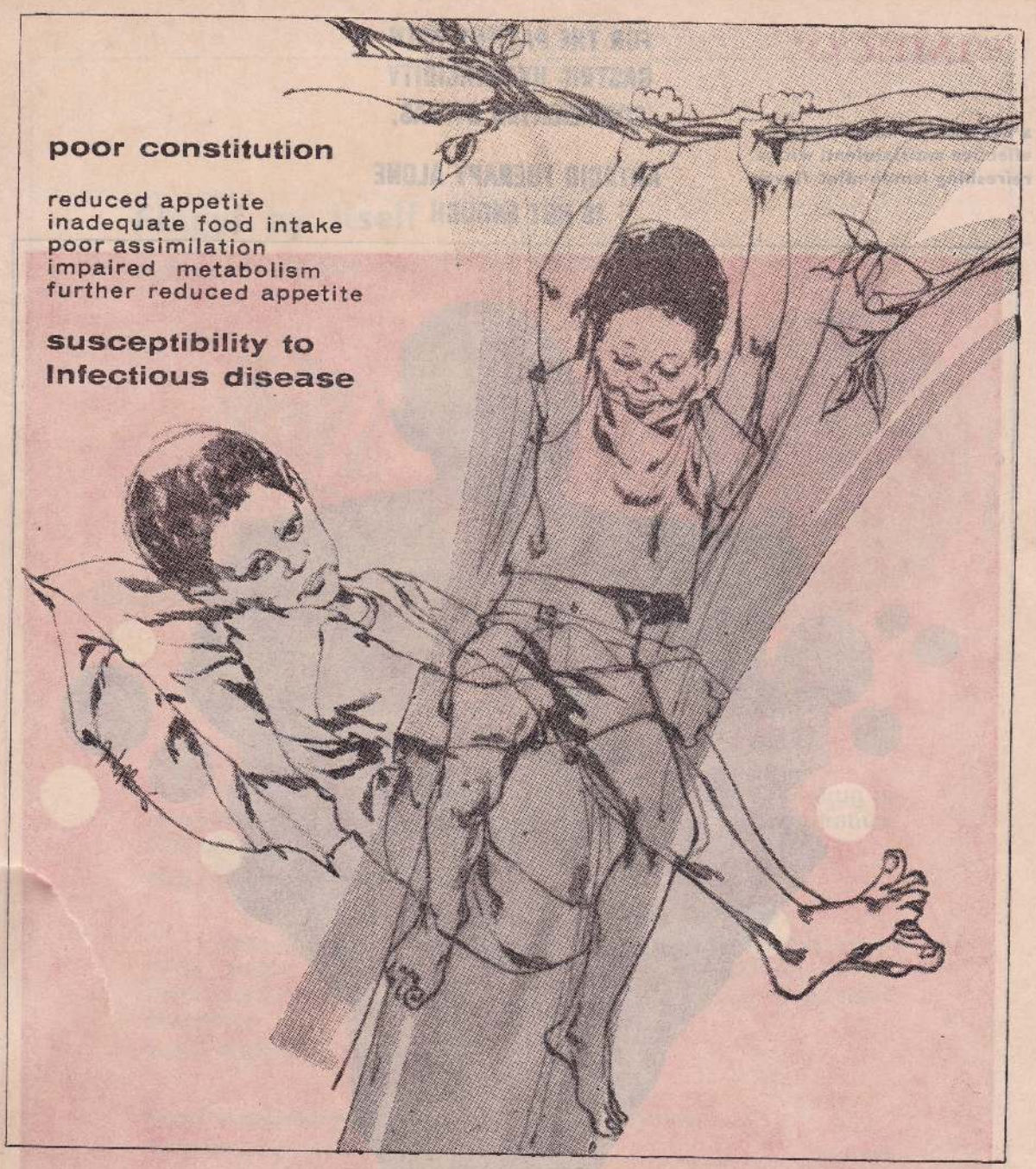

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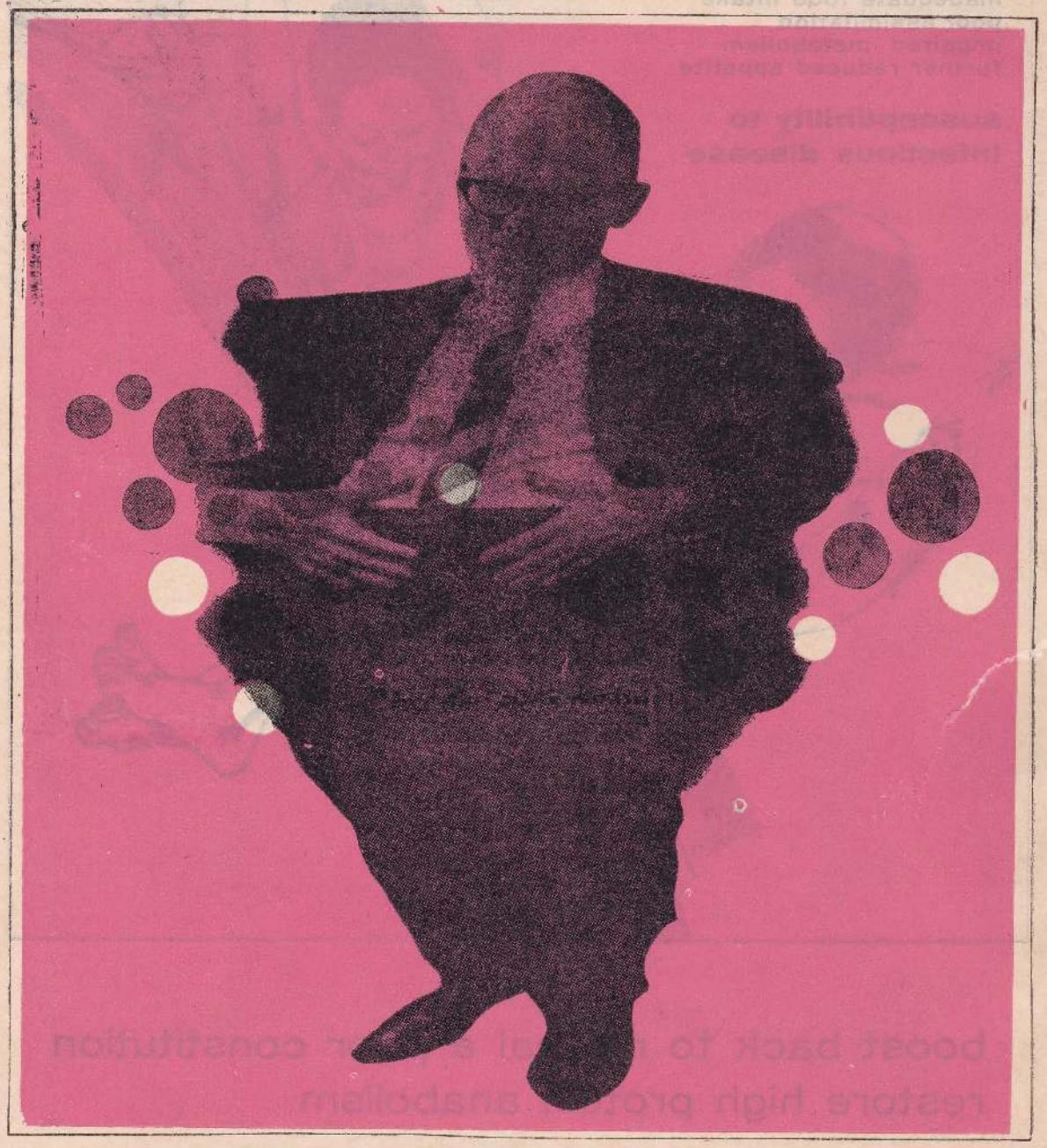

