



SINGAPORE MEDICAL ASSOCIATION NEWSLETTER

FOR PRIVATE CIRCULATION ONLY

VOL. 21 NO. 2

JUNE 1990

Recd 20/9/90

MCI(P) 6/2/90

PP(S) 18/12/89

YOUR BODY, MIND & SPIRIT IN BALANCE

Keynote Address by Dr Aline Wong,
Assoc Prof in Sociology, NUS,
Member of Parliament, Tampines GRC,
at the Public Symposium "Your Health In Balance"
in April 1990



Dr Aline Wong

“Recently, Mr Goh Chok Tong called on Singaporeans to return to being a rugged society. Speaking at the official opening of the College of Physical Education's new facilities, he noted the disconcerting trend towards obesity among school children, newly-enlisted NS and SAF reservists. (11.3.90, Straits Times). In 1984, 6% of male Primary 1 pupils were obese. Four years later, the figure doubled to 12%. In 1984, too, the obesity rate for male Primary 6 pupils was 11%. By the time they reached Secondary 4 in 1988, that cohort had 2 more per cent obese population. Last year, the percentage of obese boys in Primary 6 was 18%, an increase of 7% points in five years. From these trends, it is projected that one out of five Secondary 4 boys in 1993 will be obese. While Mr Goh pointed out that the general lack of physical fitness would be detrimental to our ability to withstand the pressure of competition and endure the rigours of military training, it should be noted that the obesity rates and trends among girls were equally serious, although somewhat less serious than among boys. Thus, physical fitness is a general problem for concern for the entire young population.

It is well known that obesity is a health problem associated with rising affluence; it can be a result of having too much good food or too much bad food, as

well as result of lack of proper exercise. Affluence among the adult population has changed our disease patterns. Now, cardiovascular diseases, coronary heart diseases and strokes account for more than one-third of annual deaths; and cancers for one-quarter. Other important diseases are diabetes and hypertension. The prominence of such diseases reflect not only the success of our public health measures and medical services in controlling other types of diseases which were the former killers, but also the changing lifestyles that come with affluence.

To the health care professionals, fighting obesity and the other health hazards obviously calls for health education and promotion, and an emphasis on prevention and early detection. Proper diet, proper exercise, rest and recreation, in short, good lifestyle, can definitely help us stay fitter. In many wealthy, industrial societies, the health craze started in the late 1970s; and Singapore is beginning to catch on. However, health consciousness and health behaviour only address two elements in the "formula" or catchword which is the topic of our discussion. What about the spirit?

To address questions of the spirit, we need to examine our fundamental values as individuals and as a society. I was quite intrigued to read the definition of health (WHO) as "a state

of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Nobody is perfectly healthy, or at all times perfectly healthy. What is important, almost in a philosophical sense, is that we take the aches and pains — both physically and emotionally — in life, and make something meaningful out of our existence. Hence, the question of values.

Many years back, in 1977-78, a national survey on youths aged 15 and 24 was conducted by academics of the then Nanyang University. A total of 1135 respondents were interviewed, comprising 557 schooling youths and 578 working ones. About one-third of both groups rated having "a happy family life" as the most desirable thing in life; another 20% chose "job security"; and 18% chose "happiness and love." On the other hand, however, the most important symbol of success in life was "having an education and a degree" (31%), "having money" (18%), "a prestigious occupation" (18%) and "social status" (18%). The report summarized the attitudes of Singapore's youth towards life as self-reliance, pragmatism, forward-looking and materialism.

The survey was carried out during the days when Singapore was a young population, with 54.7% below 25 years. There was

rapid urbanisation and industrialization, and there was great optimism. It was also the days when people's life goals were neatly summarized in the '1-wife, 2-children, 3-room flat, 4-wheeled vehicle' "slogan". Today, some of these goals have changed, but the essential traits are still with us. For example, the emphasis on education as a means of success, and the emphases on individual achievement and materialism.

This is borne out by a recent study on the perceptions and aspirations among youths (MCD Research Section, June 1988). Although this recent study adopted a different methodology — instead of a large-scale survey, it used focussed group discussions with 115 people from a slightly older age group of 18-35 — a similar profile of the Singaporean youth emerges. Because of the qualitative research methods, some of the findings seem to highlight the problems associated with, for example, the youths' emphasis on education, and their attitudes

towards work. It is said that the students are generally exam-oriented, and there is a lack of curiosity for intellectual pursuit. There is an overall feeling that the educational system is too rigid, what with streaming and stringent entry requirements at the tertiary level, so that "if you miss it, you are doomed". Among those who work, work is just another phase, a mundane part of life. Work is for a salary, for a living, to support themselves and their families. There is a distinct lack of idealism and enthusiasm in work. Job security is considered important; many work hard and say they have no time or energy left to enjoy leisure activities. On social aspirations, one common thread among all the groups researched on is the wish for more freedom and less restrictions in the country, with the strongest views being expressed by the A-level students and the professional/executive groups. The report notes that migration is now a common topic in social discourse among many youths, although it is not known how many of

cont'd on page 15

INSIDE

Garfield Says: A Fishy Story	3
Preventing Vision Loss In Our Population	4
Family, Work, Culture & Religion	5
Syphilis — Interrupting Serological Results	6
Chlamydia — Management of the Silent Epidemic	7
History of Medicine: Women Pioneers In Medicine	9

EDITORIAL

SUNDS

The cause of sudden unknown nocturnal deaths (SUNDS) amongst construction workers remains speculative. Dr Ho's letter in the last issue of the newsletter and a recent letter in the Lancet (May 12 1990) point out its similarity to the clinical picture of manual labourers of yester-years (port-workers, rickshaw pullers and prisoners) who were suffering from thiamine deficiency. Keefer, writing in Peiping, China in 1905, explained the "protective effect" of thiamine deficient peripheral neuropathy on acute cardiac beri-beri. He said that patients with peripheral neuropathy (dry beriberi) were restricted in activity by the pain and parasthesia whereas those relatively spared continued to exert themselves doing manual work and ended up with acute cardiac beriberi and sudden death. The relatively poor nutritional background of northeastern Thai workers is a point in favour of the thiamine deficiency theory. Hard manual labour will further deplete the poor thiamine reserves. There are unexplained phenomena however; why should death occur only at night, or the early hours of the morning? Also, it is known that sudden deaths observed amongst refugees from Kampuchea occurred in sedentary workers as well. Stress of adjustment has been postulated as a factor leading to fatal arrhythmias and sudden deaths. The familial occurrence of SUNDS in north-east Thais at home and in 10-20% of Thai workers overseas suggested a genetic predisposition but the mechanism is unclear.

Unravelling the cause of SUNDS will require study into families afflicted with this syndrome and biochemical studies of thiamine levels, metabolites like pyruvic acid, lactate in response to manual work amongst Thai workers. In this context also, attention should be paid to Thai workers admitted with breathlessness or chest pain. These may be those who missed sudden death. One such patient admitted to Alexandra Hospital has been found to have raised cardiac enzymes that settled once the acute episode was over.

Much work remains to be done to prove or disprove the thiamine deficiency theory of SUNDS. Meanwhile, Thai authorities are educating their workers on the use of thiamine supplements and a wiser food choice to include thiamine-rich foods like meat, pulses and animal products.

GLG

EDITORIAL BOARD

Dr Goh Lee Gan	-	Editor
Dr Chan Kah Poon	-	Member
Dr Chee Yam Cheng	-	Member
Dr Jon Goh	-	Member
Dr Tan Hooi Hwa	-	Member
Dr Julian Wee	-	Member
Dr W R Rasanayagam	-	Ex-Officio
Michael Loh	-	Executive Secretary
Chua Gek Eng	-	Editorial Assistant

The views and opinions expressed in all the articles are those of the authors. These are not the views of the Editorial Board nor the SMA Council unless specifically stated so in writing. The contents of the Newsletters are not to be printed in whole or in part without prior written approval of the Editor.

JOURNAL ROUNDUP-

by Dr Chee Yam Cheng

MANAGEMENT OF MENORRHAGIA

It is not easy to measure menstrual blood loss. From the history only 40% of women who complain of flooding, passage of clots and heavy use of tampons or pads actually lose more than 80 ml of blood per cycle. Doctors therefore also rely on the haemoglobin estimation as two-thirds of women with objective menorrhagia suffer from iron deficiency anaemia.

Common causes of menorrhagia include fibroids, endometriosis, endometrial hyperplasia and dysfunctional uterine bleeding. Hypothyroidism, a bleeding tendency should be excluded. Pelvic examination is necessary to exclude endometrial malignancy or premalignancy. The D&C offers no guarantee of detecting intra-uterine disease and is not usually therapeutic. Hysteroscopy as an outpatient procedure is the best technique for assessing the endometrial cavity, endometrial polyps and submucous fibroids being found in up to half of all patients with menorrhagia.

Several effective treatments are available but none is curative nor universally effective especially in the presence of pelvic inflammatory disease. Intrauterine contraceptive devices that release progestogen seem effective without a high risk of ectopic pregnancy. The combined contraceptive pill, prostaglandin inhibitors (mefenamic acid, naproxen, indomethacin, ibuprofen, flurbiprofen, meclofenamate sodium) and antifibrinolytic agents are also effective, reducing menstrual blood loss by about 50%. Gestrinone may even reduce fibroid size. Tamoxifen, Vitamin E and subcutaneous desmopressin may also benefit.

Poorly controlled menorrhagia is indication for about one-third of total hysterectomy operations in women during their fertile years. The operative mortality is 6/10,000 and morbidity as high as 42.8 per 100 procedures. Long term adverse effects may include premature ovarian failure, cardiovascular disease, and urinary and bowel dysfunction.

Therapeutic Asherman's syndrome can be induced by endometrial destruction using lasers and chemicals. Today hysteroscopic endometrial ablation by laser electrodiathermy and endometrial resection is reality. Focal lesions like polyps and submucous fibroids can be selectively excised, with preservation of the woman's fertility.

BMJ 16 June 1990: 1537-8.

BREAST CANCER & THE PRIMARY CARE TEAM

The United Kingdom has implemented a National Breast Screening Programme aiming to reduce mortality from breast cancer through early diagnosis by mammography. Women aged 50-64 will be screened; women aged 65 and over will be screened on request; women under 50 will not be offered routine screening. Screening is by single oblique view mammography at three yearly intervals.

The primary care teams aim to improve the quality of the programme, increase uptake, and provide information and counselling related to all aspects of the programme. They will refer all women with abnormal mammograms to the specialist multi-disciplinary team at the assessment centres for further investigation to confirm normality or make a definitive diagnosis of cancer. For 2000 patients listed per general practitioner, 150 women will be eligible for screening with 7-10 requiring further investigations, 2-3 a biopsy

and in the end, one may have cancer.

Quality assurance is essential in the screening procedure which has 3 stages - identification and invitation, mammography and further investigation. Screening should be based on whole general practices screened once every 3 years rather than screening a third of a practice each year or smaller groups on a continuous basis. Screening by whole practice has been proven to be more effective in terms of operations, cooperation and uptake.

It is important to appreciate the complexity and limitations of mammography. Abnormal results create anxiety and most women with abnormal mammograms will be found to be normal on assessment and will rejoin the routine recall system. Some may require fine needle aspiration cytology and not a biopsy. The surgeon should be the patient's choice rather than the one in the multidisciplinary team at the assessment centre.

Non-attenders should be visited and counselled. The ultimate choice not to participate in the screening programme belongs to the women who should have access to accurate information to arrive at informed decisions. Some cancer may be missed; others may develop in the interval between screens. Women should be aware of minimal symptoms and present themselves to their doctors without delay.

BMJ 23 June 1990: 1631-4.

RECONSTRUCTIVE UROLOGIC SURGERY COURSE

16 - 18 November 1990

Organised by the Singapore Urological Association, Chapter of Surgeons, Academy of Medicine in conjunction with the 24th Annual Combined surgical Meeting.

Venue: Lecture Room 1, COM Building

For further information, please contact:

Dr Peter H C Lim
Urology Course Convenor
c/o Academy of Medicine, Singapore
16 College Road, Singapore 0316
Tel: 2238968 Fax: 2255155
Telex: RS 40173 ACAMED

GARFIELD SAYS: A FISHY STORY

A year ago, I installed an aquarium in my clinic. I did it for the following reasons.

