

The Singapore Family Physician



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College of General
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January/March 1982**

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Age of child	Weight (kg)	Volume of formula (ml)	Number of feeds per day	Notes
0 to 10 days	3.5	100	8	8 feeds a day
10 to 20 days	4.5	120	8	8 feeds a day
20 to 30 days	5.5	140	8	8 feeds a day
30 to 40 days	6.5	160	8	8 feeds a day
40 to 50 days	7.5	180	8	8 feeds a day
50 to 60 days	8.5	200	8	8 feeds a day
60 to 70 days	9.5	220	8	8 feeds a day
70 to 80 days	10.5	240	8	8 feeds a day
80 to 90 days	11.5	260	8	8 feeds a day
90 to 100 days	12.5	280	8	8 feeds a day

The amount of formula should be adjusted according to the individual infant's needs. If the infant is not gaining weight or is losing weight, the amount of formula should be increased. If the infant is gaining weight too rapidly, the amount of formula should be decreased. The amount of formula should be adjusted to the infant's needs.

Preparation of Feeds: 調奶方法:

1. Put clean bottle, teat and cap in water and boil for 5 minutes.

2. Fill clean or sterilized water above to cup and pour the correct amount into the bottle (see feeding table).

3. Add LACTOGEN to the water.

4. All feeding times add the correct amount of LACTOGEN to the water. Do not add LACTOGEN to the water after the water has been added.

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Fat	22.0	3.2
Energy	270	4.0
Calcium	0.35	0.05
Phosphorus	0.25	0.04
Potassium	0.15	0.02
Sodium	0.10	0.01
Iron	0.005	0.0007
Vitamin A	1000 IU	0.15
Vitamin D	100 IU	0.015
Vitamin E	10 IU	0.0015
Vitamin K	100 µg	0.015
Vitamin B1	10 µg	0.0015
Vitamin B2	10 µg	0.0015
Vitamin B6	10 µg	0.0015
Vitamin C	10 mg	0.0015
Niacin	10 µg	0.0015
Pantoic acid	10 µg	0.0015
Folic acid	10 µg	0.0015
Biotin	10 µg	0.0015
Copper	10 µg	0.0015
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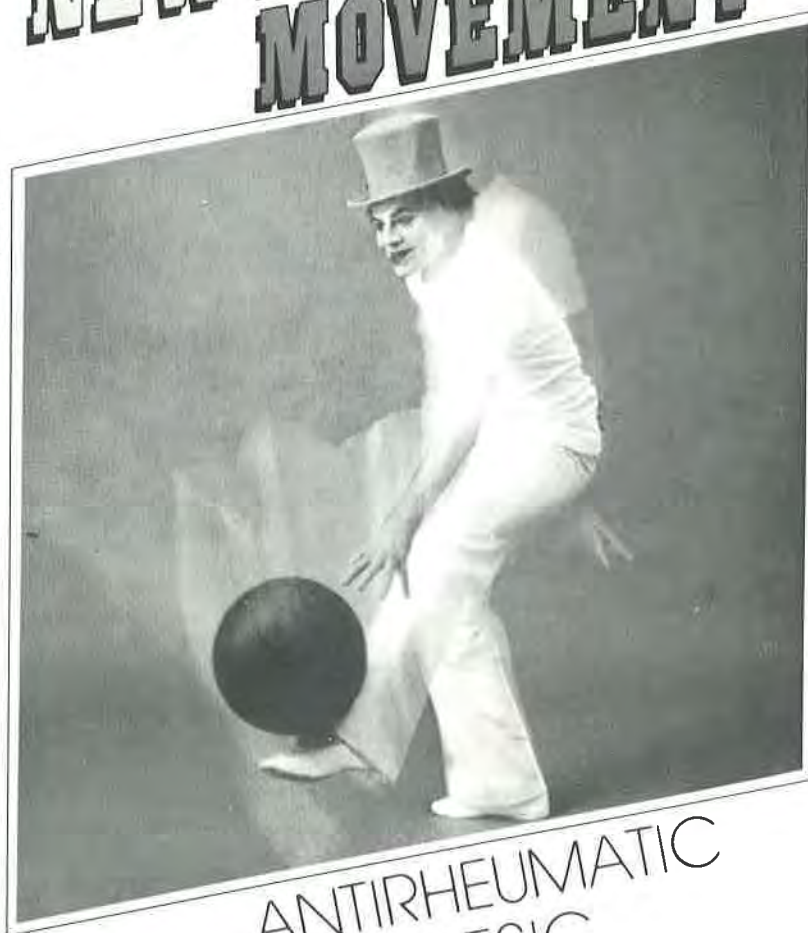
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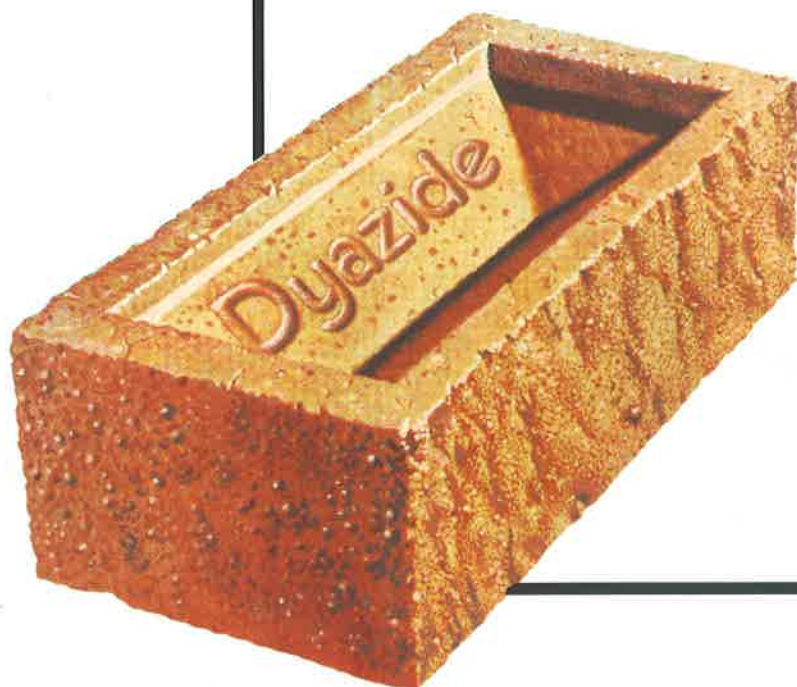
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THE SINGAPORE FAMILY PHYSICIAN

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The Eighth College Council (1981-1983)



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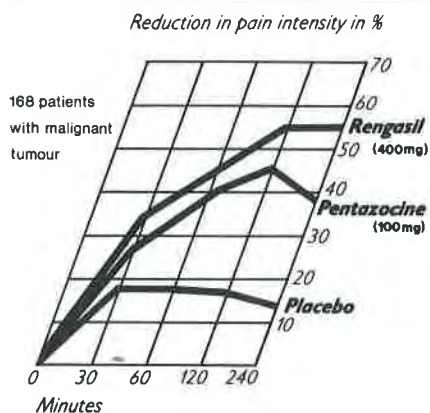
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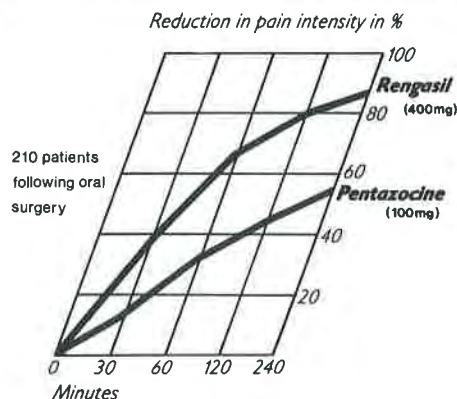
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Further product information available on request **CIBA**

1. Buckert D.: Int. Symp., 1Xth Europ. Congr. Rheumatol., Wiesbaden 1979.
2. Sperr W.: Int. Symp., 1Xth Europ. Congr. Rheumatol., Wiesbaden 1979.

EDITORIAL

The Doctor and Productivity

The Doctor and Productivity

Productivity has become a pervasive word in Singapore and no doubt will soon become a way of life with Singaporeans. It is however not a new concept as far as the doctor is concerned. The role of the doctor in increasing productivity has a long and not inglorious history. By improving the environmental conditions and health of workers in industry he has made major contributions to their productivity — the fruits of labour.

Industrial Health

In 350 B.C., Hippocrates realised the danger of industrial hazards to workers. He was particularly concerned with lead poisoning among lead workers.

Pliny in 50 A.D. mentioned the dangers of dust. Vermillion refiners wore "bladder masks" to permit them to see what they were doing without the risk of inhaling the poisonous dust of vermilion.

In 1700 Bernardino Rammazini wrote a comprehensive treatise on occupational hazards based on his observations on more than a hundred occupations. It was he who pointed out the necessity to include in every medical history, the **patient's occupation**. He also advocated to the university authorities that industrial medicine should be started in the faculty as a specialty.

