Postgraduate Medical Centre at Windsor

On Friday, 24 September, a new postgraduate medical centre was opened at the King Edward VII Hospital at Windsor. The idea for this originated after the Oxford Conference of 1961, when Windsor was selected by the Postgraduate Medical Federation and the North-west Metropolitan Regional Hospital Board as one of the sites for the development of a regional postgraduate centre. Unfortunately there were difficulties about finance. At the time it was not possible to obtain money either from the Health Service or from the University Grants Committee; nor could assistance be obtained from King Edward's Hospital Fund, since Windsor was outside the metropolitan area.

Nevertheless, the local postgraduate committee believed that a suitably equipped building was essential if the postgraduate activities of the district were to be successfully co-ordinated. The minimum requirements appeared to be: (1) a lecture theatre to seat at least 100; (2) a library so constructed that it could be used as an extension of the lecture theatre; (3) a small seminar

room which would also serve as a club-room; (4) office accommodation, a small kitchen, and toilet facilities.

It was estimated that the building would cost £10,000 (assuming no cost for the land) and that an extra £5,000 would be required to equip it. A sum of £1,500 was estimated for running expenses, including the cost of a secretary. A number of local industrialists agreed to become sponsors of the project and a local appeal raised further funds by private subscription. The Windsor Group Hospital Management Committee and the North-west Metropolitan Regional Hospital Board were also able to make contributions when financial regulations were relaxed in 1964.

A pleasant and functional building has been erected within the estimated cost. All the minimum requirements have been fulfilled and the spacious library is divided from the lecture-room by soundproof folding doors, which when opened can increase the capacity of the lecture-room to about 200 (see Fig.). A room has also been provided where smaller meetings can be held. This room has been

provided with a bar and will also act as a club-room.

Opening Ceremony

At the opening ceremony the history of the centre was described by Dr. JOHN LISTER, the clinical tutor, following introductory remarks by Mr. JOHN W. JAMIESON, chairman of the trustees and group managing director of Aspro-Nicholas Ltd. Field-Marshal EARL ALEXANDER OF TUNIS gave a short address before opening the centre, and this was followed by an address by LORD BRAIN on postgraduate medical education. Lord Brain gave a succinct description of the progress of medical education during the past generation. He said that the undergraduate period was now regarded more as an essential foundation on which further training should be based after qualification. This training was as essential for the general practitioner as for the specialist. He described the medical educator as a man aiming at a moving target, who needed to be constantly guessing what the shape of medicine would be in future times. It was now recognized that postgraduate education should ideally be continuous throughout the active life of a doctor. The distinction between teaching and non-teaching hospitals was rapidly breaking down. Centres such as this, which were the products of dynamic change, were the best possible augury for the future.

As Dr. Lister emphasized earlier in his speech, the opening of the centre is only the completion of the first phase of the project and its future success will depend on the use to which it is put. Plans have been made for future academic activities and it is hoped that the centre will become a meeting-place for social and academic functions for the general practitioners, consultants, and the local authority medical officers of the area, as well as providing facilities for the junior hospital medical staff. The long-term aim is to integrate the medical services in the district and at the same time raise the general standard of medical practice.

MEDICAL HISTORY

A Case of Sir Victor Horsley's

A Brief Extract from the History of Neurosurgery

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The technique of effective and practicable neurosurgery was evolved in the last quarter of the nineteenth century, and foremost among the pioneers in this field were Sir Rickman Godlee and Sir Victor Horsley.

In November 1884 Sir Rickman Godlee carried out the first successful extirpation of a cerebral neoplasm on a patient of

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Hughes Bennett. Two earlier operations upon cerebral neoplasms had been performed successfully, but these had been carried out on external evidence, whereas Sir Rickman Godlee's operation was carried out on purely neurological evidence. The patient died four weeks later from complications which still occur despite modern advances in post-operative care. The death of this patient raised a storm of moral protest from those who were against experiments on human beings. However, a debate attended by Hughlings Jackson, Sir David

Ferrier, and Sir Victor Horsley, among others, conceded nothing but praise for the operation.

Sir Victor Horsley was born in 1857 and was educated at Cranbrook School and at University College Hospital. He passed his M.B., B.S. London in 1881, and in 1885 he was appointed to the staff of University College Hospital. Wilfred Trotter said of him that "here was one of the greatest operators of his generation." It has also been said that he was extremely rapid in exposing the spinal cord at laminectomy; indeed, the first successful removal of an intradural spinal tumour was enacted by him in June 1887. Of this Osler wrote: "It was perhaps the most brilliant operation in the whole history of surgery." In March 1916 Sir Victor volunteered to work in Mesopotamia, where he operated in the most appalling conditions. He fell ill on 15 July 1916 with a high fever, and died the following day.

In view of the close association between the surgeons at University College Hospital and the history of neurosurgery, the following case history of Sir Victor Horsley's may be of interest.