1. I love pets. I remember at the height of my love affair with animals, I was at one time living simultaneously with a dog, a cat, a tortoise, two budgies, a snake, many rabbits and a tank of goldfishes. Later a vet told me that many people keep pets because unlike husbands, wives, lovers, children, neighbours or friends, they "don't talk back."

2. An aquarium of fishes is a relaxing sight. I would not go so far as to say that it can replace the benzodiazepines but certainly the sight of the fishes with their colourful scales, their soft and cascading tails, swimming and floating among the aquatic plants, seemingly without a care in the world, except perhaps to choose the fattest worm for dinner, can soothe taut nerves and calm agitated minds. I asked myself, what better occupation was there for suffering human beings, waiting to see a doctor than to contemplate a well-kept aquarium?

3. Water or "shui" means fortune, the currency kind. My classmate in school, Mr Kum Chia Chwee who had made a fortune selling sugarcane water, recommended that I display a container of water prominently in the clinic in order to improve business. Given the choice of a water cooler, a fountain or an aquarium, I chose the last.

4. Coincidentally at that time, one of my patients gave up his hobby. I inherited tank, filter, air-pump, fish food (fortified with vitamins), waterplants, pebbles and miscellaneous decorative items, FOC. One of my favourite decorative pieces is a pirate ship laden with treasures.

With high hopes to improve the well-being of both patients and doctor, I started to keep fishes in the clinic.

A year had since passed. Are my patients any healthier? Does having fewer patients mean they are healthier? Or have they forsaken me to seek better service elsewhere? Am I wealthier? Please judge for yourself.

I comforted and reminded myself that changes take time. After all a tank of fishes does not promise instant wealth like a lottery ticket. "Be patient," Mr Kum Chia Chwee said. By nature, I am a slow moving, rather inert and procrastinating sort of chap. Well, patients' health and doctor's wealth can wait but what was disturbing, causing concern and testing my patience was the rapid turnover of my fishes.

The fishes were healthy enough when I first purchased them but very soon they would lose their appetite, lose their colour, swim upside down and sink motionless to the bottom of the tank. Many times a week I have to conduct the final rites.

The mortality rate was indeed quite alarming and even the owner of the aquarium shop where I purchased my replacements was disturbed. At first he was quite defensive, insisting that he was an honest businessman and that he did not sell me sick fishes, later he became suspicious and then somewhat scornful of me. I could not blame him for losing respect for a doctor who could not even take care of a simple tank of tropical fish.

However, he was a nice man and with his help I became an amateur marine biologist and ichthyologist. I acquired knowledge on the Ph, temperature and impurities of water, the anatomy, physiology and life cycles of many species of fish, fish diseases and nutrition, etc.

But all these to no avail. I had to admit defeat. A

display of fishes swimming belly upwards, to put it mildly, is not a very comforting or reassuring sight to sick people.

I borrowed a pick-up to transport the paraphernalia, including a few drunken-looking survivors to my cousin, the dentist. It was then that I got my answer.

Nurses A & B & C, "Sorry doctor that we have to give away the aquarium."

"What do you mean? What do you people know that I don't know?"

Nurse A, "It's not our fault."

Nurse B, "It's their fault."

"Who are they? I'll kill the saboteurs."

Nurse C, "Your patients."

Nurse A, "They washed their hands in it."

Nurse B, "Sometimes after they visited the WC."

Nurse C, "Put out their cigarettes."

Nurse A, "Catch them with their hands, paper-cups and plastic bags."

Nurse B, "Put sweets and chocolates in."

Nurse C, "Phensedyl and coke."

Nurse A, "Calamine lotion, ice-cream and char-siew."

Nurse B, "They disconnected the tubes."

Nurse C, "Shot at them with rubber-bands."

Nurse A, "I saw one little boy wee-wee into it."

cont'd on page 15

Cefobid

cefoperazone sodium IV/IM

Cefobid Activity
against a wide range of clinically relevant organisms.

Cefobid Penetration
for clinical efficacy in a wide range of hospital infections.

Cefobid Convenience
with a simple b.i.d. dosage regimen in the majority of cases.

Cefobid Confidence
from a dual mechanism of excretion and the low side-effect profile of the cephalosporins.

PRESCRIBING SUMMARY

Description Cefoperazone sodium is a semi-synthetic broad-spectrum cephalosporin antibiotic for parenteral use only. Microbiology is active in-vitro against a wide variety of clinically significant organisms and is resistant to degradation by many beta-lactamases. Indications are indicated for the treatment of the following infections when caused by susceptible organisms: Respiratory Tract Infections (Upper and Lower), Urinary Tract Infections (Upper and Lower), Peritonitis, Cholecystitis, Cholangitis and other Intra-Abdominal Infections, Septicemia, Meningitis, Skin and Soft Tissue Infections, Infections of Bones and Joints, Pelvic Inflammatory Disease, Endometritis, Gonorrhea, and Other Infections of the Genital Tract, Prophylaxis (Cefoperazone Sodium may be indicated in the prophylaxis of post-operative infection in patients undergoing abdominal and gynecological surgery, cardio-vascular and orthopedic surgery). Cefobid may be used concomitantly with other antibiotics if such combinations are indicated. **Contraindications** Patients with known allergy to the cephalosporin class of antibiotics. **Warnings** Before therapy, careful inquiry should be made to determine whether the patient has had previous hypersensitivity reactions to cephalosporins, penicillins or other drugs. **Precautions** General Cefobid is extensively excreted in the bile. Dose modification may be necessary in cases of severe biliary obstruction, severe hepatic disease or coexistent renal dysfunction. In patients with both hepatic dysfunction and concomitant renal impairment, Cefobid serum concentration should be monitored and dosage adjusted as necessary. The serum half-life of Cefobid is reduced slightly during hemodialysis. Thus dosing should be scheduled to follow a dialysis period. As with other antibiotics, Vitamin K deficiency occurred in a few patients treated with Cefobid. A reaction characterized by flushing, sweating, headache and tachycardia has been reported when alcohol was ingested during and as late as the fifth day after Cefobid administration. Patients should be cautioned concerning ingestion of alcoholic beverages in conjunction with administration

The Starting Point for recovery in hospital infections

of Cefobid. As with other antibiotics, overgrowth of nonsusceptible organisms may occur during prolonged use of Cefobid. Patients should be observed carefully during treatment. **Usage During Pregnancy** No adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy only if clearly needed. **Usage In Nursing Mothers** Only small quantities of Cefobid are excreted in human milk. Although cefoperazone pass poorly into breast milk of nursing mothers, caution should be exercised when Cefobid is administered to a nursing mother. **Usage In Infancy** In treating premature infants and neonates potential benefits and possible risks involved should be considered before instituting therapy. Cefobid does not displace bilirubin from plasma protein binding sites. **Adverse Reactions Hypersensitivity:** As with all cephalosporins, hypersensitivity manifested by maculopapular rash, urticaria, eosinophilia and drug fever has been reported. **Hematology:** Slight decreases in neutrophils have been reported. As with other beta-lactam antibiotics, reversible neutropenia may occur with prolonged administration. Some individuals have developed a positive direct Coombs test during treatment with cephalosporin antibiotics. Decreased hemoglobins or hematocrits have been reported, which is consistent with published literature on other cephalosporins. Transient eosinophilia has occurred. **Liver:** Transient elevation of SGOT, SGPT and alkaline phosphatase levels have been noted. **Gastrointestinal:** Altered bowel habits (loose stools or diarrhea) of mild or moderate severity. These symptoms responded to symptomatic therapy or ceased when therapy was stopped. **Local reactions:** Cefobid is well tolerated following intramuscular administration. Occasionally transient pain may follow administration by this route. As with other cephalosporins, when Cefobid is administered by intravenous catheter some patients develop phlebitis at the infusion site. **Dosage and Administration Usual Dose:** Adult: 1 - 2 GM BD, Child: 25 - 100 mg/kg BD. Supply 0.25G, 0.5G, 1.0G, 2.0G, in vial.

Full prescribing information available upon request

PFIZER (M) SDN. BHD.
P. O. Box 333, Jalan Sultan,
46740 Petaling Jaya,
Selangor, Malaysia.



PFIZER PRIVATE LIMITED
18, Pasir Panjang Road,
No. 11-17, PSA Multi-Storey Complex,
Singapore 0511.

PREVENTING VISION LOSS IN OUR POPULATION:

THE SINGAPORE VISIONCARE PROGRAMME

by Dr Chew Sek Jin
Hon Secretary, SVP

On April 22, the Singapore Visioncare Programme (SVP) was launched by the Acting Minister for Health, Mr Yeo Cheow Tong. Its aim is to foster preventive eyecare in Singapore through mobile eye screening and public education. Prime objectives of its agenda are the detection and control of myopia, industrial vision problems and blinding diseases in the aged.

The SVP is a joint effort of the Singapore Women's Association, the Singapore Association of the Visually Handicapped, the School Health Service (MOH), the Health Service for the Elderly (MOH), the National Safety Council, the National Trades Union Congress and the People's Association. Mdm Yu-Foo Yee Shoon, MP for Yu-Hua Constituency and Assistant Secretary General of the NTUC is its Patron, with able leadership provided by Chairmen, Dr Khoo Chong Yew and Mrs Seow Peck Leng.

A Day to Remember: Sunday 22 April 1990

The inaugural one-day symposium at the Singapore Conference Hall attracted an audience of over 700. In his opening address, the Minister highlighted the alarming rise in visual deterioration in Singapore schoolchildren due to myopia. Citing figures from the School Health Service and pilot studies by the SVP, which showed myopia prevalence to exceed 50% in our young, he welcomed the emphasis placed on this often neglected disorder. Mr Yeo also underscored the importance and relevance of preventive ophthalmology in our increasing affluent society. With the eradication of infectious and nutritional blindness, healthcare efforts can now focus on cost-effective early detection of eye disease. The guest of honour later officiated at the opening of the mobile eye testing van, one of the highlights of the SVP.

In addition to the seminar and workshops, the public was invited to an eyecare exhibition and free eye screening. Over 250 were tested in 6 hours with a comprehensive array of visual function tests, the first of its type organized in Singapore. Included were the assessment of Snellen distance acuity, contrast sensitivity, reading vision, accommodation, convergence and latent squint. In addition, tonometry, autorefraction, ultrasonic biometry, fundus photography and slit lamp examination were performed. All subjects left with a computer printout of their examination results, and reminded of the importance of regular eye checks. Cases

with refractive errors, cataracts, glaucoma or other disorders were given recommendations to seek further ophthalmic or optometric attention.

The Need for Mobile Eye Screening

The Mobile Eye Testing Unit is a focal point of the SVP. Being outfitted with the latest and most sophisticated vision testing equipment, its goal is to bring eye testing to the doorstep of Singaporeans. Time and money are saved:

Time saved — eye screening at kindergartens, factories and community centres will reduce work disruption for the large numbers of people who need it. For example, a large commercial firm often employs more than 300 computer users; eye screening for them would include a detailed questionnaire on visual symptoms and VDT habits with an examination of refraction, accommodation, convergence, latent squint, visual acuity and slit lamp review for contact lens problems. This often requires half an hour per subject even when a streamlined procedure is employed; optimally, 10 subjects are screened per hour. As such, more precise time management can be achieved by the host company who would co-ordinate and stagger its workers' examinations over a 3-4 day period. Productivity is hence less affected. In effect, convenience has improved compliance with an accompanying increased participation of the public (industry) in their own healthcare.

Money saved — vision testing equipment is expen-

sive. A computerized auto-refractor costs in excess of \$20,000 and even a slit lamp, the basic tool of every ophthalmologist, brings with it a bill of well over \$7,000. Maintenance costs, which must include security and 24-hour dehumidification, are also considerable. Thus, a common pool of equipment and trained personnel represents the most cost-efficient method of preventive eyecare delivery to the population.

Manpower is the most expensive asset in any healthcare program. With its core of volunteer ophthalmologists, optometrists, ophthalmic nurses and technicians, mobile eye screening brings eyecare and health education to those who need it most and can least afford it. This is particularly pertinent in ophthalmology where increasing sophistication in treatment techniques and technology brings increased costs — laser panretinal photocoagulation often costs more than \$700 and diabetic vitrectomy for vitreous hemorrhage in excess of \$5,000. Glaucoma surgery (trabeculectomy) which may cost \$2,000 may also be avoided if this disease is detected early and medical therapy instituted.

Who Will the SVP Serve?

Our Children — as a complement to the School Health Service's excellent refraction program, vision testing and refraction will be offered to kindergartens, daycare centres and creches. Screening in this age group will be primarily for myopia, astigmatism, amblyopia and squint. Parents and teachers will be

informed of the methods of myopia control and the myths which envelop it.