In the U.K., the outbreak of "malignant" fever in a cotton mill in the town of Radcliffe in 1784 brought to prominence Dr. Thomas Percival and his colleagues. They made what were then regarded as revolutionary recommendations.

These recommendations were:—

- 1) All doors and windows in the mill should be opened at night and during the lunch break.
- 2) The number of windows should be increased and such openings must be made at different levels to permit adequate ventilation.
- 3) The floors of the mill should be washed weekly and the walls whitewashed periodically.
- 4) Tobacco should be used as fumigation. It was at that time thought that tobacco was dreaded by

rats and thus was effective prevention against plague. (Smokers should heed the survival "wisdom" of rats and give up the tobacco habit altogether.)

- 5) All stoves without proper vents should be replaced by fireplaces with chimneys to permit egress of foul fumes.
- 6) Peat was to be burnt as an antidote to contagion.
- 7) Machines must be lubricated with fresh oil frequently.

The outcome of these recommendations was the abrupt cessation of further cases of "malignant" fever and the County of Lancaster was more than grateful to Thomas Percival and his colleagues. A formal letter of appreciation was publicly recorded.

"This Court, impressed with the obligations it is under to Dr. Percival and his colleagues for the alacrity and attention they have shown in visiting manufacturers and cotton works at Radcliffe in the said County, and for the learned and useful information they have given respecting the same, for the purpose of putting a stop to the alarming sickness which has prevailed and still continues there, and for preventing the same in future, give the public and sincere thanks of the Court to the above gentlemen on this occasion."

The ground was prepared for subsequent legislative measures which culminated in the first Factory Act of 1833 on the appointment of a Royal Commission. Industrial health, at least from the point of view of the worker's physical and environmental well-being, became firmly established.

The Psychological Aspects

The modern doctor should transcend beyond merely looking after the physical health of workers. He must be conversant with the psycho-dynamics of workers working in a group-setting in relation with management.

The earliest model of productivity views it as a direct relationship between economic rewards and the amount of output a worker produces. It also takes the view that a group of workers is merely a collection of individuals each with his own economic goal. The consequence of this mode of thinking is the practice where individual workers are paid only on the basis of what they produce, no more and no less.

The socio-psychological view sees the social processes of the small work group as important factors which can modify organisational rewards and practices. These factors are also seen to modify the characteristics of individuals in very significant ways and therefore influencing their productivity levels. Individual and group productivity become symbolic expression of attitudes toward external authorities. Further they are also expressions of intragroup solidarity and structure.

Social Control

Among the many determinants of productivity one that is of special importance and interest to the doctor is the social control over production exerted by a group of workers themselves. Social control may be manifested by **restrictive** norms or **high-productivity** norms. The norm set by the group constitutes its control over production and tempers the influence of all other factors affecting productivity.

Areas of Conflict

Group restriction of output in industry or in other settings indicates a uniformity of social control over production. Where the group norm pegs production at a relatively high output, the less competent workers are "shown-up". The internal system of relationships among group members becomes strained.

A restrictive productivity norm serves to buffer or protect a group from external threats, the most important of which is the economic threat.

If a group increases its output, one of two bad outcomes are feared:—

- 1) Group members will have to work harder for the same quantum of rewards.
- 2) Fear that some members may be considered redundant with the consequence that the remaining members may have to work harder to produce the same output.

If individual differences among workers were expressed by different rates of production, the group exposed itself to external evaluation. The probe will be directed to explain why some are

high-rate producers and others low-rate producers. Thus members are put into competition with one another straining the established social bonds.

Groups often enforce as much uniformity of production among members as possible to mask any potential differences in ability among themselves. Uniformity of production allows the more proficient to protect those who are less efficient. It permits members to compensate for each other's daily fluctuation in mood or health. It becomes a tangible product or commodity of social exchange. One member will overproduce to help another at a time when for some reason, he is unable to keep up with the norm.

Group productivity norm maintains the integrity, stability and predictability of interpersonal relations which are important sources for satisfying individuals' psychological needs. It contributes to the solidarity of the group. It becomes a cohesive bond.

A conflict situation arises when the external demands for higher productivity challenges a group's demands for conformity to its norm. A worker may be torn between two sets of rewards. If he disregards the group norm he stands to benefit from the rewards offered by management i.e. increase in pay, better job status, job security, advancement opportunity and recognition. If he disregards the external demands for higher productivity, he is rewarded with closer friendship, liking, respect, support and the opportunity to fill a socially needed role in the interpersonal relationships among the group. When a person has to choose one set of rewards in preference to the other set, psychological conflicts arise. These conflicts may be manifested as psycho-somatic illnesses and increased absenteeism from work depending on whether he internalises his conflicts or seeks to escape from the conflict situation. A doctor who looks after industrial workers should be on the constant lookout for such symptoms. To monitor the psychological health of workers, comparative statistics of their absentee rate and incidence of psychosomatic illnesses against a national average are extremely useful.

Measurement of Doctors' Productivity

Productivity data are measured most easily from groups operating at the lower levels which cover the output of production workers. They are visible, discrete and easily enumerated.

The output of service such as that offered by the doctor is highly abstract and cannot be counted by numerical means alone. Thus the more abstract the task the more ambiguous becomes the measurement and evaluation of productivity.

Perhaps in such cases, productivity should be considered in terms of inputs and conversion processes rather than in numerical output figures.

This concept takes into consideration the amount of continuing education a doctor takes in annually. Courses of instruction could be converted into input points or merit points. Thus a doctor who amasses even a few input points annually is in effect a doctor who has a higher rate of productivity than one who eschews the need to upgrade his knowledge. The professional services provided by a doctor who has updated his knowledge are unequivocally of a better quality than those offered by one who has not bothered with the input of knowledge.

Whilst it is not possible to assess a doctor's productivity by the mere counting of the number of patients under his care, it is possible to evaluate the ways he has successfully converted his input of knowledge. These conversion processes may take the form of activities such as teaching or lecturing, research and publication. It is obvious that the higher the productivity of a doctor the more active he will be in these activities.

Conclusion

Doctors have concerned themselves in improving the environmental conditions of their

industrial colleagues and hence their productivity since the dawn of time. The doctor's role in productivity is two dimensional. Present day doctors are not only interested in the physical and environmental aspects of industrial workers but also their psychological welfare as well. By looking after the total health of industrial workers — physically and psychologically, he helps directly to increase their productivity.

On the personal dimension he can improve his own productivity by increasing the input of medical knowledge and by a conscious effort in converting such knowledge gained into practice. The personal productivity of a doctor cannot be measured by the same yardstick as that of a production worker. His output of production must be measured by considering the input and the amount of conversion processes. His work may be abstract but it is not impossible to evaluate his productivity. The basis and criteria of measurement however must of necessity be different.

The doctor's involvement with productivity extends far beyond the personal realm. His commitment has been total since the dawn of medical history. It is a record which the present generation of doctors can be justifiably proud of.

L.V.C.

Views expressed in the Editorial are not necessarily the official views of the College.

Early Days of the College

Dr E K Koh FRCGP FCGPS

Ten years is not a very venerable age but considering the difficulties which attended the birth of the College, it is a mile stone to remember and be proud of.

Like most of the other higher academic bodies for general practitioners in the world to-day, the Singapore College of General Practitioners came into being to fulfil the need for higher academic studies and research for the primary physician, namely the family doctor and general practitioner. For too long the general practitioner has taken the back seat where the rest of the medical profession has bounded forward with the latest advancements in their respective fields. If the general practitioner is not to be considered an anachronism in this day and age he must also keep up with the times. He must know the recent advances in therapeutic medicine, he must be aware of the latest thinking on healing and caring, and he must be able to look after the needs and wants of the patients entrusted to his care.

Would not all this be possible without the need to set up a special college for the general practitioners? Isn't there enough institutions of higher learning in the country which could very ably conduct refresher courses for general practitioners who wish to up-date their knowledge? These are pertinent questions that are always asked and have to be answered. Recent thinking has shown that primary medical care is a field of its own distinct from institutionalised or hospital care. Patients who are being treated outside the hospital have problems which are generally not seen in those patients who have been admitted to hospitals for treatment. The spectrum of illness and disease seen outside the hospital is also different from the kind of illnesses treated in hospital.

Because of these and many other factors it is necessary for the primary physician to focus his attention and care on the patients who are seen outside the hospital. To understand the nature of the illness better and to be able to treat his patients more effectively, it stands to reason that

the primary physician must study in depth the nature of the ailments which these patients present, and the method of management and treatment which could be used to help the sick.

This renaissance of interest in primary medical care and general practice can be said to have started both in the United Kingdom and the United States in the early fifties. In the United States increased specialisation in the medical profession forebode the exit of the generalist and family physician. There was quite an alarm at this trend because it would leave the onus of primary treatment on the individuals who was ill. He had to decide whether to take a trip to the corner drug-store for a pill to relieve his symptoms, or make the arduous and usually expensive journey to seek specialist medical treatment. The real danger lay in his ignorance in the evaluation of his symptoms and his inability to seek out the correct specialist to attend to his ailment.

