to-day treatment of minor conditions of illness. It is impracticable, however, to cater for everyone's whim and fancy, as to do so would convert the aircraft into a flying chemist's shop, so again only essentials are provided. Passengers, invalid or otherwise, are expected to bring with them their own particular medicaments.

A special oxygen set is provided, on the doctor's orders, for any invalid or elderly person who might be in need of it. It is fitted with masks to fit babies, young children, and adults. A stretcher cot, designed to facilitate loading on and off the aircraft and to give the comfort of a bed while travelling, is provided for those needing more than an ordinary stretcher. It is shorter than the standard stretcher and fits more easily across the seats of an aircraft.

Statistics

It is impossible to estimate the real number of invalids who travel by air, as usually only those who are severely disabled or anxious reveal their condition to the airlines. Certainly the number of known invalids travelling long distances has increased rapidly during the past three years, though they form only about 0.3% of the total number of passengers. For instance, in the B.O.A.C. some 900 known invalids are now accepted yearly, approximately half being for one-stage flights of under five hours and the others for long-haul flights of six hours to two days or more. In the past six years, when over a million passengers have been transported an average of 3,000 miles (4,830 km.) each, there has been only one case of natural death while in flight among these known invalid passengers, and one among all other passengers. There have, however, been two or three deaths yearly within 48 hours of completing an air journey among passengers who had not revealed their disability. The primary cause of such deaths was cardiovascular disease in the majority of cases.

Most passengers who have needed medical attention during flight (about 90 a year) have not been known invalids at the time of embarkation, the ratio being 12% known to 88% unknown. Most of these episodes have occurred in flights of six hours or more.

Conclusion

It is desirable for all invalids who intend to undertake a long air journey to consult their doctors, so that appropriate advice may be given and suitable arrangements made for their own good. It is unfair for them to expose the airlines and fellow travellers to delays *en route* and the unpleasantness of alarming episodes. Experience shows that even severely ill patients can safely travel long distances by air in pressurized aircraft, provided they are selected carefully and proper provision is made for their care and comfort.

Next Refresher Course Article.—"Convulsions in Childhood," by Dr. Bernard Schlesinger.

The seventh report of the Joint Committee, Order of St. John and the British Red Cross Society, discloses a sound financial position. A sum of nearly £10,000 was spent on relief services for prisoners of war in North Korean hands. The provision of library services in hospitals continues with good effect and increasing demand. Five bungalows given by the Pilgrim Trust and five provided by the Bernhard Baron Trust have been completed at the Settlement for Paraplegics, Garston, near Watford. A further grant has been made by the committee for the construction of eight more bungalows. With the assistance of the Royal Colleges of Nursing and Midwives and the Queen's Institute of District Nursing, the award of scholarships to nurses for postgraduate courses was continued, 27 awards being made during the year. Assistance has been given to 85,000 ex-Service men and women who required help in circumstances arising from their disablement.

PULMONARY TUBERCULOSIS IN CEYLON

BY

DONALD BARLOW, M.S., F.R.C.S.

Early in 1951 the Governor-General of Ceylon, Lord Soulbury, realizing how serious was the extent of pulmonary tuberculosis in that country, suggested to the Ceylon Government that advice on the problem should be sought from the British Isles.

It was thought that the first move should be the setting up of a thoracic surgical unit at Welisara Chest Hospital, near Colombo. Under the Technical Co-operation Scheme of the Colombo Plan an invitation was addressed to me by the Government of Ceylon to establish the unit. Arrangements for my visit were made by the Commonwealth Relations Office.

On my arrival in Ceylon it was at once clear that the then gross shortage of nurses and the absence of radiographic, pathological, and other services at Welisara Chest Hospital ruled out the immediate possibility of the formation of such a unit there. I accordingly suggested to the Prime Minister that the opportunity might be taken for me to carry out a general review of the thoracic services of the island, with special reference to tuberculosis, and also that I should set up the first thoracic unit at Colombo's teaching hospital instead of at Welisara.