Singapore suffers one of the highest rates of myopia (shortsight) in the world, second to Japan and Taiwan. With rising levels of education and occupational training, we are experiencing an increase in refractive errors in schoolchildren and young adults; one in four young men and every other primary six child is myopic. The degree of myopia is also escalating, with a considerable number of children becoming high myopes (more than -6 diopters) in their early teens. This is particularly worrying as recent studies from Taiwan show that there is a sharp rise in the incidence of macular degeneration and visual disability in these myopes when they reach 40! They are also at increased risk for the development of retinal breaks and detachment, glaucoma and cataract.

Although optical aids are essential for the visual correction of myopia, they are not a panacea for the disorder and often lead to their own unique problems. These range from cost (the average undergraduate has owned 8 to 10 pairs of glasses, costing him more than a thousand dollars), asthenopia (eyestrain) and headache from poor fitting to contact lens related corneal ulcers and allergy. A survey of undergraduate contact lens users found that half practised improper cleaning techniques. More disturbing was the revelation that almost all users did not renew their lenses till complications or intolerance occurred!

Our Workers — the National Safety Council and the National Trades Union Congress will supervise the provision of pre-employment and routine eye checks at the workplace. The aim is to maintain the vision of industrial workers performing visually strenuous or hazardous tasks. The SVP will assist the safety officers and Designated Factory Doctors in defining the visual needs of the workers, advising the use of appropriate optical aids and protective eyecare and methods to manage asthenopia.

A World Health Organization report in 1987 recommended that "visual discomfort... must be recognized as a health problem.

Such discomfort is largely avoidable". The WHO work group emphasized that attention must be given to the workplace, the work environment and to work practices to prevent eye strain. Thus, although asthenopia (eyestrain) is one of the commonest complaints among our workers, the causative factors are often not appreciated and frequently ignored. These include accommodation fatigue, presbyopia, keratoconjunctivitis sicca (dry eyes), contact lens problems, poor stereopsis, latent squint and colour vision defects.

These concerns lead us to the design of tailored industrial eye screening protocols. Crucial to its development is the careful investigation of the work environment and the specific nature of the job and the worker himself. The Department of Community, Family and Occupational Medicine, NUS, has been crucial to the success of this programme. For instance, microscope operators should be specifically reviewed for accommodation fatigue, stereopsis (3-D vision) and refraction, while arc welders require a more careful slit lamp examination for corneal damage (photophthalmia, foreign bodies). In contrast, visual field and colour vision tests would be appropriate for workers exposed to industrial lasers. In this instance, the Ishihara colour plates would be unsuitable; the quantifiable Farnsworth Munsell 100-Hue testing would be needed.

Our Senior Citizens — The major causes of blindness are age related. Although cataract heads the list, it is not preventable and can be surgically cured. In contrast, glaucoma and diabetic retinopathy often lead to irreversible vision loss. Fortunately, early detection is very cost-effective in these conditions.

In Japan, a national glaucoma screening programme unveiled a prevalence of 3%, including 1.5% of low pressure glaucoma. This unprecedented high prevalence of normal intraocular pressure in glaucomatous patients emphasizes the importance of visual field and optic disc examination in the detection of

cont'd on page 5



Dr Lawrence Chan

YOUR HEALTH IN BALANCE — FAMILY, WORK, CULTURE & RELIGION

Paper presented at the Public Symposium of
the SMA National Convention in April 1990
by Dr Lawrence Chan

"The consideration of family, work, culture and religion focuses on health in relation to the interaction of self and others, in the past as well as the present. It also brings in health in relation to a part of our intangible self, the spirit.

A large part of what we are individually has come from the past. We are affected by our culture, our education and more particularly by our family upbringing. This has to be recognised and accepted before we can improve our present condition if that is intended.

We can be thankful for the past but there are areas in which we can become better persons if we are prepared to work for it by purposefully changing our "natural bent".

In the workplace, one of the most challenging areas against a wholesome working environment is the problem of interpersonal relationships. We should be thankful for our work. Its rewards are not only the pay packet at the end of the month but also its health generating influences of fulfilment and selfworth. Our

attitude to our work will affect our relationships to others we meet at work. We can appreciate others for their contribution to the total output of the workplace. Here a team spirit is better than the individual assertions of a prima donna.

The family in Singapore today is under threat. We realise that it is not what it should be, but we are often powerless to effect a positive change. The external structures for family life are there in most cases — one's own flat or house, garden or common lawn, a maid, a car — but the children are not growing up in the way that we would want them to. True there are pressures that were not there 20 years ago — endless school work and the second language, peer pressure of possessions, sexual experience and annual holiday abroad. To support these necessities for the children, the wife works and the husband works harder and sometimes takes on a second job. But what the

children need most is for both the parents to be home more often and spend more time with them so that they can learn from the parents' role models. Someone has stated that the most endangered species today is the child! The presents we can shower on the children cannot make up for our lack of presence with them.

A group of 30 healthcare workers and Christian theologians met in UK in 1989 to discuss about health. They first of all defined health as

the strength to be human. They saw health as the correct relationship with God, with self, with others and with the environment. Thus health is more than personal wellbeing without regard about others and the environment. This enables one to hold to the concept of health as "wholeness" which is the biblical concept of "Shalom". This means peace, and also wholeness, well-being, vigour and vitality in all the dimensions of human life."

THE SINGAPORE VISIONCARE PROGRAMME

cont'd from page 4

glaucoma. In addition, angle closure glaucoma risk evaluation requires an assessment of anterior chamber depth. To accomplish this, a complex assembly of tests (automated perimetry, non-contact tonometry, biometry, pachymetry, fundus photography) must be integrated in the screening process.

Technology alone cannot prevent blindness; public education is an indispensable tool. To achieve this, the SVP with the People's Association, promotes awareness and self-care in our population by training grassroots community leaders (Community Centre Management Committees, Residents' Committees, YEC and WEC members) in the rudiments of vision assessment. These trained community helpers in turn help organise and actively participate in the eye screening held at their community centres. During the exercise, the SVP provides professional and equipment support. For continuity of care, free eye charts are also distributed to enable regular simple eye tests at the homes or community centre as well as distance and near acuity charts. The scheme was proven highly successful during

pilot projects held in Yu-Hua and Ulu Pandan constituencies where more than 400 people were examined. In future, community eye screening will also enlist the contribution of local optometrists and nurses keen to provide a service to their constituency.

1990 and on for the SVP

Monthly screening for community centres have been arranged; Kallang and Ang Mo Kio will be among the first to participate. A statistical survey of visual disorders involving 1,200 HDB flat dwellers is being organized for Ulu Pandan. This will be the first epidemiologic survey of eye disease in Singapore. In July, 5000 freshmen in NUS will be screened for myopia and contact lens problems. The SVP will accompany the School Health Service's Health Fairs to secondary schools to provide vision-care to the children. VDT-operators screening has been initiated at Hewlett-Packard and is being extended to other industries.

With its roots firmly based in our community, the SVP invites physicians keen to participate in preventive ophthalmology to provide their services and expertise. With your support, we will be in the best position to control preventable vision loss in Singapore.

PENANG INTERNATIONAL TEACHING COURSE IN RHEUMATOLOGY

Jointly organised by

Penang Medical Practitioners' Society &
Malaysian Society of Rheumatology

Dates: 23—27 November 1990

Venue: Rasa Sayang Hotel, Penang

For further details, please contact

Ms Mimi Tay, The Secretariat
Penang International Teaching Course in
Rheumatology
19 Logan Road, 10400 Penang Malaysia
Tel: 04-368501 Fax: 04-362994

Mediavax®

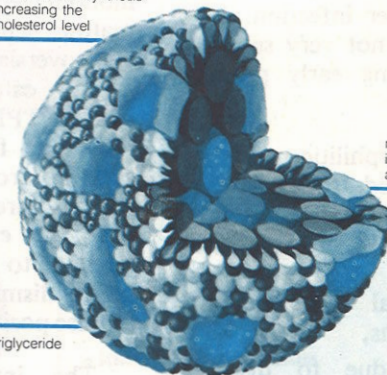
Effective and well tolerated
in treating hyperlipidemia

- no hepatotoxicity
- no potentialization of anticoagulants.

Improves Glucose Tolerance

- no risk of hypoglycemia
- no risk of lactic acidosis

reduces cholesterol synthesis
while increasing the
HDL-cholesterol level



reduces
intestinal triglyceride
absorption

reduces triglyceride
synthesis

SERVIER Les Laboratoires Servier,
Gidy, 45400 Fleury-les-Aubrais (France).
For further information, please write to:
Developpement International Servier
6, Place des Pleiades
92415 Courbevoie Cedex
France

represented by
ASIAMED PHARMACEUTICAL PRODUCTS (S) PTE LTD
421, Tagore Avenue, Singapore 2678 Tel: 4596011
F. E. ZUELLIG (MALAYSIA) SDN BHD,
11th Floor, Wisma Damansara, Jalan Semantan,
Damansara Heights, 50708 Kuala Lumpur, Malaysia.

dosage : 3 tablets daily

one with each main meal.
Patients can begin with the full dosage, or this
can be attained progressively.

	1st week
	2nd week
	3rd week

Interpretation of serological tests for syphilis

Serological tests for syphilis are very important in the diagnosis and management of patients with syphilis. Syphilis should not be diagnosed on clinical grounds alone as serological tests for syphilis are easily available even to general practitioners. However, no single test is diagnostic of syphilis, and syphilis should not be diagnosed on one set of tests alone as there may be false positives. Serological tests for syphilis should be interpreted in the light of full clinical and epidemiological information.

Serological tests for syphilis comprise non specific reagin tests and specific treponemal tests. Non specific tests depend on the appearance of an antibody (reagin) in the serum which is directed against a non specific phospholipid antigen. The most useful non specific tests are the Venereal Disease Research Laboratory test (VDRL) and the rapid plasma reagin test both of which are flocculation tests. The two commonly used specific tests are the fluorescent treponemal antibody absorption test and the Treponema pallidum haemagglutination test.

The fluorescent treponemal antibody test is the first serological test to become positive; this usually occurs three to four weeks after infection. Therefore, in early untreated primary syphilis this may be the only positive test. VDRL generally becomes positive 3 to 5 weeks after infection. The TPHA test is the last of the serological tests to become positive, usually 8 to 10 weeks after infection. It is therefore not very sensitive in detecting early primary syphilis.

Non-syphilitic reactions, or so-called 'false positive' results, to the reagin tests for syphilis are of three kinds:

1. technical false positive reactions,
2. those due to diseases allied to syphilis such as yaws, pinta and bejel, and
3. biological false positive (BFP) reactions.

Technical false positive reactions result from human errors, such as mistakes in the labeling of specimens or mistakes in recording and

reporting the final results. Positive tests which have no confirmation in the clinical findings should therefore always be checked by testing another specimen of serum from the same patient. Biological false positive reactions may be acute, lasting for less than 6 months or chronic, lasting more than 6 months. Acute BFP may occur with almost any infection and in association with pregnancy. Chronic BFP are commonly due to autoimmune diseases especially systemic lupus erythematosus but they may be due to chronic infections like lepromatous leprosy, debilitated states as in malignancy and also old age. Although false positive reactions of both types are usually low in titre, the strength of a reaction is no guarantee of its specificity and high titres are sometimes seen.

False positive FTAABS results have been reported in patients with systemic lupus erythematosus, drug induced lupus erythematosus, rheumatoid arthritis, macroglobulinaemias, diabetes mellitus, genital herpes and also in isolated cases of liver cirrhosis, autoimmune haemolytic anemia, pregnancy and small-pox vaccination. False positive TPHA results are more rare and may occur in patients with infectious mononucleosis and lepromatous leprosy. It is still controversial whether pregnancy can cause a false positive TPHA result. However, such false positives to specific serological tests for syphilis are very uncommon, and every effort must be made to rule out syphilis before dismissing these tests as false positives.

The interpretation of results of serological tests for syphilis is shown on Table 1.

A common problem encountered by general practitioners is a foreign maid or worker with a positive VDRL of low titre of up to 1 in 16. An approach to the problem is shown on flow

chart 1. The diagnosis of early latent syphilis is suggested by a history of a rash or genital ulcer suggestive of syphilis or relevant sexual exposure less than 2 years ago, negative serology in the last two years and a higher VDRL titre.