In the United Kingdom many doctors too were alarmed especially at the low status and morale of the general practitioner following the introduction of the national health service. These people felt that unless a stop was put to the rot, and medical and public opinion reversed, Britain too like the United States would soon see the end of the general practitioner and family physician. They felt strongly that such a matter should never be allowed to come to pass because the family physician and primary medical practitioner was the cornerstone of all good family and health care.

Two British doctors decided to do more than lament the situation. On 13th October 1951 the *Lancet* and the *British Medical Journal* carried a letter from Dr F.M. Rose and Dr. John Hunt which began,

"There is a College of Physicians, a College of Surgeons, a College of Obstetricians and Gynaecologists, a College of Nursing, a College of Midwives, and a College of Veterinary Surgeons ... but there is no college or academic body to represent primarily the interests of the largest group of

medical personnel in this country — the 20,000 general practitioners."

The principal architect of the English College of General Practitioners formed in 1952 was Dr. John Hunt. This later became the Royal College of General Practitioners, and John Hunt who became Lord Hunt of Fawley was untiring in his efforts to set the College on a firm and sound foundation. The early days were not easy ones. Many people were openly hostile to its formation. Some questioned the need for a separate college for general practitioners arguing that whatever further training a general practitioner needed could be provided by the existing Royal Colleges of Physicians and Surgeons. In fact as long ago as 1851 an attempt was made to form a college for general practitioners in England but this fell through because of lack of support from the profession.

Stressing the importance of the work of the family doctor, Lord Hunt in his Lloyd Roberts Lecture said, "No matter how clever the consultants or how excellent the hospitals, it is the efficiency of the family doctors, and the work they do in and near the homes of their patients, which will determine the calibre of the medical services in any country." This is an observation which all of us would do well to observe in planning for the medical care of our country.

The work of the English College in its pioneering efforts to establish the study of general practice as an accepted medical discipline did not go unnoticed in Singapore, and even in those early days of the nineteen fifties, four local doctors had already applied to join the English College. They were Dr. B.R. Sreenivasan, Dr. A.W.S. Thevathasan, Dr. Koh Eng Kheng and Dr. Teng Peng Min.

There was however at that time a lack of urgency to establish a higher educational body for general practitioners in Singapore. This was perhaps due to the fact that most of the general practitioners here were doing well in their practices despite the absence of vocational training. Unlike the situation in the United Kingdom prevailing then, where general practitioners were paid very much less than their specialist colleagues in hospital practice, the Singapore general practitioner then was usually much better off financially than their specialist colleagues in the government service.

This laissez-faire attitude however did not last long. In 1962 the Singapore Medical Association with Dr Foo Chee Guan as President gave consent to the formation of the Society of General Practice under the S.M.A. This body had come about through the work of Dr F. B. Kampfner, Dr.

Colin Marcus. Dr. John Chong and Dr. William Heng. On the 21st February 1963 the Society was formally launched and Dr William Heng, who was chairman of the protem management committee, installed Dr. Gopal Haridas as the founder chairman.

The early years of the society were difficult ones and was marked by the general apathy of many of its members. The main activities at that time centred on the holding of educational talks and social events to cement ties between doctors in the private sector and those in public service. Attendances at the various meetings were often poor and at one stage its continued existence seemed to be very much in doubt. The untimely death of Dr G Haridas in 1964 was a further blow to the Society and in his memory the Society decided to endow the Haridas Memorial Lecture. This lectureship was later sponsored in conjunction with the Singapore Paediatric Society.

Despite its limitations the Society of General Practice made the first real attempt in this country to conduct refresher courses for our general practitioners. This was usually in the form of talks on the latest forms of medical management given by specialists from various disciplines in hospital practice. There was no attempt in getting general practitioners themselves to impart their experience and knowledge to fellow general practitioners. No move had then been made at any form of undergraduate medical education in general practice, no research in general practice was done, and no plans had been laid out for post-graduate vocational training. The Society of General Practice functioned as its name implied, chiefly as a medical society serving medical practitioners with like interests. It did not profess to be an academic body and did not conduct any examinations in its field.

Some of the activities of the society in fact were of a medico-political nature and in 1966 the Society received the support of many doctors in its fight over the controversial Pharmacy dispensing issue.

The need for general practice to be promoted as a medical discipline which should be taught to medical students was first seriously considered in a series of meetings in October 1966 between the vice-dean of the medical faculty of the University of Singapore Dr Charles Toh and three general practitioners, Dr. Tan Joo Liang, Dr E K Koh, and Dr. Wong Kum Hoong. It was however not until 1969 that the curriculum revision committee of the University decided that there was a place for undergraduate education in general practice. There were no plans however to set up a separate depart-

ment for this but students would be posted for one week sessions to general practitioners who would be selected for this by the University.

By this time the Singapore Medical Association too had woken up to the limitations of the Society of General Practice. In August 1969 a committee was set up with the following terms of reference.

"To look into the feasibility of forming a Higher Academic Body of General Practitioners in Singapore and to deliberate and recommend in what form or style this academic body should be."

The Committee was chaired by Dr Koh Eng Kheng with Dr Lim Boon Keng as secretary. The other members of the committee were Drs. A.L.G. Chan, Foo Choong Khean, Lee Hoe Guan, Lee Suan Yew, O.C. Leow, Liok Yew Hee, Colin Marcus, Ng Kong Kai, Tan Joo Liang and Seah Cheng Siang. This committee discussed three possibilities, the formation of a Singapore College of General Practitioners, a chapter of General Practice within the Academy of Medicine, or as a faculty of the Royal College of General Practitioners or the Royal Australian College of General Practitioners.

After considering the options the Committee recommended that there were two feasible moves, firstly as a chapter for General Practitioners in the Academy of Medicine, or the formation of an independent Singapore College of General Practitioners.

It was perhaps fortuitous also that at this critical phase in the gestation of the College, Dr. John Hunt who was then President of the Royal College of General Practitioners arrived in Singapore in April 1969 on his way to Australia. Dr. Hunt made the special effort to meet Dr Toh Chin Chye who was then Vice-chancellor of the University of Singapore to sell the idea of general practice as a medical discipline in its own right. He also met the various heads of the medical departments including Prof Sir Gordon Ransome whom he remembered as a colleague in Barts. Without this groundwork by Dr Hunt who was much respected by all whom he met, the formation of a college for general practitioners in Singapore would have met with more formidable opposition from many quarters of the medical profession.

During his short stay in Singapore Dr Hunt was indefatigable in keeping his appointments and meeting the people whom he felt could help in the cause. He stayed up till the early hours of the morning on one occasion to write a special article for the Singapore Medical Newsletter on the subject of the need for a higher academic body for

general practitioners in Singapore. His words are prophetic.

"In Singapore you already have your medico-political organisations. The time is now ripe, I believe, for you to develop an academic body to represent your 500 general practitioners. Fifteen or more countries already have such a college or academy, all of them founded during the past 20 years. You must not be left behind."

These colleges and academies have raised the status and academic standing of family doctors, the tendency for students to avoid general practice has been reversed, education (undergraduate, special vocational and continuing) has been helped, research into all aspects of general practice has been encouraged, and, most important of all, standards of clinical and social medicine outside hospitals, and the equipment of premises needed for these have been improved.

When you in Singapore have such an academic body to watch over general practice in your country you will be amazed to find how much there is for it to do. Our College's tape recordings alone, go out now to a listening audience of 50,000 doctors a year ... It will mean a great deal of hard work for some of you; but I can assure you that this will be well worthwhile. Within a few years your University and the whole of your medical profession will bless you for having taken this step; and as it will lead to better patient care outside hospitals and therefore to cheaper patient care, your Government and all your patients will bless you too."

In 1968 the Society of General Practice under the chairmanship of Dr Ng Kong Kai was receptive to the idea of a higher academy body outside the Society for the further training of general practitioners. An important symposium on the "Founding of a College of General Practitioners" was held in September 1969 under the chairmanship of Dr Fred Samuel. The symposium came close on the heels of the 2nd Medical Convention of the Singapore Medical Association. Dr. R.W. Roberts from the Royal Australian College of General Practitioners who had attended the Convention spoke to many of those who were interested in setting up the College.

In October 1969 the first breakthrough for the recognition of general practice as an academic discipline came with the appointment of clinical tutors in general practice by the University of Singapore.

Another forum was held in November 1970 where the Master of the Academy of Medicine Mr Yahya Cohen announced that while the Academy was sympathetic to the need for the establishment

of a higher academic body for general practitioners, it regretted that it was not feasible to form a separate chapter for general practitioners within the framework of the Academy.

