

ASIAN MEDICAL JOURNAL

Vol. 10, No. 4
April, 1967

Special Edition

*The 5th Congress of the Confederation of
Medical Associations in Asia and Oceania*

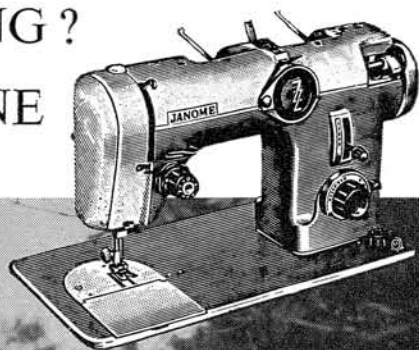


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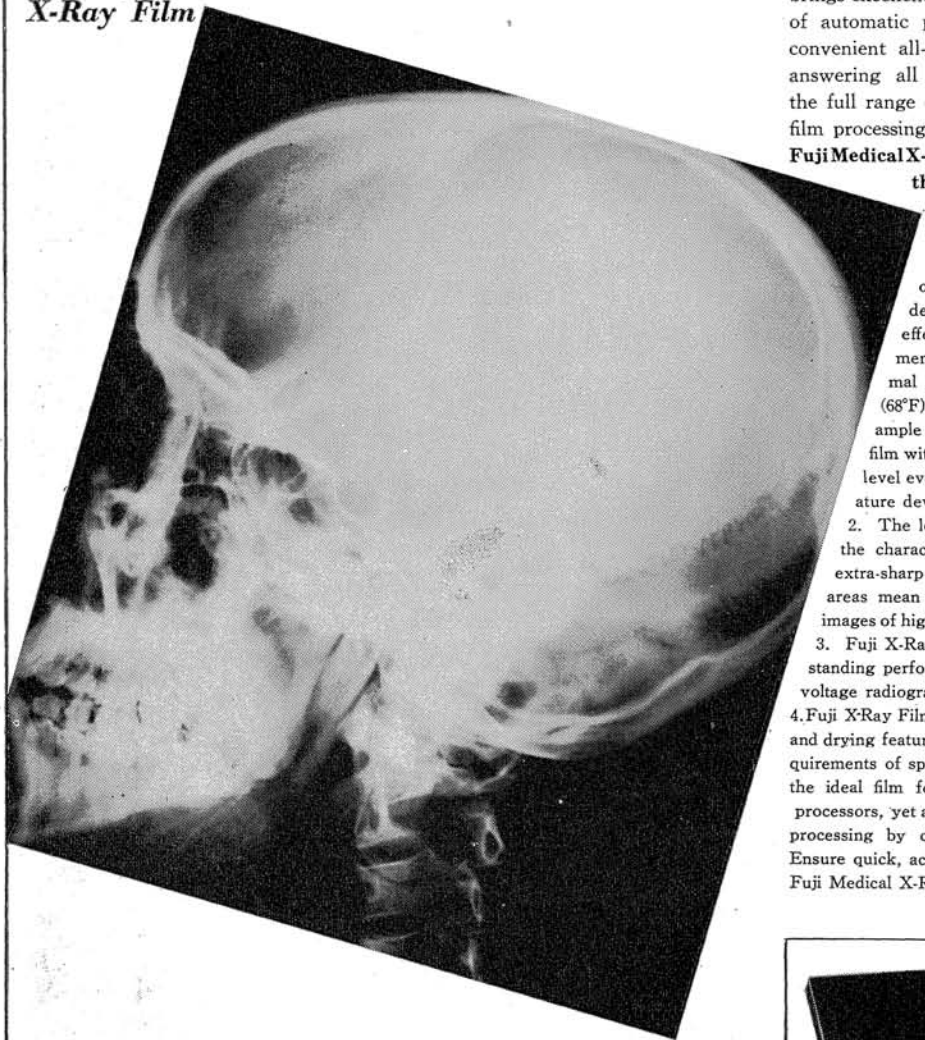
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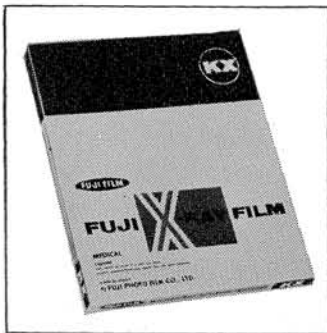
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Asian MEDICAL JOURNAL

A Journal of Medical Sciences of Japan and Asian Countries

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The 5th Congress of the Confederation
of
Medical Associations in Asia and Oceania

Special Message

On the New Activities and Achievements by the Japan Medical Association

By **TARO TAKEMI M.D.**

President, Japan Medical Association

The Japan Medical Association (JMA) has succeeded in making a big leap forward and developing a new area of activities.

Although medicine in the past was concerned with the treatment of the sick, it is no longer possible for a medical system to be content with that role. This is because the remarkable progress attained by medical science has created for itself the new role of carrying out social development, whereby medicine serves the dual purpose of preventing diseases and managing health as well as relating the health of people with their welfare.