Proper diagnosis and management of syphilis in pregnancy is a major line of defense against congenital syphilis. In Singapore, the screening test is VDRL alone. In some centres, only TPHA is used or both VDRL and TPHA are used as screening tests. A firm diagnosis of syphilis can be made in pregnancy when both the VDRL and TPHA are positive in the presence of either relevant clinical and epidemiological features or the presence of a positive FTAABS.

In the modern diagnosis of syphilis in the infants, a definite diagnosis requires demonstration of *Treponema pallidum* in a lesion by dark field examination, immunofluorescence or histological examination. However, this degree of clinical certainty is achieved uncommonly. A compatible diagnosis of syphilis can be made when an infant has a reactive VDRL in the presence of signs of syphilis such as snuffles, condylomata lata, skin and mucous membrane lesions and others. In the absence of clinical features, a compatible diagnosis is made when the infant exhibits a stable or rising VDRL titres, or when the FTAABS IgM antibodies are present, or when the mother has syphilis during pregnancy but receives inadequate treatment and the infant has a positive VDRL.

REFERENCES

1. KK Holmes et al, editors. Sexually transmitted diseases. Second edition, 1990, McGraw-Hill Information Services Company.
2. A King et al. Venereal Diseases. Fourth edition, 1980, ELBS.
3. R Shannon et al. Immunological responses in late syphilis. BJVD 1980; 56: 372-6.
4. J Lesinski et al. Specificity, sensitivity, and diagnostic value of the TPHA test. BJVD 1974; 50: 334.
5. H Young, C Henrichsen. TPHA test as a screening procedure for the diagnosis of syphilis. BJVD 1974; 50: 341.
6. MV Borobio et al. Specificity of three serological tests for syphilis: VDRL, FTAABS and TPHA in healthy people, pregnant women and dia-



Dr Lee Chui Tho

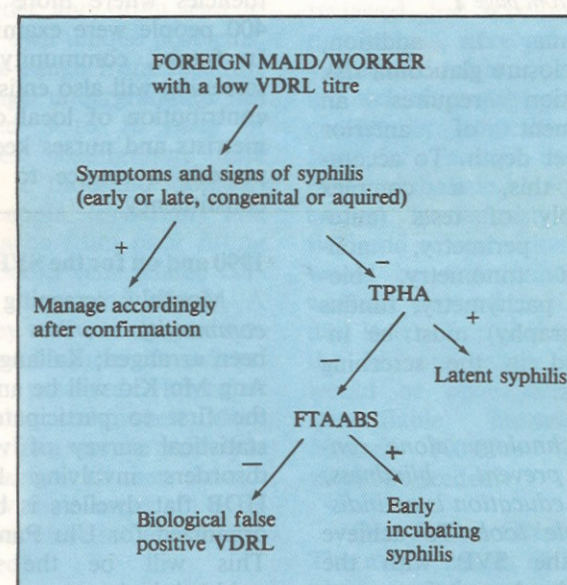
SYPHILIS — INTERPRETING SEROLOGICAL RESULTS

Paper presented at the STD & AIDS Workshop during the Medical Symposium of the SMA National Convention in April 1990

by Dr Lee Chui Tho

Table 1:			
VDRL	TPHA	FTAABS	INTERPRETATION
—	—	—	1. Syphilis not present
+	+	+	2. Very early syphilis
+	+	—	1. Untreated syphilis
+	+	—	2. Recently treated syphilis
+	—	—	1. False positive TPHA
—	+	—	2. False negative FTAABS
—	+	+	Repeat tests, KIV TPI
—	+	+	1. Primary syphilis
—	+	+	1. Treated syphilis
—	+	+	2. Untreated latent syphilis
—	+	+	3. Untreated late syphilis
+	—	—	1. Biological false positive VDRL
—	+	—	1. Treated syphilis
—	+	—	2. False positive TPHA
—	—	+	1. Untreated early primary syphilis
—	—	+	2. Recently treated early primary syphilis
—	—	+	3. Long standing syphilis
—	—	+	4. False positive FTAABS

FLOW CHART 1



betics. European journal of sexually transmitted diseases 1984; 1: 155-8.

7. W Manikowska-Lesinska et al. Specificity of the FTAABS and TPHA tests during pregnancy. BJVD 1978; 54: 295-8.
8. RD Catterall. Systemic disease and the biological false positive reaction. BJVD 1972; 48: 1-12.
9. YM Felman et al. Syphilis serology today. Arch Dermatol 1980; 116: 84-9.
10. JD Bos. FTAABS test. IJD 1982; 21: 125-30.

Introduction

Chlamydia trachomatis has been a recognised genital pathogen since early 1970. It is capable of causing a broad spectrum of diseases both in sexually active men and women and in their offsprings (Table 1). In men, C. trachomatis has been shown to be the leading cause of non gonococcal urethritis (NGU) and post gonococcal urethritis (PGU) and of epididymitis in men less than 35 years old. In women, Chlamydial infections include cervicitis, pelvic inflammatory disease and the urethral syndrome. Chlamydia is also transmitted during childbirth causing neonatal conjunctivitis and pneumonia.

EPIDEMIOLOGY

Infections caused by Chlamydia trachomatis are now recognised as the most prevalent of all STDs seen in the United States. An estimated 3.4 million Americans suffer from Chlamydial infections each year.

The situation in Singapore.

C. trachomatis infection is not a reportable disease and prevalence of this infection can only be deduced from data on non gonococcal urethritis. For the last

ten years, NGU has remained as the second most common STD after gonorrhoea.

It must be pointed out that NGU is probably undercounted relative to gonococcal urethritis. The reasons are that men with NGU have less symptoms and are less likely to seek treatment; men with NGU are not brought to medical attention as a result of contact tracing and men with co-existent NGU and gonococcal urethritis frequently are diagnosed as having only gonococcal urethritis. There would be more undercounting among the females as chlamydial infections are usually asymptomatic.

30% of our local cases of NGU in men have been shown to be caused by C. trachomatis. It also causes 50% of cases of post gono-

coccal urethritis. Isolation rates of C. trachomatis and N. gonorrhoea in various groups of women are shown in Table 2.

It is evident that the prevalence of Chlamydial infections in Singapore is not low.

Data from two studies show that 8-9% of female prostitutes with gonorrhoea are also co-infected with C. trachomatis. In 1988, Chlamydia was detected in 9%, gonorrhoea in 11% and syphilis in 3% of female prostitutes screened. Chlamydial infection is as common as gonorrhoea and more common than syphilis in female prostitutes. This has important implications on our current STD control programme which involves screening female prostitutes for syphilis and gonorrhoea only.

Table 2 allows us to identify a subpopulation of women who are at high risk of contracting chlamydial

infections. This consists of women who are contacts of men with NGU, and unspecified STD and women with endocervical gonorrhoea. The figures also show that women attending a STD clinic because of suspicion about STD are at high risk for chlamydial infection.

The study on acute PID showed a higher isolation rate of chlamydia compared to gonorrhoea although this difference was not statistically significant. 2% of the study population had both organisms isolated.

CLINICAL ASPECTS

Many chlamydial infections, especially in females are asymptomatic, and others, although symptomatic, are not easily recognised on clinical grounds alone because the signs and symptoms produced are non specific.



Dr Cheong Wai Kwong

Infections in women:

Three Chlamydia-associated syndromes are common among women (Table 3):

1. Mucopurulent cervicitis
2. Urethral syndrome or urethritis
3. Pelvic inflammatory disease

While many women with chlamydia isolated from the cervix have no signs or symptoms of infection, at least a third generally have local signs of infection.

Most commonly found are mucopurulent discharge and hypertrophic ectopy. Clinical recognition of chlamydial cervicitis depends on a high index of suspicion and a careful cervical examination.

cont'd on page 8

Table 1. Clinical spectrum of Chlamydia trachomatis infections

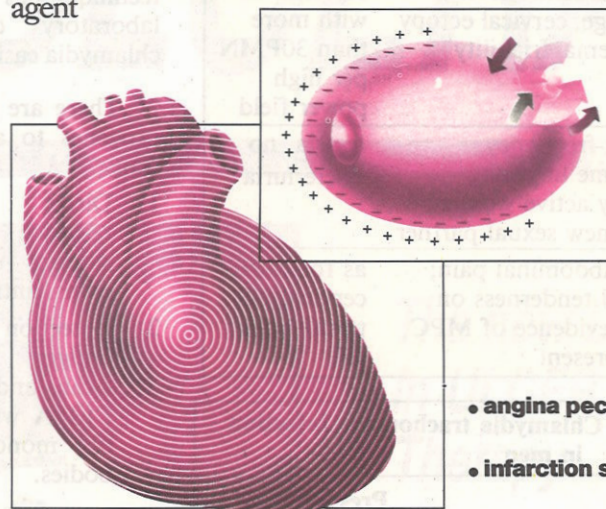
Males:	Females:
Infections	Infections
Urethritis	Cervicitis
Post gonococcal urethritis	Urethritis
Proctitis	Proctitis
Conjunctivitis	Conjunctivitis
Asymptomatic infection	Asymptomatic infection
Lymphogranuloma venereum	Lymphogranuloma venereum
Complications	Complications
Epididymitis	Salpingitis
Prostatitis	Endometritis
Reiter's syndrome	Perihepatitis
	Ectopic pregnancy
	Infertility
Infants:	
Infections	
Conjunctivitis	
Pneumonia	

Table 2: Prevalence of C. trachomatis & N. gonorrhoea in various groups of women

Group Description	C. trachomatis	N. gonorrhoea
Female prostitutes	8-12%	10%
Contacts of men with NGU	32-39%	0
Contacts of men with GC	15%	52%
Contacts of men with unspecified STD	27%	0
Gonococcal cervicitis	27%	
STD check	13%	10%
Single women seeking abortion	14%	0
Treated for Acute PID	14%	8%

VASTAREL® 20

the first cellular anti-ischaemic agent



acts at the heart of ischaemic cells

3 tablets daily

- angina pectoris
- infarction sequelae

Presentation:
Box of 60 tablets and 600 tablets, containing each 0.02 g trimetazidine dihydrochloride.
Indications:
Ischaemic heart disease (angina pectoris, sequelae of infarction).
Dosage and administration:
3 tablets per day, in three divided doses, with meals.

Les Laboratoires Servier,
Gidy - 45400 Fleury-les-Aubrais - France
Correspondent:
Développement International Servier
24, rue du Pont, 92200 Neuilly-sur-Seine - France

CHLAMYDIA: MANAGEMENT OF THE SILENT EPIDEMIC

cont'd from page 7

Chlamydial pelvic infection runs a milder clinical course than that caused by gonococci. But, paradoxically, more severe inflammatory changes could be noted at the time of laparoscopy. Such infections of the fallopian tubes which are often not recognised as PID, contribute significantly to the increasing number of women who experience ectopic pregnancy or involuntary infertility.

Infections in men:

Two Chlamydia-associated syndromes are common among men (Table 4):

1. Non gonococcal urethritis (NGU)
2. Acute epididymo-orchitis

It has been shown that nearly one third of men with urethral chlamydial infection did not have symptoms or signs of urethritis. Urethral chlamydial infection is more often asymptomatic than gonococcal urethral infection. Post gonococcal urethritis frequently results from infection with *C. trachomatis* and it occurs in 15-35% of gonococcal urethritis. In an estimated 1% to 2% of men, *C. trachomatis* infection may ascend from the urethra to the epididymis, pro-

ducing acute epididymitis. Recent studies suggest that *C. trachomatis* accounts for 50% to 75% of cases of acute epididymitis in young, sexually active, heterosexual men.

Chlamydial infections are, indeed, often silent, especially in women. Hence the term "silent epidemic". What are the implications of this silent epidemic?

Local studies have shown that 50% of Chlamydia positive women are married and of child bearing age. The implications are explicit when we recall that pelvic inflammatory disease caused by *C. trachomatis* can lead to tubal infertility and ectopic pregnancy.

Furthermore, pregnant women with chlamydial genital infections have a 50% chance of transmitting chlamydia to the newborn resulting in inclusion conjunctivitis and pneumonia.

It must also be remembered that chlamydial infection in women may so remain silent and persist for years and thus making women an important reservoir of infection.

In men, chlamydial urethritis may lead to epididymo-orchitis. It is important

to recognise chlamydia as a possible cause in young sexually active men and to treat such cases with the appropriate drugs so as to avoid potential sequelae of infertility.