The die was now cast. If the general practitioners wanted to have a higher academic body they had to do it on their own and accordingly the Society of General Practice on 22 November 1970 initiated the formation of a pro-tem committee to form a College for General Practitioners. Dr. Wong Heck Sing headed this committee. The other members of this committee were Drs. L.G. Chan, Chen Chi-nan, Chuah Chong Yong, Foo Choong Khean, E.K. Koh, Lee Soo Chew, O.C. Leow, B.K. Lim, Colin Marcus and Ng Kong Kai.

This committee did a lot of spade work for the formation of the College. Dr Wong himself travelled down to Australia and met many of the senior officials of the Royal Australian College of General Practice in order to tap from their experience. Dr Ng Kong Kai also met several officials of the Australian College when he went there.

The idea of a College for general practitioners was not unanimously welcomed by all members of the medical profession here. To some specialists it seemed strange that general practitioners would want to regard their work as a kind of specialty that required vocational training. Some were unhappy because they were afraid that a College for general practitioners would compromise their standing as specialists within the medical profession. Amongst the general practitioners too there were some who disliked the idea of an academic body that could act as a watch dog over the standard of general practice in the country. A few felt that the establishment of a higher academic body meant only an opportunity for those who sought positions within the council to set themselves as superior to the ordinary rank and file general practitioner. We were lucky to have the moral support of some of the eminent specialists in the country. Dr. Arthur Lim who was President of the Singapore Medical Association during that period, and Dr. Seah Cheng Siang of the Academy of Medicine gave us much encouragement. It was fortunate that those who disliked the idea of a College or dissented in its formation were few and with the support of most of the general practitioners in the country the College of General Practitioners was formed on the 30th June 1971. The pro-tem committee had done its work well, and Dr B R Sreenivasan one of our most senior general practitioners and a past Vice-Chancellor of the University of Singapore was invited to be the founder President of the new College.

The other members who made up the foundation committee were Drs. Wong Heck Sing, Wong Kum Hoong, Foo Choong Khean, Chen Chi-nan, E.K. Koh, Lim Boon Keng, Colin Marcus and Ted Wong Hoption. Dr. Chee Phui Hung was very helpful in the drafting of the constitution of the College with his knowledge and expertise on these matters. With the formation of the College, the Society of General Practice decided to change its name and role to the Society of Private Practice to serve the interests of all medical practitioners in private practice.

It has been a long uphill climb for many to set the College on the firm foundation it rests on today. Some of the doctors who were in with us at the beginning, sadly are no longer with us, but their hard work has not been in vain. Many were the long meetings which often stretched into the early hours of the morning through which the members of the various committees sat. Friendships were made and broken through the discussions and arguments that went on during the meetings but with the sacrifices came success. Shortly after the formation of the College it was able in March 1972 to jointly sponsor the 4th Medical Convention together with the Singapore Medical Association and the Malayan Medical Association. Many doctors from the R.A.C.G.P. attended the Convention.

The recrudescence of interest in general practice in this part of the world also led to the formation of sister colleges in Malaya, Hongkong and Sri Lanka.

With an academic body of their own, our general practitioners can now look forward to a useful participation in extending the frontiers of medical knowledge and care. We in Singapore can be proud that when the challenge was laid down we have not been found wanting. With our participation in regional and world gatherings featuring topics on general practice, our members have held their own with the rest of the profession within the world community. The holding of the forthcoming WONCA (World Organisation of Colleges and Academies of General Practice) Congress in May 1983 in Singapore is an event which will signal another milestone in the short history of the College. Together with the granting of patronship by the President of the Republic in 1974 and the recognition of the M.C.G.P. as a registrable additional qualification by the Singapore Medical Council in 1977, the College has come a long way since its foundation ten years ago. What has been achieved has been spectacular, what has yet to be achieved in the years ahead will no doubt prove to be even more promising.

Bladder Irritability in Female Patients

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INTRODUCTION

In general practice, as well as in the urological outpatient service one often meets female patients complaining of symptoms of irritable bladder such as frequent and painful micturition, lower abdominal discomfort, bladder cramps, urgency and dyspareunia. Evaluation of these cases along the lines of urinalysis, urine culture, haematology, blood chemistry and X-ray investigations can bring to light a number of abnormalities such as lower urinary tract infection, bladder stone, foreign body, distal ureteric stone, ureterocele etc., which can be successfully treated medically or surgically.

In a proportion of patients presenting with the above combination of symptoms however, no abnormalities will be demonstrated. In this group of patients further urological evaluation is indicated in order to establish the cause of the irritable bladder.

DIFFERENTIAL DIAGNOSIS IN IRRITABLE BLADDER SYNDROME

Having ruled out the conditions mentioned in the Introduction the following possibilities remain to be considered.

1. **Carcinoma in situ** can cause irritable bladder. Repeated urinalysis may show sterile pyuria alternating with normal urine. Urogenital tuberculosis should have been excluded. Cytology, followed by cystoscopy with systematic multiple biopsies are indicated to diagnose early non papillary bladder carcinoma.
2. **Interstitial cystitis** is diagnosed in the early stage by the typical strawberry-like epithelial haemorrhages after distension of the bladder which often has a small capacity. The lesion is most often found in the dome of the bladder and requires cytology and biopsy to be differentiated from carcinoma in situ. In later stages the diagnosis may be made by directly observing the ulceration described by Hunner in 1915. An important factor in the history of these patients is that the discomfort is mainly experienced

prior to voiding and is relieved by voiding, be it only for a short while.

3. **Urethral diverticulum.** This entity has been known for a long time but it has always been difficult to diagnose. It occurs in about 3% of asymptomatic women and this figure may well be higher in symptomatic patients. With the method of positive pressure urethrography, by which both sides of the urethra are occluded with a double balloon catheter and X-ray dye is injected into the urethra, many of these cases can be diagnosed and subsequently treated successfully.
4. **Neuropathic bladder.** This condition may show as either hyperactivity or hypoactivity of the detrusor muscle. In the early stages of demyelinating disease symptoms of irritable bladder may occur. In such case it is often impossible to find abnormalities by means of cystoscopic evaluation, biopsy, cytology etc. However, early indications can be either a small bladder capacity and beginning trabeculation in the absence of organic outflow obstruction or a large atonic bladder with residual urine, also in the absence of organic outflow obstruction. Urodynamic investigations are obviously indicated in these cases to give more objective data.
5. **Nervous bladder and the urethral syndrome.** These entities have been described in detail by various authors. When the history reveals diurnal frequency and suprapubic discomfort while the patient is often able to sleep through the night undisturbed and urinalysis and culture are repeatedly negative, emotional causes must be suspected. Cystoscopy reveals either no abnormalities or a variety of findings which are often difficult to interpret or to hold responsible for the symptoms. Membrane-like covering of the trigone, small cysts, granulations and pseudopolyps of the bladder neck can be encountered. However, in patients having cystoscopies for other reasons, one also comes across these abnormalities occasionally and they then seem to

cause no problems. Patients in this category are diagnosed to have a nervous bladder or the urethral syndrome. These terms can be considered synonymous. The diagnosis is made by exclusion and is therefore not very satisfactory.

INVESTIGATIONS

In order to accurately diagnose these conditions the following methods of investigation usually suffice.

1. Measurement of residual urine after voiding to assess the emptying capacity of the bladder.
2. Measurement of the urethral calibre with bougies a boule to rule out organic outflow obstruction due to mental or urethral stricture.
3. Measurement of the urethral length. A very short urethra may give rise to disturbances of the urethral sphincter mechanism.
4. Measurement of the bladder capacity. A very small bladder capacity results in urinary frequency, a large capacity may be accompanied by detrusor atony, stasis of residual urine and chemical or bacterial irritation of the trigone.
5. Measurement of the urinary flow. Objection of the amount of urine passed per time unit can be helpful in assessing urethral and detrusor function.

6. Cystometry is indicated when there is suspicion of neuromuscular dysfunction of the detrusor muscle.
7. Urethrocystoscopy to determine any abnormalities in the urethra such as diverticula or post-inflammatory stricture. The base of the bladder and the trigone can be the site of various abnormalities causing bladder irritability. The ureteric orifices and the bladder epithelium should be inspected for their shape, position and the presence of epithelial abnormalities or trabeculation.
8. Serial cytological investigations of the urine may elicit carcinoma in situ.
9. Positive pressure urethrography can be helpful in the diagnosis of urethral diverticulum.

CONCLUSION

An irritable bladder often constitutes a frustrating syndrome for the patient as well as for the doctor. A systematic approach to diagnose the underlying disease may be rewarding. After excluding organic disease by the available methods of investigation some cases remain in which we must suspect an emotional cause and treat accordingly.