First Thoracic Unit

Thanks to the ready co-operation of the Ceylon Government and the university and hospital authorities, I was quickly able to establish a thoracic unit at the General Hospital, Colombo, equipped with all modern facilities, and I performed a considerable number of thoracic operations there. Since that time the unit has been functioning very satisfactorily, first in the charge of a Scandinavian team, and, at present, under Mr. Abbey Smith, thoracic surgeon to the Warwick Group of Hospitals, with a team comprising an anaesthetist (Dr. L. O. Mountford), a surgical registrar, a ward sister, and a physiotherapist. Mr. A. T. S. Paul and another surgeon from Ceylon are now working with the team, and are expected to take over the unit after further training. The present team is to remain for six months, and it is hoped that the Commonwealth Relations Office will persuade the Treasury to finance a further first-class British team there before the unit is finally handed over. The formation of other units is planned.

Results of the Survey

Once the Colombo unit had been established the wider issues of thoracic services in general were carefully studied in relation to economic and other matters, and at the invitation of the Prime Minister the findings were reported in a White Paper.*

The conclusions and recommendations were the result of an island-wide survey. It was estimated that there were some 200,000 patients with active pulmonary tuberculosis out of a total population of 7.5 millions. At the time of the survey about 3,000 beds were allocated for these cases. The problems studied were, and still are, very serious indeed. The gross overcrowding in hospitals, with as many patients lying on the floor as upon the hard beds, the pathetic lack of nurses so that it was not unusual to find more than 100 patients in all stages of tuberculosis in the charge of one heroic nurse, the lack of rest and of any real treatment for tuberculosis, and the poor state in general of radiographic and pathological facilities, as well as many other matters of equal gravity, could not fail to demand notice. These diffi-

culties were described in the White Paper, and measures for dealing with them suggested. The Ceylon Government accepted the document in full and at once set out to implement the recommendations. Subsidies for the dependants of all tuberculous patients, improved living conditions, extension of hospital bed accommodation, training of doctors and nurses, and many other measures are now agreed and are developing. The Governments of Great Britain, Australia, and other countries are giving substantial financial aid. There is every indication that Ceylon will lead the East in the terrible battle against tuberculosis.

How the West May Help the East

Later, having seen something of the corresponding problems in India, and having discussed the matter with Rajkumari Amrit Kaur and other authorities, it occurred to me that, if the work in Ceylon could be brought to a successful issue in reasonable time, measures which proved successful there might be adopted State by State, or even town by town, in India, Pakistan, and elsewhere. Hopeless as the tuberculosis problem may seem in these countries, where starvation vies with tuberculosis for the honours of death, it is less hopeless when viewed in the light of planning in relatively small areas. It cannot yet be dealt with on a country-wide basis.

In England, and more especially in the Scandinavian countries, and in the United States of America, pulmonary tuberculosis is under control. In 10 years' time I believe it will largely have died out in these countries. I then visualize a time, not so far distant, when it will be the duty and privilege of every chest surgeon to offer six months' to one year's service at the height of his career—say after 10 years' service in consulting work in England, America, or Scandinavia—to go to the countries of the East to do what he can to teach doctors and nurses on their own ground, and to lend a hand in curing tuberculosis and other thoracic disease. Such service, offered and accepted in the right spirit, is the only hope of cure for the millions of tuberculosis cases in the East, and then only if their economic state can be improved.

*Report on the Thoracic Services of Ceylon, with Special Reference to Pulmonary Tuberculosis. Published by the Ministry of Health and Local Government, Colombo, May, 1952. Price 80 cents (postage 15 cents).

Reports of Societies

THE PSYCHOLOGY OF EATING

On January 31 the Scottish Group of the Nutrition Society held a symposium on "The Psychology of Eating"* in the Marischal College, Aberdeen.