DIAGNOSTIC METHODS

The lack of a sensitive, specific test for diagnosis and screening has been a major factor contributing to the chlamydia epidemic.

The available methods include:

1. Isolation by cell culture
2. Antigen detection
3. Serology

Cell culture:

This is presently the "gold standard" for laboratory diagnosis. The sensitivity and specificity of currently available isolation methods for *C. trachomatis* from genital specimens are unknown as no standard for comparison exists. It is estimated that culture has a sensitivity of 80-90% and a specificity of 100%.

Disadvantages:

1. Technically difficult
2. Specimens must be refrigerated and transported at 4 degrees to the laboratory within 24 hours
3. Specimens must be placed in specially prepared transport media
4. It takes 4 to 7 days for results.

Antigen detection:

The development of non culture antigen detection technique has made specific laboratory diagnosis of chlamydia easier.

There are 2 general approaches to antigen detection:

1. Direct immunofluorescence staining of smears using monoclonal antibodies.
2. Detection of chlamydial antigen eluted from swabs and measured by ELISA with polyclonal or monoclonal antibodies.

Advantages and Disadvantages of Antigen Detection Methods

Direct Smear FA Test:

Advantages:

1. Uncomplicated transport and storage of specimens

2. Rapid processing time
3. High specificity

Disadvantages:

1. Requires high quality fluorescence microscope and experienced technicians
2. Relatively labour intensive
3. End point is subjective (like all IF techniques)

Enzyme Immunoassay:

Advantages:

1. Uncomplicated transport and storage of specimens
2. Requires less technical expertise
3. Has objective end point (optical density)
4. Large numbers of specimens can be tested at one time

Disadvantages:

1. Low sensitivity in male urethral infection

Serology:

Complement fixation test only helps diagnose cases of LGV. ELISA tests have been developed but none are recommended for wide use.

Selection of the Appropriate Test

Cell cultures may be of greater value in screening low risk populations because of their high specificity. In populations of women in whom the prevalence of infection exceeds 10% and in symptomatic men, both the DIF test and EIA test provide alternative diagnostic methods with satisfactory sensitivity and specificity.

Diagnostic tests for *C. trachomatis* offer an opportunity to prevent sequelae of chlamydial infections in women through earlier diagnosis and screening of high risk populations. Physicians should begin to use these tests in much the same way they now use culture for *N. gonorrhoeae*. However, further studies need to be done to evaluate these new tests when used in low prevalence populations.

MANAGEMENT

Who should be treated?

1. Non gonococcal urethritis
2. Mucopurulent cervicitis
3. Pelvic inflammatory disease
4. Epididymitis (men less than 35 years old)

Sex partner referral:

Individuals exposed through sexual contact with patients who have any of the above problems should be evaluated for STD and treated for presumptive chlamydial infection. Referral of sex partners of women with MPC or PID is often overlooked.

30-40% of females whose sexual partners have NGU harbour *C. trachomatis*. Of men who are sex partners of women with confirmed MPC or PID, 25-50% have chlamydia isolated from the urethra. Many of these cases are asymptomatic.

Routine prescription of treatment for sexual partners without being interviewed and examined by a physician is not recommended for the following reasons:

1. Possible associated STDs are not excluded
2. Poor drug compliance probably because the necessity for treatment is not explained personally.
3. Potential adverse drug reactions and medico-legal implications

Drugs of Choice:

Tetracycline and erythromycin remain the drugs of choice in the treatment of chlamydia genital infections.

Co-infection with chlamydia is common in patients with gonorrhoea. It may therefore be advisable for patients with gonorrhoea to be given a course of anti-chlamydia treatment, especially in set-ups where laboratory diagnostic facilities are not available.

CONCLUSIONS

Physicians often view chlamydial infections such as non gonococcal urethritis as trivial compared to syphilis and gonorrhoea. Public health measures such as medical surveillance of prostitutes have for the last two decades been aimed at controlling syphilis and gonorrhoea and recently at AIDS. It is perhaps timely that we consider a chlamydia control programme.

90% of men with NGU in Singapore contracted the infection from female prostitutes. And the isolation rate of chlamydia from female prostitutes is 8-10%.

cont'd on page 9

Table 3: Diagnosis of Chlamydia trachomatis infection in women

Condition	Clinical Criteria	Presumptive Lab Criteria
Mucopurulent cervicitis (MPC)	mucopurulent cervical discharge, cervical ectopy and edema, friability	cervical GS with more than 30PMN per high power field
Acute urethral syndrome	dysuria-frequency syndrome in young sexually active women; recent new sexual partner	pyuria, no bacteriuria
Pelvic inflammatory disease (PID)	lower abdominal pain; adnexal tenderness on exam; evidence of MPC often present	as for MPC cervical GS positive for GC

Table 4: Diagnosis of Chlamydia trachomatis infection in men

Condition	Clinical Criteria	Presumptive Lab Criteria
Non-gonococcal urethritis	dysuria, urethral discharge	urethral GS with 5 or more PMN/high power field
Acute epididymo-orchitis	fever, epididymal or testicular pain, evidence of NGU, epididymal tenderness or mass	as for NGU

HISTORY OF MEDICINE: WOMAN PIONEERS IN MEDICINE

Their names are hardly known today — Suslova, Bokova, Morgan, Dimock, Atkins, Walker, Vogtlin. With all the interest in women's history they are the subject of no major biographies. No monuments have been raised in their memory. They are barely mentioned in the standard histories of early women's education in medicine. Compared to an Elizabeth Blackwell or a Marie Zakzewska or a Sophia Jex-Blake — all subjects of scholarly attention — they would seem to have played only a passing role in the drama of women's battle to study medicine.

And yet these seven women made possible the greatest victory won by medical women in the nineteenth century. Their success at the University of Zurich opened the doors to the full acceptance of women as fellow students with men in a university setting.

It was in Zurich that medical coeducation was realized for the first time.

Here in the late 1860s the Zurich Seven studied side-by-side with men. Unlike Geneva or Cleveland or Jex-Blake's Edinburgh, the Swiss victory over the deep-seated opposition to women in medicine was followed by dozens of new enrollments, then hundreds, and ultimately by the largest number of female medical students of any country in the world before 1914. Along with Paris, which followed hard upon the heels of Zurich, the Swiss universities led the world for half a century in their openness to women.

The crucial period came in the years after 1864. In that year, a Russian woman, Maria Knjaznina, applied for permission to attend lectures in anatomy and microscopy at Zurich. The request came to a university and city in the grip of profound social change. Both were affected by the lively democratic spirit in the canton, by the growing importance of its commercial expansion, and by the presence of an increasing number of political

refugees and radical emigres. There was furthermore precedent in the new university for women auditors, and Knjaznina's application was quietly approved. The following spring, a second Russian woman, Nadezhda Suslova, also from St Petersburg, was allowed to attend lectures at the university. Both women had been swept up in the great wave of reforms following the Russian defeat in the Crimea and the liberation of the serfs, when for a time Russia led the continent in job and schooling opportunities for women. Women had begun to attend university lectures in Russia in 1859 and by the early 1860s over sixty women were attending courses at the St Petersburg Medical-Surgical Academy. But a wave of student radicalism involving a number of the women students led to the abrupt expulsion of women from the universities. Among them was Nadezhda Suslova, destined to play a central role in the unfolding drama at Zurich.

Suslova was born the daughter of a serf who subsequently freed himself from indenture to a wealthy landowner in the small town of Panin. Her ambitious father had seen to it that she and her sister received a good basic education. In the 1860s the Suslovas moved to St Petersburg where Nadezhda was caught up in the women's movement of the capital city. She was able to attend the lectures of some of the most famous professors at the University of St Petersburg. She was active in a section of the revolutionary "Land and Freedom" movement. With the help of the sympathetic physiologist, Ivan Sechenov, she won permission to study at the Medical-Surgical Academy, but her studies in anatomy and physiology at the academy were cut off by the government ban on further study by women and she then made the decision to go to Zurich. She knew that a number of Russian men, as well as Poles and a few other Slavs, were already studying in the city.

Doubtless she knew, too, that Maria Knjaznina had been admitted to medical lectures the preceding fall. And it was common knowledge that Zurich, like most European universities, demanded little of its foreign students in the way of preparatory education. Nowhere else in the world, in any case, was it possible for a woman to take her place in medical lectures in a recognized university.

But would Zurich allow her to take a medical degree? For a time both Knjaznina and Suslova continued as auditors in the university, while the academic senate was divided on the question of whether women could be fully matriculated. Knjaznina dropped her studies in 1867 but Suslova took the bold step of requesting permission to take the examinations for a medical degree. The Zurich faculty and cantonal government were now forced to face squarely the issue of women at the university. The zeal and perseverance

cont'd on page 10

CHLAMYDIA

cont'd from page 8

similar to that of gonorrhoea. There is therefore a need to conduct selective screening for chlamydia in high risk populations such as prostitutes. It has been estimated that routine screening of women with antigen detection assay would be cost effective in population in which the prevalence of infection exceeds 7%.

Finally, let us take a look at a hypothetical situation to reiterate the importance of controlling this silent epidemic. (Figure 1)

It would be largely through:

- 1) Recognition of Chlamydia associated conditions by practitioners.
- 2) Appropriate treatment of such infections.
- 3) Counselling patients regarding the ill effects of the infections and to refer all sex partners for medical evaluation and perhaps
- 4) Selective screening of high risk populations that this silent epidemic can be checked to prevent a secondary epidemic of ectopic pregnancy and tubal infertility in females.

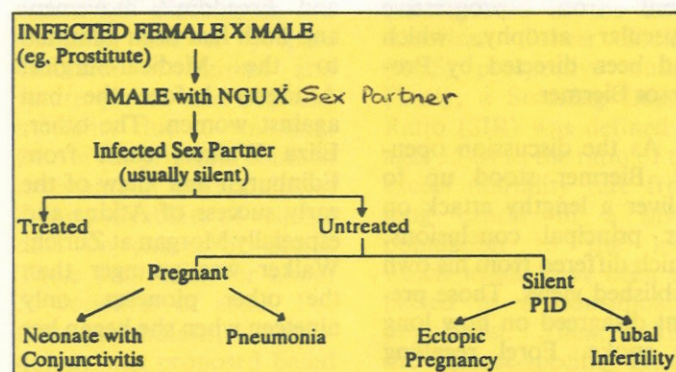
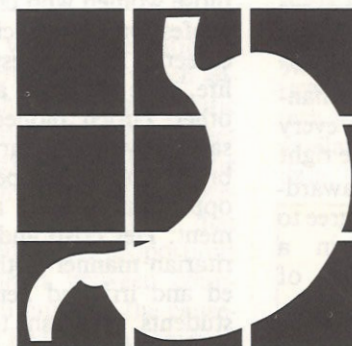


Figure 1: Effects of Chlamydial Infection

20mg, 40mg

ULCERAN

Famotidine



The new Dimension
in ULCER
Therapy

SETS IT STRAIGHT
WITH ONE TABLET DAILY

Medochemie Ltd

SOLE DISTRIBUTOR DEREK MARKETING LTD TEL: 3369761

HISTORY OF MEDICINE

cont'd from page 9

of the shy Russian woman had made a strong impression on her professors and fellow students. She had fulfilled all the conditions for the examinations except for formal matriculation. The rector of the university consulted members of the medical faculty and the educational authorities of the canton before making his decision; he concluded that university regulations neither permitted nor forbade the matriculation of women and decided to admit her *retroactively* to the winter semester of 1865.

It was a crucial decision. Suslova's request had fallen on ground made fertile by the liberal reform movement in the canton and by the progressive attitudes of the Zurich professors. The medical faculty in 1867 numbered such liberally-minded men as Anton Biermer, internist and dean, the noted surgeon Theodor Billroth and his assistant and successor Edmund Rose, the friend and counsellor of 1848 refugees Adolf Fick, the fatherly Hermann von Meyer, professor of anatomy, and the German liberal histologist Heinrich Frey. Most were Germans who found Zurich both a liberal oasis from continental conservatism and an important way-station on the road to a major chair in Germany.

But it was Suslova herself whose quiet abilities triggered a sympathetic response from the faculty. She lived unobtrusively in Zurich and worked hard; she had few friends outside the Russian emigre community; and like many in her generation, she was an ardent feminist, a follower of the nihilistic doctrines sweeping her homeland, and she believed strongly in serving the common people of Russia. A fellow student, the Swiss August Forel, later a famous psychiatrist, described her as "quite shy." Another said she had little of the emancipated woman about her: "Hers was quiet, serious nature, with deep feelings and a thoughtful, melancholy look from behind deep-set brown eyes." The pathologist Rindfleisch, who knew her at Zurich, said that "she was in appearance so modest that no one had the slightest reason to complain, but at

the same time diligent, very skillful in making microscopic preparations; her questions and answers showed a complete understanding of what was going on. I was very satisfied with this pupil."