Common Perianal Diseases (Excepting Piles & Abscesses)

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INTRODUCTION:

While it is true that haemorrhoidal disease and perianal suppuration constitute the commoner acute surgical conditions managed in any general practice, there are many other chronic anal conditions which are usually dismissed as of minor importance and of little consequence, and therefore, of little interest. This paper is a clinical study of these conditions of the anorectal region which give continuing discomfort, and often appreciable pain to the patient, and they merit equally prompt surgical referral when diagnosed. Anal lesions such as fissures, fistulae, tags for instance, and the pot-pourri of rectal and anal polyps, perianal warts, pilonidal sinuses as well as the conditions of anal stenosis and prolapsed rectum deserve as much attention as the haemorrhoid or perianal abscess. Over a one and a half year period, 100 such proctologic conditions were treated at the Dept of Surgery, Changi Hospital.

CLINICAL MATERIAL & METHOD:

During the period Nov 1979 to May 1981, 100 patients with anorectal complaints were admitted into this study once haemorrhoids or perianal abscess were excluded as being the cause of the symptoms. Following a full history and clinical examination, the appropriate treatment was given and the results analysed with respect to presenting symptomatology, clinical diagnosis, results of treatment, the type of anaesthesia utilised and the morbidity arising from treatment.

RESULTS:

Of the 100 patients studied, there were 67 males and 33 females. Eighty were Chinese, 11 Malays and 9 Indians. The age range was between 12 years to 80 years with an average of 32.5 years. The duration of complaints varied between 2 days to 10 years. Table I shows the main symptoms. The commonest complaint was of perianal discharge (50 cases), followed by pain (39 cases), bleeding (25 cases), perianal lump (23 cases), perianal irritation (8 cases), difficulty in defaecation

TABLE I: ANAL SYMPTOMS

Discharge	50 cases
Pain	39 cases
Bleeding	25 cases
Lump at anus	23 cases
Irritation	8 cases
Difficulty in defaecation	3 cases
Diarrhoea	2 cases

(3 cases) and there were 2 cases complaining of diarrhoea. Only 8% of the patients in this series had associated medical diseases (5 hypertension, 3 diabetes).

An examination under caudal anaesthesia was arranged for all patients but in 27 cases, a general anaesthetic became necessary for the reasons shown in Table II. With the sphincters relaxed, it was possible to make a firm diagnosis (Table III) and to proceed with treatment.

All excised tissue (including fistulous tracks) were subjected to histological examination which did not show any serious disease. All the 60 anal fistulae were of the low variety, and none of the rectal polyps were malignant. Surgical management was therefore straightforward in every case.

Only 2 forms of complications were noted, viz: recurrence and secondary haemorrhage. Eight cases of fistula-in-ane and one case of pilonidal sinus recurred. Two cases of fistula-in-ane developed secondary haemorrhage in the post-operative course. These problems were treated in the standard way.

The average stay in hospital of the 100 patients was 5 days but the range was between 3 days to 3 weeks. The period away from work was 5 days to 4 weeks depending on the condition treated with an average of 7 days.

DISCUSSION:

In this study of common perianal conditions other than piles and abscesses, the pattern of these

TABLE II: ANAESTHESIA

Total No. of caudals	73
Total No. of general anaesthetics	27
Reasons for general anaesthetic:	
— patient request (15)	
— lesion too high for caudal (4)	
— caudal not working (3)	
— nervous (3)	
— fractured sacral process (1)	
— patient too young (1)	

TABLE III: DIAGNOSIS

Anal fistula (15 ant., 30 post., 5 lat.)	60
Anal fissure (6 post., 1 ant., 1 combined)	8
Anal papilloma	9
Perianal warts	2
Rectal polyps	3
External skin tags	10
Pilonidal sinus	3
Anal stenosis (post-operative type)	3
Prolapsed rectum	2

TABLE IV: SURGICAL MANAGEMENT

Anal fistula	: Fistulectomy
Anal fissure	: Sphincterotomy +/- excision
Anal papilloma, rectal polyp, warts & external skin tags	: Excision
Pilonidal sinus	: Wide excision +/- closure
Anal stenosis	: Dilatation
Prolapsed rectum	: Thiersh operation

afflictions conform to standard descriptions. However, certain important similarities should be mentioned: e.g. the symptomatology and greater prevalence in males (Sanan, 1968), low incidence of posterior fissures (Hardy, Cuthbertson, 1969) and the rather characteristic distribution of anal fistulae (Hughes, Cuthbertson). That our overall incidence of anal fissure was very low was a surprise since this condition is very common in western countries. The explanation must lie in the daily bowel action in our populace — a practice which is

considered essential to remain healthy in the local Chinese. This practice probably prevents the formation & subsequent passage of hard stools alleged to be the cause of fissure-in-ano. Hawley states that high anorectal fistulae are rare. We do not have any in our series. Our 13.3% (8/60) recurrence rate of fistula is high when compared to other reports (Wang et al, 1980: 4.4%). This admittedly must be due to improper technique. Pilonidal sinus has a tendency to recur when treated by excision and primary closure. This was borne out in one of our cases. Average hospital stay & time off from work is on the whole insignificant, the real morbidity being due to the high recurrence rate in respect of fistulae and pilonidal sinus.

The other conditions mentioned in this paper are very much less common. Besides being easy to diagnose, they are simple to treat so long as basic principles are obeyed. The scope of this discussion does not include situations when malignant change is noted in excised tissue.

SUMMARY & CONCLUSIONS:

1. This is a one and a half year clinical study of 100 cases of common anorectal diseases excepting perianal abscesses & piles.
2. The commonest presenting complaints were discharge, pain, bleeding and a mass at the anus.
3. The incidence of disease is more common in males but fissure-in-ane is not common in our local population.
4. Treatment is straightforward and with good results except in anal fistulae/pilonidal sinus & can be done under regional anaesthesia in the majority of patients.
5. In competent hands, the morbidity should be insignificant after surgery, and the patient should return to work after about 1 week medical leave.

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Spasticity: Medical Management

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INTRODUCTION

Spasticity is defined clinically as an increased resistance to passive stretch with increased muscle tone, increased tendon reflexes often accompanied by weakness of voluntary movement. From the middle of the 19th Century, pioneers in neurology began to realise that spasticity was a very important neurological sign and it was Charcot who made an early distinction between elastic rigidity i.e. spasticity and plastic rigidity i.e. extra-pyramidal rigidity.

The increased muscle tone during passive stretch is often "clasp-knife" in character and patients with severe spasticity often experience **spontaneous clonus** and **painful reflex muscular contractions** i.e. "cramps" in response to trivial stimuli. It is a well known phenomenon that spasticity and paresis usually occur together although this is not always the case. However, spasticity must be differentiated from physical contractures which can superimpose upon conditions and compound the whole problem. If the definition of spasticity as a state of increased stretch reflex is accepted then measurements should be directed towards this reflex.

MEASUREMENT OF SPASTICITY

- 1) CLINICAL METHODS: Clinical examination and recording of
 - a. Resistance to passive stretch: Matthews Scale
 - b. Degree of increased muscle tone: Ashworth Scale — this is most widely used in Drug Trials
 - c. Movement Synergy: Oswestry Scale
 - d. Gait Analysis — in terms of distance and time
 - e. A.D.L. Scores — degree of self-care independence
- 2) LABORATORY METHODS: Electromyographic analysis of motor activity

MEDICAL MANAGEMENT OF SPASTICITY

In the medical management, a number of guidelines should be first considered:

1. It must be emphasized that spinal spasticity poses very different problems from cerebral spasticity. Spasticity may be either flexor or extensor in manifestation but a moderate degree of extensor spasticity ("Requisite Spasticity") may be a useful aid to motor function especially in the lower limb as in the hemiparetic gait. Flexor spasticity is more often troublesome and results in contractures and decubitus ulcers at joint margins.
2. Adductor spasticity at the hips especially if bilateral, poses great problems in perineal toilet, and ambulation is impossible. The significance also extends to the area of sexual intercourse.
3. Bedsores, urinary tract infections and calculi, loaded bladder and bowels etc should be treated before attempting medication for spasticity as this often proves futile due to the severity of reflex spasm involved.
4. The degree of spasticity is often variable, depending on the mental state of that patient, posture, position of the head on the trunk etc.

MEDICATION FOR SPASTICITY

1. Nathan 1959 used intrathecal injections of phenol in glycerin and had dramatic results but this was limited by the adverse effects on the bladder.
2. Local injections of alcohol/phenol provide only temporary relief and are often used prior to surgery to determine whether neurectomy will be beneficial e.g. obturator neurectomy.

[This lecture was delivered at a forum on "Management of Spasticity" organised by the Singapore Physiotherapy Association at Mount Alvernia Hospital 1980]

3. Local cooling: although experimental cooling to -12°C (Koutson 1973) showed marked reduction in spasticity, clinical methods are often limited to ice-packs to relieve painful muscle spasms prior to physical therapy. However local cooling is often a good indicator of whether the muscles are:

- a) Cryopositive i.e. due to gamma-fibre spasticity
- b) Cryonegative i.e. due to alpha-fibre spasticity

The importance of this lies in the fact that gamma-spasticity is almost invariably relieved by Baclofen (Lioresal) whereas beneficial effects of this drug on alpha-spasticity are rare. Some workers claim that the latter group responds more to diazepam (Valium).