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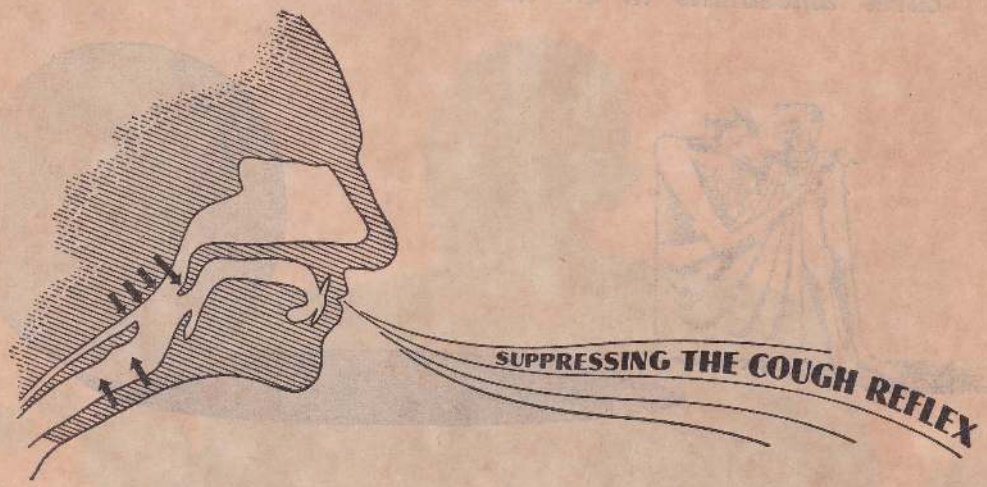