Suslova passed the difficult qualifying examinations for the MD degree in the summer of 1867. She then went to Graz to write her thesis under the direction of her old friend Ivan Sechenov, whose reputation in physiology was growing. She returned to Zurich to defend her thesis in December 1867. On the twelfth of that month, flanked by the rector of the university and the dean of the medical faculty, she slowly entered the examining room, which was filled to overflowing. Behind her marched the entire medical faculty, who took their places around the long green examining table. She was then twenty-four years old, dressed in a simple black dress, shy and somewhat nervous. In her heavily accented German, she read a summary of her thesis on the significance of the lymphatic system in the human body. There followed sharp questioning from the surgeon Edmund Rose, the physiologist Ludimar Hermann, and other members of the faculty. In the words of a professor who was present, it was "no empty ceremony". Several of her interpretations were attacked but she defended her views courageously, using observations from her own research. At the conclusion, Professor Rose stood to congratulate her on her performance and to laud the Zurich experiment in women's education. "Soon," he said, "we are coming to the end of slavery for women, and soon we will have the practical emancipation of women in every country and with it the right to work." Thus was awarded the first medical degree to a modern woman in a recognized university of high academic standards.

Word of Suslova's success spread across Europe and America. Even before her final examination, two English women were allowed to matriculate in the fall of 1867. Both Elizabeth Morgan and Louisa Atkins

had lived in London; both had received a far better education than the typical Englishwoman of that era; and both realized the hopelessness of seeking a medical degree at home. Morgan had been studying medicine with private teachers and had passed the preliminary examinations for an apothecary's license before the Council of Apothecaries Hall passed a resolution barring women from licensure. Atkins was a young widow who had lost her husband in India and now felt the need to fill the painful void in her life by hard work and service to others. Unlike the cool and self-possessed Morgan, Atkins was an unusually friendly, gentle woman who knew little science and was discouraged by the difficulties of medical study. Only by dint of extraordinary self-discipline was she able to complete her degree in the normal five years, including a thesis on pulmonary gangrene in children.

But Elizabeth Morgan became a legend through her prodigies of achievement. She did as much as sixty hours of university work each week (including a course in Sanskrit), finished her medical work in three years, and impressed students and faculty alike with her regal bearing and cool intelligence. After her childhood in a minister's family in Wales, she had been allowed to attend schools in Paris and Dusseldorf, and had then commenced the study of medicine. When she was denied permission to take the apothecaries' examination, she left for Zurich "hoping to breathe freer and purer air than seemed possible in England, where the medical profession was heaping its anathemas... on those women who chose the profession of medicine as a career." For the rest of her life, like Suslova and the other Zurich pioneers, she saw the years in Zurich as a bright and happy period of opportunity and achievement. Her crisp and authoritarian manner both amused and irritated her fellow students. When she took her place alone in the anatomical laboratory, according to August Forel, "we found this rather comical, but the seriousness, the aristocratic calm, and the queenly superiority of this remarkable girl exacted such respect from us all that none of us would

have dared to make a tactless or sarcastic remark." The well-disposed anatomist Hermann von Meyer, trying to protect her modesty, suggested that certain demonstrations were "not decorous or respectable for a lady" but Morgan replied: "Herr Professor, it is much more shocking and improper to make exceptions here." Within months, she was treated by her male colleagues as an equal. According to Forel, she seemed to become more and more like a man: "elle devient de plus en plus synonyme d'un étudiant du sexe masculin."

Three years after Suslova qualified for her MD degree, Elizabeth Morgan became the second woman to defend her thesis before the entire faculty. By this time other women had entered the university and interest in the medical women was running high. Morgan's reputation and the hint of disagreement with her thesis director, Anton Biermer, added to the interest. On 12 March 1870, the examination room was filled to overflowing a full half hour before the ceremony had been scheduled to begin. The faculty decided to move the examination to the great aula, the largest auditorium in the university, to accommodate faculty colleagues and eager students. This room, too, was quickly filled with more than four hundred spectators, including fifty women who had come to support their candidate. At twenty minutes after eleven o'clock the main doors opened and all eyes turned to the attractive young Englishwoman of medium height, clad in a long black dress, who entered the auditorium accompanied by the university rector and the dean of the medical faculty. She took her seat next to the podium as Professor Rose welcomed the crowd and read her *curriculum vitae*. Then she read in her low voice a summary of her thesis on progressive muscular atrophy, which had been directed by Professor Biermer.

As the discussion opened, Biermer stood up to deliver a lengthy attack on her principal conclusions, which differed from his own published views. Those present disagreed on how long he spoke. Forel recalling twenty-five minutes, another professor estimating

only ten minutes. But all agreed that it was a sharp, sometimes angry, attack and tension mounted in the auditorium. Forel later wrote that "I can still see the cool demeanor (of Miss Morgan), who made notes constantly as Biermer spoke and then responded in a half-hour address until Biermer had had enough. She made it clear in her English-accented remarks that she had used English and American sources not available to Biermer, and that this was the cause of the disagreement. The next questions came from the ranks of the men students, as was customary, and they were answered, according to one source, in a "quiet, measured, and clear response." Biermer expressed his satisfaction with her replies and added: "You have, honored Fraulein, an important role in the solution of the great social problem that has occupied us here in Zurich. By your scholarly earnestness and zeal, you have become a worthy model for the women studying here..." There followed the ceremonial awarding of the doctoral degree and a concluding speech by Professor Rose. "My dear girl," said Rose, "I greet you for the first time as a colleague. I can not refrain from expressing to you out of a full heart my recognition for your efforts and your tact. I am glad to confirm... that you have given a new guarantee for the success of the social experiment being quietly made here in Zurich, an experiment that affects... the whole world." It had been, said Forel in understatement, "a remarkable day."

The fourth and fifth women to study medicine in Zurich arrived in the summer of 1868. Both had been influenced by the success of women from their own country. Maria Bokowa had known Suslova in St Petersburg, where they both had been active in the "Land and Freedom" movement and both had been admitted to the Medical-Surgical Academy before the ban against women. The other, Eliza Walker, came from Edinburgh and knew of the early success of Atkins and especially Morgan at Zurich. Walker was younger than the other pioneers, only nineteen when she began her

cont'd on page 11

HISTORY OF MEDICINE

cont'd from page 10

medical studies. Less is known of her early life but Forel reports that she was well liked and calls her "la tres jolie Ecossaise" in a letter to his mother. She spent four years in Zurich and passed her final examination with special distinction. Her thesis on blockage of the arteries of the brain, directed by Biermer, relied on fourteen cases that she had seen at the Zurich clinic as well as a complete search of the literature. While still a student, she became the first woman assistant in the Zurich cantonal hospital, working in the woman's ward.

The final members of the Zurich Seven were a young American, Susan Dimock, and the Swiss pioneer, Marie Vogtlin. They came to Zurich in the fall of 1868 and soon became friends. Dimock, a native of North Carolina, had decided at age thirteen that she wanted to be a physician. After her father's death, she and her mother had moved to Massachusetts, where there were

relatives. While teaching school, she studied medicine from books suggested by Dr Marie Zakrzewska, the German-born founder of the New England Hospital for Women and Children in Boston. She finally persuaded her mother of her deep interest in medicine and came to the New England Hospital to work and study in January 1866. Both Zakrzewska and another pioneer, Dr Lucy Sewall, were impressed by her intellect and aptitude for medicine. After being refused admission at Harvard Medical School in 1867 — as was her English fellow student at the Hospital, Sophia Jex-Blake — she was encouraged by Zakrzewska and Sewall to go to Zurich in 1868. Her letter of inquiry was answered by Dean Biermer who told her "there exists in this University no lawful impediment to the matriculation of female students, and (they) enjoy equal advantages with male students."

By the time Vogtlin graduated in 1874, the

Zurich experiment was clearly a success. Never again would a serious question be raised about the admission of women. Outside Switzerland, however, except for France, restrictions on the medical education of women continued in most major countries into the twentieth century. As late as 1907, neither Germany, Britain, Russia, nor the United States had opened its medical schools to women as widely as Switzerland. By that time, more than a thousand women were studying medicine in Swiss universities, a number greater than the rest of Europe combined and equal to the total enrollment of women in the 150 medical schools of all kinds, including women's schools, in the United States.

For this astonishing record, a large portion of the credit goes to the Zurich pioneers. It was this band of remarkable women who convinced a tolerant but skeptical faculty that women could indeed study medicine on the same terms as men. Once persuaded, the faculty and the canton never turned

back in their defense of women in medicine. They examined but rejected the American alternative of developing separate schools for women. "Men will always regard such separate women's schools," said Professor Rose in summary, "with mistrust and small regard" and they would at best attract "only mediocre faculty" and students. The faculty responded at length to criticisms from foreign professors and wrote frequent replies to inquiries from medical schools in Europe and America seeking information about the Zurich experiment. Always they praised the pioneer women for their intelligence, tact, and perseverance.

They were remarkable in the strong motivations that caused them to overcome obstacles at home and reach their rendezvous in Zurich. Though coming from very different cultures and political systems, they shared the experience of growing up in a stable, middle-class home where they each acquired a thirst for education and the new knowledge that was trans-

forming science and medicine. All of them were keenly aware of the forces that were shaping the place of women in economic life. They shared high intelligence, a remarkable self-discipline, and an almost missionary zeal to make their lives useful to a larger society. The two Russians were clearly more political and actively feminist in their social views than their sisters from the West, but all could be militantly stubborn when necessary. All sought a normal family life, most of them married and raised children, and all carried on a practice in medicine following their years in Zurich. Like women doctors everywhere in the nineteenth century (and indeed most men doctors), most of them tended toward general practice, especially among women and children, but some were unusual in their pursuit of careers in surgery, ophthalmology, and research.

Extracted from the *Journal of the History of Medicine*: Vol. 44, Jan. 1989

JG

WHO CONSULTATION ON TOBACCO-ATTRIBUTABLE MORTALITY

In recent years, several countries have attempted to quantify the impact of smoking patterns on the health status of their populations. The United States of America has been pre-eminent in this field although several other countries, including the United Kingdom, France, Switzerland, Australia and Singapore have also carried out assessments of smoking attributable mortality.

In November 1989, WHO convened a statistical Consultation in order to recommend a standard methodology for assessing mortality attributable to smoking, and to prepare estimates of current and future global and regional mortality due to smoking. One of the principal issues in determining methodologies is the availability of reliable data on causes of death. These data exist for about 50 countries or areas. For these populations, a methodology was proposed based on a comparison of current levels of mortality from lung

cancer, taken as an indirect indicator of past smoking patterns, with levels prevailing among lifelong non-smokers in the United States (as reported in the latest American Cancer Society (ACS) prospective study). Firstly, a Smoking Impact Ratio (SIR) was defined at ages 55-64 as the ratio of the excess mortality rate from lung cancer in a given population to the level which would have been expected in a non-smoking population. Then, taking the disease-specific Excess Mortality Ratios (EMRs) from the ACS study, these

ratios were systematically scaled by a factor which ensures that the age-specific excess mortality ratio at ages 55-64 exactly matches the SIR. This procedure is predicated on the fact that variations in the proportions of smokers between countries will multiply the cause-specific EMRs by a common factor.

The adjusted EMRs are then applied to the observed distribution of causes of death in a given country to estimate the overall mortality attributable to smoking. The methodology is current-

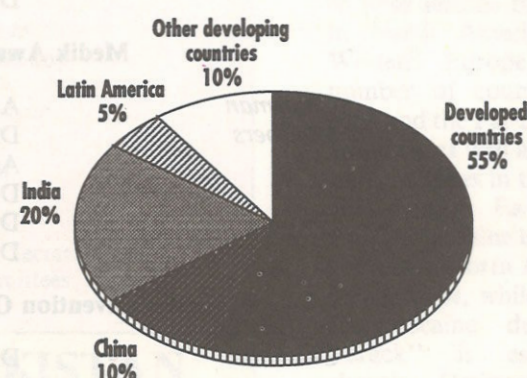
ly being applied by WHO to national mortality data. It is expected that the methodology will lead to more refined estimates for the developed countries; previous studies have suggested a global annual number of around 1.5 million deaths attributable to tobacco in these countries.