4. Drugs Used: 1) Valium (Diazepam)
2) Lioresal (Baclofen)
3) Dantrium (Sodium Dantrolene)
4) Soma Co. (Carisoprodol)

(i) VALIUM (DIAZEPAM)

Diazepam is a compound acting chiefly on the CNS. The limbic system is influenced by the lowest level of dosage whereas the cortical centres respond only to relatively high doses. The selective inhibition of the limbic system by diazepam is important in the treatment of emotional reactions. The muscle-relaxant effect is very pronounced and is produced on one hand by the inhibition of spinal reflexes and on the other hand by influencing central substrates related to the limbic, thalamic and hypothalamic systems. Diazepam is therefore indicated in peripheral and central muscle spasticity and contraindicated in myasthenia gravis.

However, a Toronto study in 1977 on patients with multiple sclerosis showed that Valium seems to have no action at spinal level per se. It produced no significant alteration in the spasticity of **complete spinal lesions**. In contrast, the **incomplete spinal lesions** with M.S. showed marked improvement after Valium. As mentioned above, in other studies, Valium had good results where Lioresal failed to act. However the problem of tolerance arises often with Valium although it is our interesting observation that patients with marked spastic paralysis can tolerate high initial doses of Valium without sedative side effects.

(ii) LIORESAL (BACLOFEN)

Baclofen is a derivative of gamma-amino butyric acid (GABA). Ever since the study by Birkmayer in 1967, attention has been focussed on GABA which depresses all types of spinal neurons and

inhibits, mono-synaptic and multi-synaptic reflex activity. As mentioned above, in the numerous studies on spinal and cerebral spasticity, it has been found that spinal spasticity responds better to Baclofen than cerebral spasticity. The difference in therapeutic response may be due to the fact that gamma-spasticity is common in spinal lesions, whereas alpha-spasticity is more common in cerebral lesions (independent of fusimotor spasticity). To simplify the prescription, the following is an easy rule:

- a. Cryopositive group — gamma spasticity (spinal spasticity — responds better to Baclofen)
- b. Cryonegative group — alpha spasticity (cerebral spasticity) — responds better to Valium.

Lioresal is well tolerated in general except for nausea and gastrointestinal upsets occasionally with vomiting or diarrhoea, giddiness, hypotension, vertigo, mental confusion, euphoria or depression. It is contraindicated in epilepsy or convulsion disorders as it can precipitate convulsions. The most important side-effect is muscle weakness and overdose can cause hypotonia of the respiratory muscles, the flaccidity of which may persist for up to 3 days after withdrawal of the drug. However most of the side effects are dose-related and can be minimised by reducing the dose of Lioresal. The optimum dose is 40 — 60 mgm per day (divided doses). **The problem of "apparent" muscle weakness in the lower limbs is due to loss of functionally useful spasticity.** This can be a paradoxical effect when the main rehabilitative objective is directed toward functional, independent ambulation. Numerous studies have been done on Lioresal but I would like to quote a French study by SACHAIS et al, 1977 which found in a double blind, multicentre trial of **106** patients with multiple sclerosis — a beneficial effect of more than 65% on such patients (as against placebo) with a maximum dose range of 70 — 80 mgm/day. Clinical improvement was in the reduction of spasticity, painful flexor spasms, clonus, tendon reflexes and resistance to passive stretch.

Our personal experience have been similar especially with **incomplete spinal spastic paralysis** from spinal cord injuries, transverse myelitis and Caisson's disease. We observed reduction in spasticity and an improvement in ambulation although hyperreflexia remained the same. At this point I would also like to mention that Lioresal has a beneficial effect on the neurogenic (upper motor neuron bladder) as quoted in a study by ROUSSEAU in New York who found that Lioresal reduces sphincteric resistance, increases bladder capacity and reduces the residual urine and results

in a better urine stream at micturition. These are also our observations in the neurogenic bladder with marked outlet obstruction due to external sphincter spasm. Indirectly, therefore relief of bladder retention of urine decreases reflex spasticity of the limbs.

(iii) DANTRIUM (SODIUM DANTROLENE)

Dantrium acts directly on skeletal muscle fibres i.e. at the neuromuscular junction. It is therefore practically devoid of central sedative effects except after prolonged administration. Dantrium acts equally on direct and reflex responses. Adverse reactions include fatigue, skin eruptions, drowsiness, drooling and tingling of fingers in addition to raised SGOT. A Michigan study on 77 patients over 2 years showed good results in the reduction of muscle spasms, clonus and muscle tone but a high incidence of side effects. Dantrium is recommended therefore for short term use and is particularly of value in chair and bedridden patients with painful muscle spasms and muscle cramps. A French study of 50 patients with multiple sclerosis treated with Dantrium showed 65% reduction in spasticity. An interesting study by Weiser (UK) demonstrated that patients with chronic spinal cord disease with good residual motor function in the lower limbs derive most benefit with **low doses** of Dantrium (100 – 200 mgm/day).

COMBINATION OF DANTRIUM, LIORESAL & VALIUM

As recommended by Zach of Paraplegiczentrum Basel, Switzerland, these 3 drugs may be used in lower dose combination either all together or any 2 drugs at one time. We have only used the triple combination on 1 patient with severe hip /flexor spasticity.

(iv) SOMA CO (CARISOPRODOL)

This drug is used more often in painful muscle spasms associated with low backache but nevertheless a study by ASHWORTH in 1964 on 24 patients with severe spasticity from multiple sclerosis quoted 65% success in the reduction of flexor spasms but the beneficial effects were hindered by the major side effects of drowsiness.

5. BIOFEEDBACK

In order to promote sensory motor learning, BRUDNY et al of New York, 1971, used EMG Biofeedback to produce visual and auditory signals to direct therapy towards establishing voluntary control of paretic muscles and reduction of spasticity. In this study of 37 vascular hemiplegics, 60% showed significant reduction in spasticity with functional improvement. The study was also extended to include spasmodic torticollis and spinal paralysis. This has opened a new development in the physical treatment of spastic paretic limbs and extensive studies are at present being conducted in rehabilitation clinics the USA and Europe.

Management of the Clinically Benign Solitary Breast Lump

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INTRODUCTION:

The discovery of lumps in the breast during the active reproductive years of women is very common. It is generally recognised that the majority occur during the period 25 to 35 years & that the majority are benign. However the low incidence of carcinoma during this age period and the finding that the lump is single and mobile should not blind the physician to the equal reality that cancer occurs with increasing frequency when age advances and that it may be present in the 'clinically benign' lump in the breast. This paper is a study of 110 cases of clinically benign single lumps in the breast referred for treatment at the Dept of Surgery, Changi Hospital from 1979 through 1981.

MATERIAL:

There were 110 consecutive cases of solitary & freely mobile breast lumps. All cases of clinically obvious cancer, multiple lumps, and those clinically diagnosed as mammary dysplasia were excluded from this study. All cases were subjected to thorough physical examination and excisional biopsy of the lump.

RESULTS:

The ages of the patients ranged between 29 and 80 years with a mean of 29 years. The predominant presenting symptom was pain (59.37%) which was increased during menstruation in 15.62% of the cases. A breast lump was discovered after a physician's help was sought for the pain. Lump, as a presenting symptom ab initio was present in 43.75% of cases. The duration of the complaint varied from 2 days to 20 years.

Clinical examination (TABLE I) showed that the commonest site of the lump was the upper outer quadrant(46.5%) followed by upper inner quadrant(24.5%), lower inner quadrant(13.6%), lower outer quadrant(9.1%), the subareolar region (5.4%) and involving nearly the whole breast(0.9%). The average size of the freely mobile lump was 2.1 cm while the range was between 0.5 to 6 cm in diameter.

TABLE I: ANATOMICAL DISTRIBUTION

SITE	NUMBER	PERCENT
Subareolar region	6	5.4
Upper outer quadrant	51	46.5
Upper inner quadrant	27	24.5
Lower inner quadrant	15	13.6
Lower outer quadrant	10	9.1
Whole breast	1	0.91

**TABLE II:
CLINICAL VS. HISTOLOGICAL DIAGNOSIS**

LESION	CLINICAL DIAGNOSIS	HISTOLOGICAL- PROVED
Fibroadenoma	98	65#
Infection/abscess	5	5
Breast Cyst	4	4
Fat necrosis	3	3

the rest being mammary dysplasia on histology

Two of the patients clinically diagnosed as having benign breast lesion turned out to have cancer. They subsequently underwent simple mastectomy and postoperative radiotherapy. One patient was aged 18 while the other was 38 years old. Both were initially diagnosed as having fibroadenoma of the breast. One third of the clinically diagnosed fibroadenomata, turned out to be mammary dysplasia on histology. The less common lesions were: 5 chronic abscesses, 4 breast cysts, 3 areas of fat necrosis.