Professor REX KNIGHT, of the Department of Psychology, Aberdeen, was in the chair, and he opened the meeting by saying that modern research on eating illustrated five of the main features of contemporary psychology. First, anecdote and unverified speculation had given place to controlled observation and experiment. Secondly, it was now recognized that likes and dislikes in food, and the psychosomatic aspects of digestion, were partly influenced by unconscious factors—for example, among adults, as well as children, aversion from food was often an indirect aversion from something or someone else. Thirdly, studies of the relationship between temperament and physique all took account of attitudes to eating, as in W. H. Sheldon's description of his "viscerotonic endomorph" as one in whom "the digestive tract is king." Fourthly, the current emphasis on the influence of social factors was reflected in the stress laid on the influence of culture-pattern, group-dynamics, and other social forces on eating habits. Fifthly, psychological phenomena were being increasingly linked to the physiological mechanisms that underlie them.

Professor W. M. MILLAR, of the Department of Mental Health, Aberdeen, then reviewed the psychiatric implications of disturbances of eating and nutrition. Eating disturbances appeared as the cause, correlate, or consequence of most psychiatric conditions. They were usually related to the inner significance of the act of eating rather than to the qualities of particular foods. Most common was anorexia, which appeared typically in cases of depression and involutional melancholia. The general relation of emotions, and particularly of rage and fear, to gastric function had been general knowledge since the experiments of the physiologists on the development of conditioned reflexes and their analysis of gastric mechanism by means of sham-feeding and the use of the Pavlov pouch. Later studies had suggested that the old or "visceral" brain might still play a part as an organ of "affectivity" in the relation between rage and fear on the one hand and alimentary function on the other.

Aetiology of Peptic Ulcer

Professor C. F. W. ILLINGWORTH, of the Department of Surgery, Glasgow, recalled that the study of peptic ulceration had been marked by a succession of wild theories, dogmatically asserted. As a student he had been taught that the ulcer was certainly the result of bacterial infection of the teeth and tonsils—whose removal was essential. It was important to be certain that more modern theories were based on a sounder foundation. There was certainly strong evidence for believing that anxiety reacted on the stomach, whether in the headmaster's study or on the public platform, and observation in patients with gastric fistula left no doubt that changes in gastric motility and secretion could be caused by emotional stresses. But that was not by itself proof of the psychological causation of an ulcer in the stomach; it simply gave a good *prima facie* case for objective investigation. Some psychiatrists had suggested that peptic ulcer could be related to a history of disturbing childhood influences, such as the divorce of parents, but Kellock's recent survey gave no evidence of this. Others had related the onset of haemorrhages to period of acute psychological stress, but clinicians were not satisfied that this was always the case. However, it was generally agreed that the patients belonged to a single psychological type, anxious and underweight.

It was well recognized that perforated peptic ulcer had shown a steady rise in incidence since the beginning of the century, and this was commonly attributed to the increased psychiatric stresses to which twentieth-century man was subject. But twentieth-century woman was equally subject to them, yet it was interesting that the increasing incidence of ulcer was confined to men. The high incidence of perforation in London during periods of air bombardment had been attributed to psychiatric stresses, but a similar increase occurred in Glasgow before the raids began. Indeed, in Glasgow the severe raids were followed by a noteworthy fall in the perforation rate.

Contrary to general opinion, there was no foundation for the belief that men in certain occupations, such as bus drivers, were more prone to ulcers. The only possible exception was for foremen and managers—possibly this was explained by the promotion of those who were of the type that worried about, and looked ahead to, the future.

Anorexia Nervosa

Dr. C. F. ROLLAND, of the Department of Therapeutics, Edinburgh, said that anorexia nervosa was characterized by a fall in body weight resulting from an antipathy to food, and in this sense was the antithesis of obesity, though much less common. It followed the development of a morbid

*The papers given at the symposium will be included in the *Proceedings of the Nutrition Society*, which are distributed to members. Inquiries about the Society should be made to Dr. G. M. Bourne, London Hospital Medical School, London, E.1, or, in Scotland, to Dr. E. C. Owen, Hannah Research Institute, Kirkhill, Ayr.