For those countries (most of the developing world) for which this methodology cannot be applied due to lack of data and dissimilarity of population characteristics compared with the ACS study population, the determination of mortality attributable to smoking is necessarily much more subjective. In this case, estimates of the regional cause-of-death pattern were first derived from available epidemiological data. Mortality related to

tobacco consumption was then estimated within a range of plausible estimates based on this cause-of-death structure and what is known about smoking patterns in developing countries. The results are summarized in the figure at left.

Overall, the Consultation estimated that tobacco (primarily smoking) kills about 2.7 million people every year, with a confidence interval of roughly 2 million to 3.8 million deaths. Moreover, it was estimated that if current smoking trends continue there will be around 8 million such deaths in 2025, with the majority of these deaths occurring in developing countries.

Source: WHO TOBACCO ALERT April 1990



WELCOME

The SMA welcomes the following new members:-

Boey Kok Hoe

Goh Pui Kiat

Lee Ling

Lim Ui Chong

Lo Cher Kuan

Loi Kuan Loong

Dede Selamat Sutedja

Tan Eng Choon Gerard

STANDING COMMITTEES AND REPRESENTATIVES OF THE SMA FOR 1990/1991

STANDING COMMITTEES

Continuing Medical Education Committee

Chairman Dr N K Yong

Community Health Education Committee

Chairman Dr Yap Lip Kee
Members Dr Lim-Tan Soo Kim
Dr Jean Ong Choo Khim
Dr Julian P'ng
APMPS Representative Dr Lee Su Lan
THE Representative Mr Richard Lim

CPR Training Programme Committee

Chairman Dr Low Lip Ping
Members Dr Chan Heng Thyee
Ms Chong Ah Yok
Ms Celestine Fong
Mrs Helena Foo
Mr Goh Teck Koon
Mr I Kamaldin
Dr Susan Quek
Dr Baldev Singh
Dr Soo Chee Siong

Editorial Board of Singapore Medical Journal

Editor Dr Chee Yam Cheng
Members Dr Low Yin Peng
Dr Phoon Wai Hoong
Dr Saw Huat Seong
Dr Baldev Singh
Assoc Prof Tan Choon Kim
Assoc Prof Tsoi Wing Foo
Dr Wang Yee Tang
Dr Ivy Yap

Editorial Board of SMA Newsletter

Editor Dr Goh Lee Gan
Members Dr Chan Kah Poon
Dr Chee Yam Cheng
Dr Jon Goh
Dr Tan Hooi Hwa
Dr Julian Wee

Ethics Committee

Chairman Dr N K Yong
Secretary Dr Tay Boon Keng
Members Dr Chee Yam Cheng
Dr Giam Choo Keong
Dr Leong Vie Chung
Dr Clarence Tan
Dr Tan Kok Soo
Dr Tan Yew Ghee
Dr T Thirumoorthy
Dr Yeo Siam Yam

Committee for General Practice (incorporating Joint SMA/APMPS PHC Committee)

Chairman Dr W R Rasanayagam
Members Dr Chua Sui Meng
Dr Leong Vie Chung
Dr Tan Kok Soo
Dr Tan Yew Ghee
Dr Tay Boon Keng
Ex-Officio Member

Guideline on Fees for Doctors in Private Practice in Singapore Joint SMA-APMPS Committee (incorporating Life Insurance Report Fees)

Chairman Dr Tan Yew Ghee (SMA)
Members Dr T B Lim (APMPS)
Dr Tan Kok Soo (APMPS)
Dr N K Yong (SMA)

Information Technology Committee

Chairman Dr Wong Poi Kwong
Members Dr Cheong Pak Yean
Dr Goh Lee Gan
Dr Ronnie Tan
Dr Teo Keng Seng
Dr Yap Lip Kee

Medik Awas Committee

Chairman Assoc Prof Ti Teow Yee
Members Dr Chng Hiok Hee
Assoc Prof Lee How Sung
Dr Lim Poh Heng
Dr Tan Chay Hoon
Dr Tan Seng Kee

SMA Convention Organising Committee

Chairman Dr V P Nair

SMA Premises Committee

Chairman Dr W R Rasanayagam
Members Dr Tan Yew Ghee
Dr Tay Boon Keng

SMA Secretariat Committee

Chairman Dr Tay Boon Keng
Members Dr Giam Choo Keong
Dr Gong Ing San
Dr V P Nair
Dr W R Rasanayagam
Dr Tan Yew Ghee

STANDING COMMITTEES & REPRESENTATIVES OF THE SMA FOR 1990/1991

cont'd from page 12

Sports & Games Committee

Chairman	Dr Giam Choo Keong
Convenors —	
Badminton	Dr A K Abraham
Billiards	Dr Woffles Wu
Bowling	Dr Lau Chee Chong
Chess	Dr Wong Yip Chong
Golf	Dr Ang Hong Beng and Dr Wong Yik Mun
Soccer	Dr Tan Yew Ghee
Squash	Dr Jonathan Pang
Tennis	Dr Ernest Wong
Track Relay	Dr Sunil Kumar Sethi

REPRESENTATIVES FROM SMA

Singapore Anti-Narcotics Association
Dr Douglas Kong

Singapore Professional Centre (SPC)
Dr Tay Boon Keng
Dr Yap Lip Kee

Advertising Standards Authority of Singapore
Dr Philbert Chin S S

Singapore Red Cross Blood Centre
Dr Yap Boh Seng

Commonwealth Medical Association (CMA)
Dr W R Rasanayagam

Medical Association of South East Asian Nations (MASEAN)
Dr W R Rasanayagam
Dr Tay Boon Keng

MASEAN Standing Committee on Primary Health Care
Dr W R Rasanayagam

MASEAN Committee for Postgraduate Medical Education, Training & CME
Dr Tay Boon Keng (Chairman)

Professional Auditors
Boon Suan Lee & Company

Honorary Legal Advisor
Mr Kumar Lal
Mr Amarjit Singh
Dr Myint Soe

Note: The SMA President and Honorary Secretary are Ex-officio members of all Standing Committees.

XIXTH ALL PAKISTAN BIENNIAL MEDICAL CONFERENCE

6—9 Nov 1990
Lahore, Pakistan

For further information, please contact

Dr Kaleem Butt
Secretary General
Pakistan Medical Association
PMA House
Garden Road, P O Box 7267
Karachi-3, Pakistan
Tel: 714632/711159

WHO PRESS

DRUG DEPENDENCE AND ABUSE: THE GLOBAL SITUATION

Trends

* Drug abuse is worsening rapidly around the globe, in both developed and developing countries. In many countries, drug abuse has today become one of the major causes of health and social problems. Counting all those who abuse drugs, or are dependent on them, the world total could be in the hundreds of millions. Although it is difficult to quantify the number of persons abusing drugs, the United Nations has estimated that there are over five million injecting drug users in the world.

* There has been a continued escalation of cocaine, heroin and methamphetamine abuse, although the abuse of cannabis, amphetamine-type substances, benzodiazepines and sedative-hypnotics has also reached high levels in many countries. Heroin abuse continues to pose serious problems in North America and Western Europe, in a number of countries in Asia and the Far East and Oceania, as well as in certain countries in the Near and Middle East. The abuse of cocaine has risen sharply in North America and Europe, while use of the cocaine derivative "crack" is escalating sharply. Designer drugs have also appeared in the United States and have spread to many other countries, posing another threat. The abuse of psychoactive drugs such as tranquilizers, depressants and stimulants of the central nervous system is also a problem, affecting the health of the peoples in both developed and developing countries.

* Drug abuse knows no boundaries of social class, sex or age. Drug abuse is increasingly affecting young people in both industrialized and developing countries. Children and adolescents

are becoming involved in drug abuse at an earlier age than before. Although the majority of persons using or abusing drugs are males, the proportion of women abusing drugs continues to increase in both developed and developing countries. An increasing number of infants are being born in the developed world already addicted to drugs such as heroin, or cocaine.

* In the Americas, and recently in Asia, injecting drug users have become increasingly vulnerable to infection with HIV, the human immunodeficiency virus which causes AIDS. Intravenous drug users represent a large proportion of reported AIDS cases on the East Coast of the United States and in southern Europe, especially in Spain and Italy. In Asia, extensive spread of HIV infection among drug users has been documented in Thailand, and HIV infection has also been found among intravenous drug users in Rangoon, Myanmar. Thus, the global epidemic of drug use threatens to expose new populations to explosive HIV spread.

* Abuse of drugs is a growing problem in all regions of WHO. In Africa, government reports indicate a deterioration in the drug abuse situation. Problems with cannabis have escalated in recent years due to the abuse of narcotic drugs, such as heroin and cocaine. In the Americas, the abuse of cocaine, cannabis and multiple drugs, often involving alcohol and psychotropic substances, continued to increase. In Asia and the Far East, heroin abuse has continued to increase, reaching epidemic proportions in some countries. In Europe, the main problem is the abuse by

injection of heroin, with cocaine and amphetamine use rising rapidly. In the Near and Middle East, cannabis abuse is now accompanied by use of heroin in several countries.

The Role of WHO

* Reduction in the health and social problems caused by drug abuse is an essential part of the WHO mandate for achieving the objective of Health for all by the year 2000. Within the total response to drug abuse, the health element deserves greater prominence because it is precisely the health sector which can play a key role in mobilizing, supporting and sustaining effective action to reduce demand at international, national and community levels.

* WHO advises the Secretary General of the United Nations on psychoactive substances, which create public health and social problems. For example, designer drugs, captagon and pemoline, are recent examples.

* WHO is uniquely placed to lead the global efforts of health, science, medicine and social services against drug abuse and dependence. The three main objectives of WHO's global action to reduce drug abuse are:

- * preventing the spread of drug abuse in individuals, families, communities and countries;
 - * developing effective approaches to the treatment of drug dependence and associated diseases;
 - * collaborating in controlling the supply of licit psychoactive substances.
- * Within the context of its current programme for preventing and controlling drug abuse, WHO has promoted or carried out activities, including:
- * Monitoring the world situation with respect to the use and abuse of psychoactive substances.

cont'd on page 14

DRUG DEPENDENCE

cont'd from page 13

- * Reviewing the health consequences of different drug control policies.
- * Assessing the effectiveness of health promotion to reduce drug abuse.
- * Developing special programmes for adolescents, and for use in the workplace and at community level.
- * Assessing the quality of care in drug dependence treatment.
- * Preparing training materials for use in primary health care.
- * Analysing the use of methadone in the treatment of opiate dependence;
- * Improving the handling of drug-related problems in emergency rooms.
- * Testing interventions designed to prevent HIV-related risk-taking behaviour among drug users.
- * Assessing the abuse potential and medical usefulness of psychoactive drugs and recommending a pro-

per level of international control to be applied under existing conventions.

- * Building upon policy development at country and regional levels, WHO will seek to establish and maintain more effective linkages with other United Nations bodies, such as the U.N. Division of Narcotic Drugs, the International Narcotics Control Board and the U.N. Fund for Drug Abuse Control, on activities related to the prevention and control of drug abuse.
- * WHO plans to intensify its activities at all levels in the fight against drug abuse. This process will be begun by an intensification of current programmes, utilizing the existing resources of the Organization. Given the vast scale of the problem and the urgent need to mobilize a whole range of different activities, there is a longer-term need for substantially increased resources globally for the fight against drugs.

Source: IN POINT OF FACT, WHO, Feb 1990.

PSYCHOACTIVE DRUGS

by Dr Inayat Khan

Chief Medical Officer

Psychotropic & Narcotic Drug Unit

1. What is the situation in the world today regarding the abuse of psychoactive drugs in the developed and developing countries?

The abuse of illicit drugs such as cocaine, heroin and methaqualone constitutes a major public health and social problem today. But though they are less visible, the misuse or abuse of psychoactive drugs such as tranquilizers, depressants and stimulants of the central nervous system is also a problem, affecting the health of the peoples in both developed and developing countries.

2. What activities has WHO undertaken in an effort to control the abuse of such substances and what further actions are required?