Of the 110 operations, there were only 3 cases with postoperative complication, viz: skin breakdown(1), hematoma collection(1) and infection(1).

DISCUSSION:

Detection of breast cancer in its earliest form has been stressed by the Singapore Cancer Society.

Public attention has been repeatedly directed to the need for self-examination and reporting of any symptoms relating to the breast. The whole exercise is to detect any breast lump early and to distinguish the malignant from the benign variety. Although several new methods (e.g. thermography, mammography and xeroradiography) have been shown to be able to do this in a significant proportion of cases, it must always be emphasised that accuracy is never 100% and that no modern-day machine can be used to mitigate clinical indications for breast biopsy. Also, under no circumstances can the patient be assured that the lump is definitely benign on a clinical diagnosis only, even if the patient is the typical 'fibroadenoma' age group (Hobsley, 1979). Final diagnosis is only made when the lump is excised and submitted to histological examination (Hadfield 1976). And finally, carcinomatous change can occur in a fibroadenoma (Unni, 1966).

The incidence has been variously reported as between 1.2 to 15%. Excision will therefore remove all pathological tissue capable of any such change.

Hence we confirm the age-old surgical addage, that a lump in the breast is a cancer, until proved otherwise. This has been clearly demonstrated in this study where a 1.8% risk of overlooking a true carcinoma from a benign lesion is real and there-

fore justifies histological confirmation irrespective of the age of the patient.

CONCLUSION:

1. Clinical differentiation of a benign lump from a malignant breast cancer is difficult.
2. Routine excisional biopsy is recommended for all breast lumps, irrespective of their clinical characteristics or the age of the patient.
3. The procedure of breast biopsy is attended with very low morbidity (3/110).
4. The added psychological advantage of allaying all fears of cancer in those shown to be histologically benign cannot be overemphasized.
5. Excisional biopsy therefore continues to be the correct management decision in the practice of surgery for breast lesions, as it provides not only the diagnosis but is the treatment by itself.

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News from the Council

M.C.G.P.S. EXAMINATIONS

The Tenth College Examination for Diplomate Membership will be held in October 1982. In order to be admitted to the examination, a candidate must:

- (a) be a registered medical practitioner or have an acceptable qualification;
- (b) have held a registrable qualification for not less than five years;
- (c) have been engaged in general practice for not less than three years,
- (d) be an Associate or Ordinary Member of the College of General Practitioners Singapore for not less than two years.

Members wishing to take the examination should start the preparation now. Further details will be announced soon.

COURSE IN CONTINUING MEDICAL EDUCATION ON OBSTETRICS & GYNAECOLOGY

A Course in Continuing Medical Education on Obstetrics & Gynaecology has been organised by the Continuing Education Unit of the College. The programme is as follows:

- (i) **Theory Sessions** on Friday Evenings from 9.00p.m. to 10.30 p.m. at Academy Lecture Theatre:

DATE	TOPIC	LECTURER
5.2.82	Human Sexuality	Prof S S Ratnam
12.2.82	Antenatal Care	Assoc. Prof T G McCarthy
19.2.82	Hypertensive Disease in Pregnancy	Assoc. Prof Charles Ng Sen Ark
*26.2.82	Modern Management of Labour and the Puerperium	Assoc. Prof R L Tambyraja
5.3.82	Subfertility	Assoc. Prof Charles Ng Sen Ark/ Assoc. Prof M Tsa Kok
12.3.82	Menstrual Disorders	Assoc. Prof Mark Cheng
* 19.3.82	Female Genital Malignancies	Dr Lawrence Chan Kok Chin Consultant Obstetrician & Gynaecologist
26.3.82	Abnormal Vaginal Discharge/Pruritis Vulva	Dr Cheng Wei Chen Consultant Obstetrician & Gynaecologist
2.4.82	Stress Incontinence in the Female	Dr Khew Khoon Shin Consultant Obstetrician & Gynaecologist
9.4.82	NO SESSION – HOLIDAY (GOOD FRIDAY)	
16.4.82	Office Gynaecology for Family Physicians/ General Practitioners	Prof S S Ratnam

*** THESE TWO LECTURES WILL BE HELD AT THE PATHOLOGY LECTURE THEATRE SINGAPORE GENERAL HOSPITAL**

(ii) **Practical Sessions** on Sunday Afternoons from 2.00 p.m. to 4.30 p.m. at Kandang Kerbau Hospital Lecture Hall:

1 **SUNDAY, 21 FEBRUARY 1982**

Ultrasound examination in Obstetrics & Gynaecology.
Academic Staff conducting: Dr M Rauff and Dr Y C Wong.

2. **SUNDAY, 7 MARCH 1982**

Obstetric History:

- a) Briefing on Obstetric history taking (30 mins): Assoc Prof Charles Ng
- b) History taking in small groups of five (30 mins)
- c) Presentation of history followed by discussion (45 mins)

Demonstrators:	Assoc Prof Mark Cheng	Assoc Prof M Tsakok
	Assoc Prof Charles Ng	Dr M Rauff
	Assoc Prof R L TambyRaja	Dr W Wun.

3. **SUNDAY, 14 MARCH 1982**

Obstetric Examination:

- a) Briefing on Obstetric examination by Assoc Prof R L TambyRaja
- b) History taking and Obstetric examination in small groups of 5 (45 mins)
- c) Presentation of history and Obstetric examination with demonstrators (45 mins)

Demonstrators:	Assoc Prof Charles Ng	Assoc Prof T McCarthy
	Assoc Prof R L TambyRaja	Dr M Rauff
	Assoc Prof M Tsakok	Dr R N V Prasad.

4. **SUNDAY, 21 MARCH 1982**

Mass in Lower Abdomen:

- a) Talk on differential diagnosis (30 mins) by Assoc Prof Mark Cheng
- b) Demonstration of examination of abdomen to 2 groups — Assoc Prof M Cheng Dr A Ilancheran

5. **SUNDAY, 28 MARCH 1982**

Video tape session on:

- a) Gynaecological Examination
- b) Some office gynaecological procedures

Academic Staff conducting: Assoc Prof T McCarthy.

MEDICAL NEWS

'Pregnancy wastage' is high in India

By Dr Prem

BOMBAY — A high perinatal mortality leading to 77 deaths per 1,000 births, together with a high infant mortality, is responsible for a "sizeable pregnancy wastage" in India.

These are the findings of a recent national survey, reportedly the first of its kind, which was sponsored by the Federation of Obstetrics and Gynaecology Societies of India.

At the root of the problem are ignorance and acute lack of facilities for antenatal care in many parts of India. Approximately 70 per cent of women who loose their babies never visit a doctor during pregnancy, partly through lack of awareness but also because of the absence of, or failure to utilise, existing facilities. Further, the quality of care and management at several antenatal clinics in the country is "miserably unsatisfactory."

Approximately two-thirds of the perinatal mortality are attributable to prematurity and intrauterine growth retardation. This is frequently associated with absence of or inadequate antenatal care and with antepartum haemorrhage.

Another major factor, in about 17 per cent of cases, is late hospitalization. This may be through placency or through failure of the midwife or doctor to recognize and refer complications and, in rural areas, the lack of maternity hospitals.

Even when in hospital, women in the labour ward may fail to receive adequate treatment. Deaths in this category are, in many instances, avoidable as they fall within the control of the hospital administration.

The survey concludes that with all the emphasis on birth and population control, those babies which are born should be given all the health care needed for their full development and sustained growth."

Spare the dancing foot

LAS VEGAS — Cortisone injections or surgery

is seldom needed for foot injuries in dancers and can shorten a career, the American Orthopaedic Foot Society was told by Dr G. James Sammarco, associate clinical professor of orthopaedic surgery at the University of Cincinnati.

Surgery tends to stiffen the foot and cause loss of motion in the toes, while steroid injections can cause abscesses. In a study of professional ballet dancers, he found that these treatments were rarely appropriate for such common conditions as a collapsed big toe, abscess secondary to callous formation and metatarsal stress fracture.

Dancers should seldom cease dancing during treatment, Dr Sammarco said, although long recovery periods are common.

SELF POISONING IN SINGAPORE — MAIN CAUSATIVE FACTORS

SYNOPSIS

Self-poisoning is the main form of attempted suicide in Singapore. A psychiatric investigation was carried out in 100 consecutive referrals of self-poisoning cases. There were 30 males to 70 females. The modal age group was 20-29 years, which accounted for 43 percent. The main causative factors were interpersonal problems (58%), mainly resulting from quarrels with spouse, partner of family members, followed by illness (13%), schizophrenia (7%), insomnia (7%), work problems (7%) and financial problems (6%).

SEROIMMUNITY OF NATIONAL SERVICE-MEN IN SINGAPORE TO POLIOMYELITIS

SYNOPSIS

A national immunisation programme to control poliomyelitis in Singapore was introduced in 1962. Its implementation has given rise to a birth cohort

of persons born in 1955-1958 who missed the programme and could constitute a group susceptible to poliomyelitis.