Case Report

A man of 68 recently presented at Moorfields Eye Hospital with blurring vision. Routine questions revealed that at the age of 5 he had been admitted to University College Hospital on 18 July 1902 under the care of Sir Victor Horsley. The presenting symptoms were pain in the neck which caused him to carry his head on one side, loss of power in the legs, and occasional fainting fits which had been present for two months. The "fainting fits" had been described as a period of intense pain culminating in a faint and immediately preceded by vomiting. There had been no convulsions and the fit generally lasted for several minutes. On recovery "the patient generally remained in a dazed or unconscious state for about eight hours." There was "no history of mental or nervous disorder in his family," and the only relevant past history was that at the age of 2 years he had struck the back of his head on a chair. Following this episode he had complained of occipital headache for two days.

On examination he had looked healthy but walked "with a reeling gait, tending to fall backwards." He soon became unable to walk or even to sit upright without support. His pupils were equal, dilated, and reacted slightly to light. There was no ptosis, nystagmus, or strabismus, but there was a marked bilateral optic neuritis which was maximal on the right side. His tongue protruded centrally, and though there were no marked motor signs "the total muscular power seemed feeble." It is recorded that Sir Victor Horsley demonstrated a weakness of the right hand grip. He made a diagnosis of cerebellar tumour.

A craniectomy was carried out by Sir Victor under chloroform anaesthesia on 26 July 1902. The procedure of the operation was as follows: An oblique incision was made over the external occipital protuberance, and the aponeurosis and muscles were cleared from the bone. As the periosteum was stripped from the skull "there was smart haemorrhage from 2-3 emissary veins which was stopped with bone wax." The bone over the right cerebellar hemisphere was nibbled away and was found to be very thin. When the dura mater was exposed it immediately bulged outwards into the wound. The dura was incised to relieve pressure, and once opened the cerebellar foliae were exposed. Running between two of the foliae was a thin dark line. When these foliae were separated "there appeared to be a tumour. The pressure from within the tumour caused it to extrude by half an inch [12.7 mm.], and in order not to cause ill effects by the sudden release of pressure the wound was temporarily closed and dressed."

Two days later (on 28 July 1902) the wound was reopened and the flaps turned back, when it was found that most of the tumour had freed itself from the cerebellar substance and had been lying directly beneath the flaps. The remaining attachments were divided, and with a wide excision the removal of the tumour was carried out in a total fashion. A drain was inserted "and the wound was dressed in the usual way." Two days later there were no signs of shock and the C.S.F. was said to be "not considerable."

An uneventful recovery was reported, though it was not for five months that absolute steadiness in walking and turning was achieved.

The pathologist's report on the tissue removed described several masses of soft tissue having the bulk of a large walnut, the whole mass resembling "bruised brain tissue." The tissue was very friable, and was of dark brownish colour as if from an infiltration of blood. The histological report states that the mass was a glioma.

A recent visit to hospital showed him to be a healthy-looking man of 68 years. The only complaint he has voiced over the past 63 years was that of occasional exacerbations of oesophageal spasm; this has been investigated radiologically. He sleeps and eats well, managing to carry out his job as a stockbroker's clerk.

Recent physical examination revealed a mild bilateral intention tremor when the patient was performing fine movements with his upper limbs. The optic disks showed secondary atrophy more marked on the right. This last finding is in keeping with Horsley's original observation. The maculae showed senile degeneration which accounts for his recent visual symptoms.

Comment

It is interesting to reflect that this cure was inspired and carried out without the assistance of any of the diagnostic conveniences to which we are all so accustomed, and emphasizes the importance of an astute clinical assessment in the form of an accurate history and examination.

With regard to the case described, it is unfortunate that the microscopical sections of the tumour have been destroyed, but nevertheless it is interesting to speculate on the nature of the lesion. It should be borne in mind that the pathology of cerebral and cerebellar tumours was not perhaps as well understood in that epoch as it is to-day, and that to a certain extent all brain tumours were classified as "gliomas." Nevertheless, three alternatives may exist: firstly, that the tumour removed was indeed a cerebellar glioma as we understand it to-day, and that a total excision was effected; secondly, that this tumour was benign; and thirdly, that it may have been an intracerebellar haematoma which had become encapsulated. It is unlikely that the first alternative is correct in the light of present-day knowledge. The second alternative seems feasible in that the tumour may well have been a cystic haemangioblastoma into which haemorrhage had occurred. This would certainly coincide with the macroscopic appearance of the tumour. The third alternative that this may have been an old intracerebellar haematoma may coincide with the past history of head injury at the age of 2 years.

It remains to say that this patient has suffered no disability as a result of a procedure performed 63 years ago in the very infancy of neurosurgery. This is a very remarkable case which was operated on by a very remarkable surgeon.

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