WHO covers the area of demand reduction, that is, prevention, treatment and

rehabilitation of drug abusers. As a preventive measure, WHO reviews the abuse potential and other effects on the central nervous system as well as medical usefulness of psychoactive drugs and recommends an appropriate level of control to be applied within the international legal framework. Scientific methods for this purpose are constantly reviewed and updated. Education and training of health care personnel, development of curriculum and training materials, for example, is another area of our activity. An informed health care professional is a key factor to promoting the rational use of psychoactive drugs. In future, we plan to further develop and expand our activities based on the experience gained, and make full use of our

cont'd on page 15

DOCTORS' FOOTBALL — RESULTS

A total of 70 doctors participated in the SMA 7-A-Side Football Tournament for the Leong Hin Seng Trophy on 20 May 1990.

There were 6 teams:

- | | |
|-----------------------------------|-----------|
| 1. Singapore Armed Forces Doctors | (SAF) |
| 2. National University Hospital | (NUH) |
| 3. Private Practitioners | (GP) |
| 4. Singapore General Hospital 'A' | (SGH 'A') |
| 5. Singapore General Hospital 'B' | (SGH 'B') |
| 6. Toa Payoh Hospital | (TPH) |

The League Championship was won by SGH 'A', with the GP's as League Runners-up.

SGH 'A', GP's, SAF and TPH qualified for the Semi-finals. In one game, GP's beat SAF 3-1. In the other, SGH 'A' beat TPH 2-1.

SGH 'A' and the Private Practitioners met in the Final, and SGH 'A' emerged champions to win the Leong Hin Seng Trophy with a score of 4-1.

FULL RESULTS

(A) League Championship Table

TEAM	P	W	D	L	F	A	POINTS
SGH 'A'	5	4	0	1	7	1	12
GP	5	3	1	1	5	2	10
SAF	5	2	2	1	4	2	8
TPH	5	2	1	2	7	5	7
NUH	5	1	1	3	2	5	4
SGH 'B'	5	0	1	4	2	11	1

(B) Detailed Results

TOP SCORER AWARD	: Dr Philip Tseng (SGH 'A')
BEST GOALKEEPER AWARD	: Dr Richard Tan (TPH)
LEAGUE CHAMPION	: SGH 'A'
LEAGUE RUNNER-UP	: GP
CUP CHAMPION	: SGH 'A'
CUP RUNNER-UP	: GP



The League and Cup Champions, SGH 'A' (in green jerseys) and the League and Cup Runners-up, the Private Practitioners (in yellow jerseys).

Dr Tan Yew Ghee
SMA Soccer Convenor

YOUR BODY, MIND & SPIRIT IN BALANCE

cont'd from page 1

them will actually make the decision to do so.

The results of the 1988 study, although based on a small sample, generally square with what keen observers would have noted to be social changes over the last decade. Strictly speaking, there were no major discontinuities during the last decade: economic growth, political stability, meritocracy, manpower development, harmonious social relationships. Whatever may have been accentuated in our traits — national traits if you like, must be the results of cumulation of the same sets of environment pressures, of viable alternatives, materialistic values, and the fact that consumerism feeds upon itself. What is worrying is that, with more exposure to the outside world, young people are beginning to think about opting out (of the country).

What has the above to do with health and health issues? Metaphorically, I suppose one can say that a nation can be healthy only if its social fabric is cohesive, e.g. family solidarity, value consensus, cooperation and harmony in social relationships, citizen loyalty. On these counts, Singapore is still doing alright. At the individual level, the kinds of values people hold vis-a-vis work, education, personal success and such like, can still be described as positive. But ultimately, the sense of

well-being must stem from a sense of satisfaction with life itself. Interestingly, just like the matter of physical health, mental and spiritual health is also in our hands. We can maintain a balance among all three, if we take an honest look at our values.

On the question of education. No doubt, the only major resource Singapore has is human resource; thus, we must put a high premium on manpower development. There is also a strong correlation between educational attainment and occupational status, with the income and prestige that this brings. However, the emphasis on education must not be on the paper qualifications alone. The emphasis must be on developing the individual's potentials. To change our population's attitude towards education, the parents should begin to see their children's education in a broader, longer perspective. A lot of the educational pressure felt by young people actually comes from parental expectations. Today's parents are too anxious about their children's progress in school. Each year, the examination fever affects not just the students' health, but their parents also, and doctors will bear me out on this.

On work, beyond providing for the basic needs of life, work brings intrinsic

satisfactions, such as a sense of purpose and fulfilment, a sense of contribution towards the well-being of society. Singaporeans work hard; some are even workaholic. But one can ask, who do they work for? Most work for their own and their family's material interests. What about contributions towards society? I do not wish to sound moralistic. All I wish to say is, there is a larger purpose to life, and if we miss it, we miss a very important source of life-satisfaction, and we will be the ultimate losers. Similarly with leisure. Some people work hard and play hard. They engage in sports and recreation mainly to keep fit, in order that they can work harder. Some people do not have time at all for leisure activities, to the detriment to their health and family relationships. Many Singaporeans are getting very fond of travelling overseas for holiday. Are they necessarily getting more refreshed and better informed about the world upon their return? Is there not a trace of looking at such travels as part of a middle-class lifestyle and keeping up with the Joneses? In our mad rush to work, to make a living, to keep up with a lifestyle, we have forgotten how to relax, to reflect, or keep in touch with nature and with ourselves.

To sum up, a balance between work/study, family life and recreation will go a long way towards making life not just healthier, but also more satisfying. A beginning can be made by each person through examining one's priorities in life.

One last word about the use of high-tech medicine for the elderly. The life-saving qualities of modern hi-tech medicine are not disputed. Among doctors, however, there is a growing recognition that it is better to add life to years, rather than just years to life. The moral dilemmas faced by doctors as well as patients and their families are accentuated by the capabilities of hi-tech medicine. Solutions to such dilemmas do not lie in the realm of public policy, but in the realm of religion. If we have a proper perspective on life and death, death indeed would lose its sting, and life can be a cup that overfloweth. "

Garfield

GARFIELD SAYS:

cont'd from page 3

Nurse B, "Cleaned their combs."

Nurse C, "Cleared their throats, phlegm..."

"Enough, enough, why didn't you tell me?"

Nurses A & B & C, "Doctor, don't be angry, we are only following your instructions."

"Patients, you said, are customers and customers are always right."

"We are also constantly reminded that patients do not behave normally because they are not well. They are in pain both physically and emotionally, therefore they are not themselves. We must not do anything to

upset them. We must be tolerant. We must be understanding. We must not raise our voices. We tried to clean up the mess the best we could. Poor fishes."

"Patients not themselves eh. Pita, Pita, Pita."

Nurses A & B & C, "Yah, quite pitiful."

"Did I say pity?"

Nurses A & B & C, "No?"

"I said pita."

Nurses A & B & C, "A new drug?"

"A new medical word, to describe an incurable symptom - pain-in the a _ _ _"

PSYCHOACTIVE DRUGS

cont'd from page 14

resources — that is, the network of our own regional and country offices, collaborating institutions and individual experts.

3. What is the value of educating individuals and health care personnel?

We are also aware of the weaknesses of conventional education programmes, and the need to add "B" of "belief" to KAP or knowledge, attitude and practice. Among the approaches we wish to explore for this purpose is an integrated programme with the primary health care infrastructure as well as a full involvement of teaching institutions.

4. There has been some criticism that such activities are possibly overly expensive and difficult to quantify. Are educational measures cost-effective?

We agree that the effect of educational programmes is difficult to quantify. We believe, however, that it is a good educational programme that will have slow, but far-reaching effects on human behaviour. Just think of the other option of dropping all such activities whose effects are not readily quantifiable. A few good programmes in the health sector would have to be discontinued since it is often difficult to conduct a mean-

ingful evaluation of long-term effects of some activities.

5. What are the most commonly abused prescription drugs in developed and developing countries?

Excessive or irrational use of hypnotic-sedatives, tranquilizers, anorexigenic drugs and stimulants is widely seen in, but not confined to, developed countries.

6. Looking to the future, what sort of developments and challenges do you expect?

With the rapid increase in transnational movements of man, goods and technology, we will be facing a challenge of the globalization of the drug menace. The only way to counter this challenge is for all of us who are fighting drug abuse problems to unite ourselves more effectively than those who are on the other side of the battle front. All the UN agencies should make more efforts to ensure better coordination and concerted action to respond to this challenge.

Source: WHO FEATURES Feb 1990.

8TH ASEAN CONGRESS OF CARDIOLOGY - 1990

THEME: ASEAN CARDIOLOGY IN THE NINETIES

Date : 7 - 11 DEC 1990

Venue : Raffles City Convention Centre, Westin Stamford Hotel, Singapore

Further information can be obtained from:

Congress Secretariat
8th ASEAN Congress of Cardiology
Times Conferences Pte Ltd
Times Centre, 1 New Industrial Road Singapore 1953
Tel: (65) 380-7433/380-7420/284-8844
Fax: (65) 286-5754 Tlx: 25713 TIMESS

POST ASEAN CONGRESS WORKSHOP LIVE DEMONSTRATION TEACHING COURSE IN PTCA & VALVULOPLASTY

Date : 12 - 14 December 1990

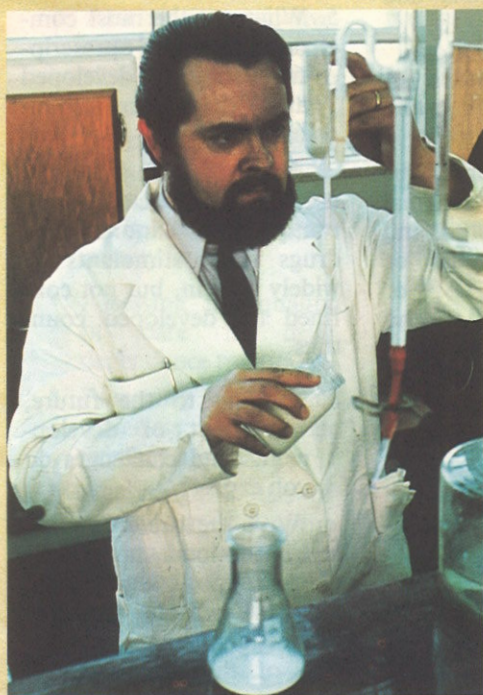
Venue : Mt Elizabeth Hospital

For enquiries, please contact

Sister Lee
3 Mt Elizabeth #17-06
Mt Elizabeth Medical Centre Singapore 0922
Tel: 7334466 Fax: 7371616

Frisolac[®]H

As near to nature as humanly possible



Frisolac H is formulated with all the care in the world to approximate as closely as possible to the best infant nutrition there is – breast milk. And all mothers should be urged to breastfeed.

However, when breastfeeding is not possible, there's nothing better in the world for a baby to thrive on than Frisolac H.

Its protein, fat, carbohydrate, mineral and vitamin contents are meticulously adjusted to optimise nutrient values and minimise the demands on infant digestive capacity.

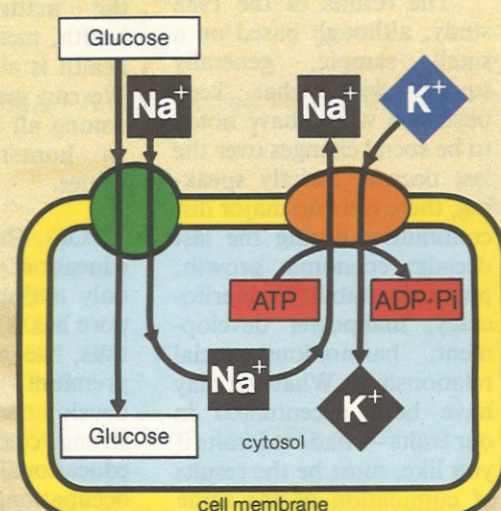
Take, for example, sodium and potassium.

The sodium/potassium balance

Since the kidneys of infants should not be overloaded, it is best that the osmolality of an infant formula approximates that of human blood. The principal extracellular osmol is the sodium ion and the principal intracellular osmol is the potassium ion. The sodium/potassium ratio in an infant formula should therefore be similar to that of human milk.

Using such a ratio will avoid both exceeding the infant renal osmolar load and reduce the risk of excess sodium which could lead to hypertension.

By means of a highly advanced milk serum demineralisation process, the sodium/potassium ratio of Frisolac H is adjusted to closely resemble that of breast milk and comply fully with the requirements of the WHO/FAO Codex Alimentarius. Further proof that Frisolac H is as near to nature as humanly possible.



- Na⁺-K⁺ ATPase
- Carrier for cotransport of Na⁺ and glucose

The ATP sodium-potassium pump.



Next best to nature



For further information please contact:

DIETHELM SINGAPORE PTE LTD. Tel: 4711466