A study of the seroimmunity of 127 men in this cohort was carried out. National servicemen in the Singapore Armed Forces were chosen as subjects. It was found that 35.4% of them showed susceptibility to poliomyelitis infection.

It was pointed out that the relatively high concentration of this age cohort in an army environment would increase the rise of disease transmission and that these susceptibles be immunised against poliomyelitis as a precautionary measure.

Pain is Pain: Hypochondriacs Really Are Sick

"Physicians should realize that hypochondriacs really are sick, says a Los Angeles psychiatrist who suggests encouraging these patients to try to master one symptom at a time.

'Pain is no less painful if its cause is imaginary,' says Warren R. Procci, MD, assistant professor of psychiatry and behavioral science, University of Southern California (USC). 'In fact,' he says, 'hypochondriasis can be more agonizing than diseases with physical causes' because it is dis-

ruptive and seemingly hopeless.

The cause of hypochondriasis is not known, Procci admits. 'All we know is that it can strike anyone ... although it does seem to get more prevalent as people get older and more conscious of their bodily functions. Moreover, the condition is beyond the patient's conscious control, unlike the manipulative behavior we call "malingering".'

Procci, who also is director, psychiatric consultation service, Los Angeles County-USC Medical Center, notes that hypochondriacs are at risk 'of talking themselves into unnecessary surgery, of becoming addicted to massive quantities of drugs, of submitting to risky techniques of quackery, and of succumbing to suicidal depression.' Furthermore, because they have 'cried wolf so often, they are in jeopardy of being ignored when they really need medical attention.'

Tackling one symptom at a time is no panacea, Procci says, but until a more effective answer is discovered, this approach can be linked with 'simple human understanding' and suggestions of activities that may divert the patient's attention from some symptoms."

COME SHARE OUR WORLD

Tenth Wonca World Conference on Family Medicine.

May 20th - 24th 1983
Singapore



The College of General Practitioners Singapore will host the Tenth WONCA World Conference on Family Medicine. The Organising Committee takes great pleasure in inviting all Family Physicians/General Practitioners to this excellent opportunity to meet your colleagues from other parts of the world and to exchange and discuss views and ideas on Family Practice.

An extensive varied programme has been planned. The Scientific Programme will include plenary sessions and workshops on

- * the clinical aspects of
- * research in
- * education for, and
- * future health care in

Family Practice, besides free-paper sessions on different subjects.

Besides the Opening Reception and Closing Banquet for all registrants, all accompanying physicians' spouses and children will be treated to a separate comprehensive, social programme to give them an insight into our rich multi-cultural heritage and an opportunity to pick up bargains in the shopper's paradise that is Singapore.

In conjunction with the Conference, we will also hold a Medical Trade Exhibition where you will be able to see the latest in pharmaceuticals, clinical and laboratory equipment, and related items.

Come share our world

Official Conference Carrier:



Official Tour Operator:



For more information contact:

The Organising Secretary
Tenth WONCA World Conference College of General Practitioners Singapore 4-A College Road
Singapore - 0316. Telephone: 2207730 Telex: RS 25086.



Asian Conference on Occupational Health

September 5–10, 1982

Organized by

Society of Occupational Medicine, Singapore

and

National Safety Council of Singapore

TENTATIVE PROGRAMME

VENUE: MANDARIN HOTEL, Orchard Road, Singapore
THEEME: HEALTHY WORKERS – KEY TO PROGRESS

Date	Time	Programme
Sun	0900 – 1700	Registration
5 Sep '82	1700 – 1800	Welcome Reception
Mon	0900 – 1000	Registration
6 Sep '82	1000 – 1100	Opening Ceremony
	1100 – 1130	Reception
	1130 – 1400	Scientific Exhibition
	1400 – 1700	Scientific Sessions
Tues	0900 – 1230	Scientific Sessions
7 Sep '82	1400 – 1700	Scientific Sessions
Wed	0900 – 1230	Scientific Session
8 Sep '82	1400 – 1700	Industrial Visit
Thur	0900 – 1230	Scientific Sessions
9 Sep '82	1400 – 1700	Scientific Sessions
	1930 –	Banquet
Fri	0900 – 1230	Scientific Sessions
10 Sep '82	1400 – 1700	Scientific Sessions

TRADE EXHIBITION

The Conference will have a concurrent exhibition. Further information for exhibitors can be obtained from the Secretariat of the Conference.

SOCIAL PROGRAMME

An interesting social programme which includes a welcome tea, official reception, banquet, industrial visits and tours will be arranged.

SCIENTIFIC TOPICS FOR PROGRAMME

- * Health Hazards and Control of Physical Agents
 - Noise & Vibration
 - Other Physical Agents (ionising radiation, compressed air, laser, non-ionising radiation, etc.)
- * Symposium on Occupational Health Services
- * Occupational Diseases of lead and other metals and their control.
- * Symposium on Occupational Health Education
- * The Skin and the Work Environment
- * Carcinogens in the Work Environment
- * Symposium on Agriculture and Plantation Health
- * Accidents at Work
- * Occupational Lung Diseases
- * Occupational Health and Safety of Women at Work
- * Free Communications

OFFICIAL LANGUAGE

The language of the Conference will be English.

APPLICATION & INFORMATION

The Secretariat,
10th Asian Conference on Occupational Health,
Kreta Ayer P.O. Box 241,
Singapore 9108

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Protein needs increase in relation to a baby's age and weight.

So too do his needs for energy. His diet must thus become "calorie-dense" so that in satisfying his hunger his nutritional needs are satisfied too. If the milk supply becomes limited, then it is essential that the remaining milk supply compensate in protein, the protein that may be lacking in the traditional pap.

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"From the age when mixed feeding is established, there is little or no advantage in continuing for long to give cow's milk which has been meticulously modified in composition to resemble breast milk, and there could be an advantage in using milk which is relatively unsophisticated and which is a fairly rich source of nutrients".

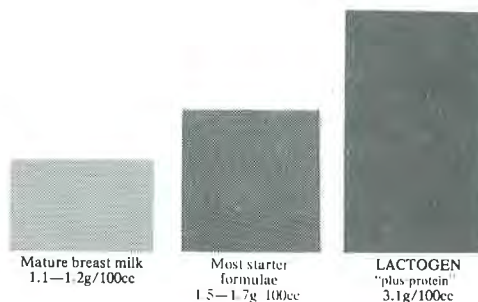
"Present day practice in infant feeding"
Dept. of Health and Social Security, U. K. 1974

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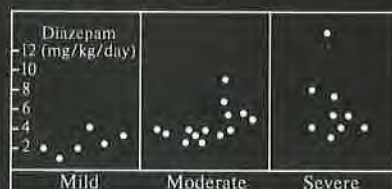
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MUSCLE SPASM
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 THE PROBLEM:
HOW TO OBTAIN
MUSCLE RELAXATION?
«VALIUM»
ROCHE
 OR
CURARIZATION
 ?

Femi-Pearse¹ treated 42 patients, 17 of whom received «Valium» Roche alone, while 25 were also given a barbiturate. Their age distribution was as follows:

Age in years	0-1	1-10	11-20	21-30	31-40	>41
Number of patients	2	6	17	10	4	3

Optimum dosage of «Valium» Roche in relation to the severity of tetanus (as characterized by Jenkins and Luhn⁴) in 30 patients:



Mean	2.4 mg/	4.3 mg/	9.3 mg/
dosages:	kg/day	kg/day	kg/day

Optimum dosage of «Valium» Roche in 30 patients.

Duration of treatment (in association with the usual therapeutic measures and patient care): two to six weeks. Although spasm was not controlled in 3 cases, Femi-Pearse¹ stated with regard to the muscle-relaxant effect of «Valium» Roche in tetanus:

‘The drug is recommended as a useful addition to the small range of muscle-relaxants available for the care of tetanus. It is free from respiratory and circulatory depression and from toxic damage to the bone-marrow, liver and kidneys.’

The same author and his co-workers have since reported on further experience with «Valium» Roche in tetanus^{2,3,5}.

References

1. Femi-Pearse, D.: Experience with Diazepam in Tetanus. *Brit. med. J.* 1966/2, 862-865.
2. Femi-Pearse, D., Afonja, A. O., Elegbeleye, O. O., Odusote, K. A.: Value of Determination of Oxygen Consumption in Tetanus. *Brit. med. J.* 1976/1, 74-75.
3. Femi-Pearse, D., Sodipo, J. O.: Management of Tetanus. *West Afr. med. J.* 16, 155-161 (1967).
4. Jenkins, M. T., Luhn, N. R.: *Anesthesiology* 23, 690 (1962).
5. Odusote, K., Apantaku, J. B., Femi-Pearse, D.: Myoclonic Status in Severe Tetanus Patients on Diazepam. *East Afr. med. J.* 52, 571-572 (1975).

«Valium» Roche is a Trade Mark



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