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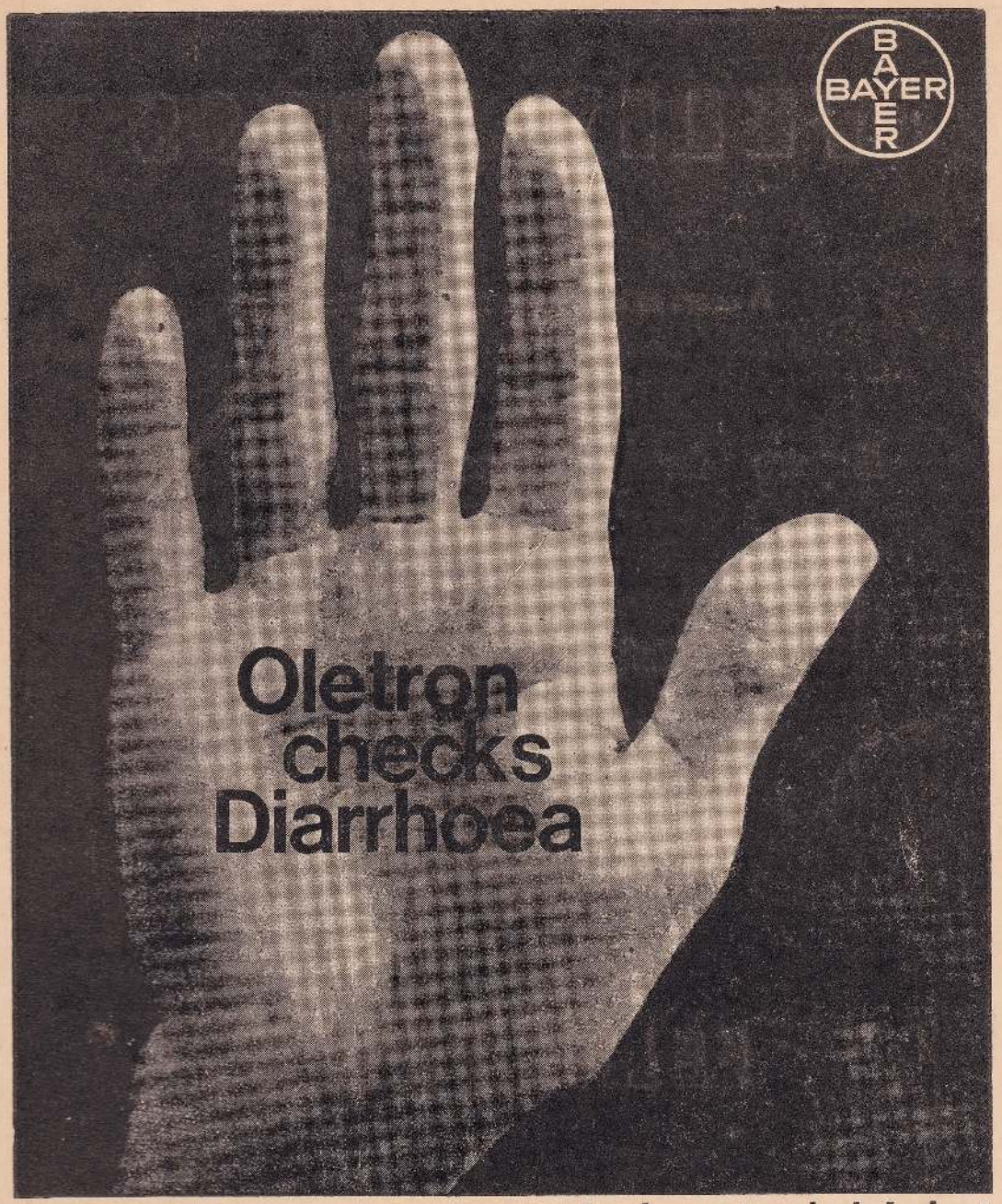

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