JMA has made a new definition for medical treatment. That is, medical treatment is the social application of medicine. This phrase, "the social application of medicine" has not been used before in the sense JMA is now using it.

Social Application

What we mean by "the social application of medicine" is the creation of the best possible conditions for man during his existence on this planet to maintain the highest level of his health.

This definition notably enlarges the meaning of medical treatment as conceived in the past. It also compels us to carry out a qualitative reform in the system of medical treatment. Medicine must now take into account socio-biological, cultural and regional aspects of the health of man. Consideration must also be made of changes in population pattern.

Industrialization, a social and economic factor, must also be taken into account. Likewise, the problems of air pollution, water pollution radiation, etc. which vitally affect the health of man must also be studied.

It is obvious that medical treatment we speak of has many facets and has a multi-level structure. Thus, to present the problems related to the

multi-facetedness and multilevel structure of medical treatment is the basic step toward systematization of medical treatment.

It is extremely interesting to consider the new concept of medical treatment in terms of the region in which it operates.

JMA created a Community Health Study Council in order to study the industrial structure, economic structure, climate and geography, customs and health conditions of the people of a community.

Experiments Conducted

We also conducted several experiments on clinical and public health problems regarding such matters as giving guidance to community residents on nutrition, bringing up infants and school lunch. One of the achievements made clear by these attempts is the fact that we were able to improve measurably in five years the extremely poor health conditions of a certain agricultural village in Japan.

The community is Sawauchi Village of Iwate Prefecture which had the highest infant mortality in Japan. Yet, in five years, the infant death rate which used to be 37 out of 1,000 was reduced to zero.

At the same time, special guidance on nutrition was given the community. The physicians in the community acted as custodians of the health of every individual resident of the community, applying in his guidance medical knowledge to such matters as food, clothing, shelter, food sanitation and the health of mother and child.

The Community Health Study Council cooperating with university professors of the region and of Tokyo and the physicians in the community prepared a carefully laid annual plan. The Health Center, a local office of the Ministry of Health and Welfare, also participated in the project. As well as the Village, Office, the administrative agency for the community.

Civic leaders representing the residents and school-teachers also pitched in. As a result of this drive, within a year infant mortality was reduced to one-half and to zero in five years.

Infant Mortality Erased

Every resident of the community carries with him a health card which serves as a reminder of the importance of his health. In this village where people traditionally ate little meat, animal husbandry was started. As it is the case with farmers in a remote village, the villagers were at first ex-

tremely timid about doing something in which they had no experience. Therefore, it was necessary first to give them education on new industries.

At the time when I first visited this village, some of the families were bathing in the same water in the bath for several months without changing it. It was an incredible situation that prevailed in this particular community.

I chose this community for this experiment because I believed that as the growth of the Japanese economy progressed, regional disparity among communities also increased and that this must be stopped somehow.

If this particular village had been left on its own until today, its infant mortality would have been higher than it was and the disparity between it and other communities in terms of the standards of living and health would have further widened.

Widening Gap

This widening gap between communities is paralleled by the gap found among the developed and underdeveloped regions of the world. I believe that this problem must be dealt with as one that affects the welfare and happiness of mankind as a whole, not merely of the underdeveloped areas. Yet, no specific measures nor policies have been formulated by either WHO or United Nations.

This is so because behind the problems of regional disparity, there are the extremely knotty problems of population. I have been very interested in the parallel found between the worldwide problems and problems within one nation, such as Japan.

I pushed the experiment in Iwate Prefecture because I felt, if the problems may be solved within Japan, we might find a suggestion for the development of the underdeveloped areas.

Throughout the underdeveloped areas of Japan, community health study groups have been formulated to benefit from the experience of the one which took up Sawauchi Village.

Major improvement is likely to be witnessed in the next five years in all of the underdeveloped areas of Japan. One thing which deserves special mention about them is that health improvement in these regions has a remarkable effect in reducing the incidence of disease, which would mean unburdening the poor of the cost of paying for medical expenses.

An experiment such as the one I have described has been conducted in several communities as projects of JMA, and each has attained satisfactory results, proving eloquently how important it is to have community control to combat poor health and disease.

Health Insurance System

The Japanese Government has suffered a deficit of about ¥100,000 million in the health insurance system it manages during the last five years. An analysis shows that the deficit is due largely to the fact that the insured are receiving medical attention at a rate which is increasing by 10 per cent each year and that the medical expense per case is now double that of five years ago.

The Government and the health insurance societies have been loudly claiming that the doubling was caused by the physicians dispensing excessive amounts of medicine or giving too many injections to their patients.

The life expectancy of the average Japanese today is over 70 years and infant mortality is 20 out of 1,000. The improvement of health as evidenced by these indices is a result of the socio-biological contribution by the physician and medical sciences.

To regard the increase in medical costs as a social crime, therefore, is, I must say, a grievous misjudgment on the part of financial specialists who are wholly out of tune with the times.

