

Ward II from 1946 to 1953 and was chairman of its Public Health Committee from 1947 to 1953, when her husband was transferred to Salisbury.

In 1953 the Minister for Health asked Dr. Robertson, as chairman of the Standing Committee of Public Health for the F.W.I.S.R., to form a national association to combat tuberculosis in Southern Rhodesia, where local groups had already been formed in Bulawayo and Salisbury. Through the efforts of this committee a Salisbury branch was formed, and later this became incorporated in R.A.P.T. Dr. Robertson was the first chairman of R.A.P.T. (Salisbury) and represented R.A.P.T. at the Commonwealth Tuberculosis Conference in London in 1955.

During the days of planning for a university in Rhodesia, Dr. Robertson served on the inaugural board until a permanent board was established in 1955.

She first arrived in Southern Rhodesia in 1934 and was engaged in general practice in Plumtree, Sinoia and Bulawayo.

DR. A. J. P. COETZEE, M.B.E., M.R.C.S.,
L.R.C.P., D.T.M. & H.

Dr. Coetzee, who was awarded the M.B.E., is known throughout Rhodesia, and especially on the Copperbelt, as an efficient hygiene specialist and has rendered outstanding services in this field. Through his methods, dysentery and other diseases transmitted by flies and mosquitoes have been eliminated from the mining camps which fell under his aegis.

Dr. Coetzee has been a leading figure in the medical profession on the Copperbelt for over 20 years. During nearly all of this time he has been Chief Medical Officer at Nkana Mine and has built up a large and efficient medical organisation there.

He has been president of the British Medical Association for several years and has done a great deal to further its aims.

Of recent years he has taken a leading part in the development of treatment for chronic alcoholics.

Dr. Coetzee has been one of those instrumental in launching the Nkana/Kitwe Polo Club, of which he has been one of the leading players. He has also done much to foster his old sport, rugby football.

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The Opening of the St. Joseph Hospital, Nguludi, Nyasaland

St. Joseph Hospital, which lies thirteen miles from Limbe in wooded and hilly country, was opened on 28th January by the Director of Medical Services, Dr. Sheffield.

In his welcoming speech Monseigneur Johannes B. Theunissen, the Lord Bishop of Blantyre Vicariate, explained that the main building had been used for 20 years as a teachers' training school, but had now been largely rebuilt and converted into a hospital. The Ministry of Health had paid 50 per cent. of the building and equipment costs and generous gifts had been received from medical societies in Holland. Messrs. Phillips had donated the X-ray equipment. His staff of fathers, brothers and sisters had all worked extremely hard supervising the building.

The Director of Medical Services, Dr. Sheffield, in his speech praised the missionaries, saying what a fine hard-working body of men and women they were and how much the country and its inhabitants owed to them. This mission hospital was a typical example of their work.

Those present at the opening included Mr. Spencer Wilkinson, the Chief Justice, and Mrs. Spencer Wilkinson; Mr. Rangely, the Provincial Commissioner; Captain and Mrs. Florence, the Mayor and Mayoress of Blantyre; and Mrs. Southworth, the wife of the Puisne Judge. Dr. Dimond, the doctor on the staff of the hospital, Dr. P. Wingate, the Provincial Medical Officer, and Dr. Goodall represented the medical profession.

The hospital caters for Africans and Asians and has approximately 50 beds for medical, surgical and maternity cases. About 70 out-patients attend daily. On the staff is a radiographer and pharmacist and eight European sisters. The wards are extremely clean and free from flies. After a tour round the buildings the guests were entertained to tea.

JOHN GOODALL.

The Farm Clinic at Zunedza, near Inyazura, S. Rhodesia

Members of the medical profession will be greatly interested in the farm clinic which Mr. Evan Campbell started just over four years ago. It has proved a great success, largely due to the efficiency of its trained African orderly, who is also a microscopist.

Mr. Campbell's labour force numbers approximately 130 to 150 and is treated free of charge. Other Africans may come to the clinic for treatment and are charged 4d. a visit towards the cost of medicines and dressings. This does not really cover the expenses, but Mr. Campbell believes that they should contribute something towards their treatment.

All bilharzia and V.D. cases are treated free, as the drugs for those patients are provided free by the Government. The average monthly visits of outpatients is 500. Inpatients, including maternity cases, number 15 to 30 each month. They are charged 2s. a day, and this fee includes all food, medicine and attention. Again the cost is not covered. Maternity cases pay 15s.

The clinic building includes:—

- 1 Medical orderly's room.
- 1 Male ward (4 beds).
- 1 Female ward (4 beds).
- 1 Maternity ward (1 bed).
- 1 Kitchen with an electric stove.
- 1 Nurses' room.
- 2 Showers.
- 2 W.C.s (one for each sex).
- A verandah.
- The orderly's house.

The clinic has operated very successfully for most illnesses, and any case that cannot be dealt with there is sent to the Rusape hospital. It has been of great benefit, not only to Mr. Campbell's own staff, but to that of his neighbours and also to Africans living in the Makoni reserve. What he loses in cash is amply repaid by having his own labour force continually under observation, so that if anything goes wrong it can be rectified immediately. He also arranges for series of hygiene lectures for the women in the compound, but judging by the state of their homes, he feels the women do not pay much attention to the advice given by these lectures.

Salisbury Clinical Club

THE NEONATE IN DISTRESS

On 31st October, 1957, Dr. E. Sanders addressed the Clinical Club on "The Neonate in Distress," confining himself almost entirely to hyaline membrane disease of the lung in the newborn—a disease which he admitted might not even exist.

The presence of an asphyxial membrane in the alveoli and alveolar ducts of the lung has been known for a long time. Some have attributed it to heart failure and others to aspiration of amniotic sac contents by the foetus in utero.

A third view considered the membrane was a degenerative process due to injury of the respiratory membrane of the foetus by an agent.

It was known that if a baby breathed for a minimum of an hour this membrane was not found. By staining the membrane one was struck with the hyaline tissue, the eosinophilic stain and the amniotic squamous cells which might be present. Some workers argued that this membrane arose from the lung itself, but others regarded it merely as an artefact.

Dr. Sanders discussed each theory in turn, first dealing with aspiration of amniotic material. In the presence of anoxia, especially in a difficult labour, inspiratory movements of the foetus occurred, followed by aspiration of the material into the lungs. Few alveolar squamous cells were found, because at the end of pregnancy fewer of these cells were present. The condition was more often seen in premature infants because they were less able to dispose of the amniotic fluid than older babies. These membranes thus blocked the passages and caused death.

The second theory maintained that the membrane was due to disease of the lungs, which was especially liable to occur with high oxygen tension in premature babies. The premature baby was more disposed to this because it possessed more maternal hormones such as oestrogens.

The third theory, advanced by Lendrum, was that the formation of the membrane resulted from a sudden increase in the load in the left ventricle with congestion of the lungs. As the infant lung absorbed water very quickly, the protein left behind formed the membrane lining the alveolar spaces.

Recently the condition has been divided into two types. The first was the aspiration syndrome of postmatures. If a full-term foetus was subjected to a difficult labour, it was liable to aspirate amniotic contents and meconium, which was passed as the result of the stress. Histological examination of lungs removed at autopsy showed the presence of amniotic cells. During life, however, it was believed that the condition might be recognised on X-ray by the coarse, irregular streaks of increased density spreading from the hilar regions to the periphery by small areas of segmental collapse. The second type, known as hyaline membrane disease, occurred only in premature infants, and on X-ray there was a diffuse, fine miliary stippling throughout the lung fields.