Health of People

The old-time finance specialists think that a health insurance system is a success if it could be managed on within the limits of the revenue. These people cannot evaluate in terms of monetary value improvement in the degree of health of the people.

Politicians of the past are responsible for the prevalent line of thinking which regards medical expense as an item in social consumption. Statesmen in the new age—particularly those who aim to build a welfare state—must assess how much improvement medical expenditure has attained in the socio-biological conditions of a community.

It is also necessary to compute what per cent of national income has been accounted for by medical treatment from the viewpoint of preserving and nurturing labor power. New progress in econometrics now makes such computations possible.

Some economists have reported that in the United States as much as 13 per cent of national income covers medical treatment. But no such computation has been done in Japan.

JMA intends to make fresh efforts in this direction. In the meantime, however, we are convinced that the medicine we have today is a

great success for the contribution it is making to the welfare of people even when we consider its role only after health breaks down.

Curtailing Expenses

Yet, the Government has been intent upon curtailing medical expenses by limiting the number of medical consultations per person. One method the Government plans to institute for this purpose is to make a patient pay a certain amount of money for each consultation apart from his health insurance payments. As for medication, too, the Government plans to make a patient pay for it on top of the payment through the insurance.

Such measures as contemplated by the Government would destroy the basic principle of social insurance that everything must be covered by premium. Seriously concerned over the possibility that the low-income people would be forced to forego medical attention because they would not be able to shoulder the financial burden, JMA has been strongly protesting against the Government for the proposed policy.

Social Insurance System

What is now called the social insurance system was legally established about 40 years ago, when average life expectancy in Japan was 45. The system was divided roughly into the following types: the health insurance society-managed health insurance, Government-managed health insurance, national health insurance, seamen's health insurance, mutual aid association and daily life security.

All members were considered to have an average life expectancy of 44 or 45, so that the social insurance system never showed a deficit. However, the society-managed health insurance does not include as its members those aged more than 55, which means that employes retiring at 55 are not eligible to receive the benefits of the insurance at the very time when he begins to need medical care most badly.

To put it the other way around, employes before retirement age seldom enjoy the benefits of insurance while they are healthy and in the prime of life—largely because their companies offer all-round health management programs and facilities.

Once a man has retired from his job at the age of 55, his income often comes to naught or is sharply reduced, and he cannot afford to pay a large sum of money regularly to provide for his possible medical treatment.

Nat'l Insurance Setup

This is where the national health insurance system comes in, but the very fact that many of its members are retired workers who are now more liable to contract an old age disease of one kind or another—men who have been transferred from the society-managed health insurance system—naturally proves to be a great financial burden on the system itself, thus bringing on a deficit.

The national health insurance system is the only community insurance system in Japan. It should be developed as a system which takes fully into account the characteristics of each community. Yet, the system in reality covers those citizens who are not covered by health insurance societies.

These people, not employees of major enterprises, include the aged and those suffering from chronic diseases. Because of this condition, the system is at present denied possibility for development.

The Government-managed health insurance system, on the other hand, covers employees of small business. By and large, these people are low-income earners and consequently liable to fall ill. These two systems of health insurance have suffered a deficit of ¥100,000 million this year.

Deficit Expected

And the deficit is something to be expected because of the nature of the system and not to be attributed to the physicians involved. Nor it is to be blamed on the insured.

Indeed it is a tragedy that the Government has shown no understanding of these facts. If all the various health insurance systems of Japan could be unified as a single system—a community health insurance system—then it would be possible to resolve the age factor as a biological element. At the same time, such an insurance system would play the economic role of redistribution of income for the lower income people.

The present framework of social security comprising several sectors which are not at all in balance with one another makes redistribution of income, an economic effect of social security, ultimately impossible.

Disparate Systems

Under the present circumstances of social security in Japan, income

could not be redistributed through medical services. This situation must be quickly rectified.

We have been insisting upon unification of the disparate systems of health insurance. The strongest opponent to our advocacy has been labor unions. Labor unions in Japan are a new aristocracy. They comprise men and women who are young in age and have high incomes.

The members of labor unions have also formed health insurance societies, from which they strictly bar anyone who do not earn as high a wage as they themselves or are not as healthy as they themselves are. In other words, the unionists exclude those former fellow union members who retire from their employment and automatically cease to be union members.

Thus, the labor unions are antisocial organizations which are enemies of the indigent. Because the health insurance system is deeply involved with such organizations, it is extremely difficult to reorient the system in the right direction. The interference by the unions would aggravate as the average age of the population goes up.

It is clear from the above that to view medical expense under a social security system, where medicine comes into play only when health broke down, as a social consumption item is a relic of a past age. We must make a new start with a new viewpoint.

Health Insurance as Investment

The medical expense in the sense we think of must be viewed as an investment in the maintenance of people's health, not as a social consumption. Here we find a new social significance of medical services.

Health investment as such must be recognized in any advanced society. The investment must be considered to yield sufficient interest because the health of people makes a major contribution to the progress of society.

Here is the need for revision of the way of thinking of old-fashioned cost-conscious finance specialist.

A matter of crucial importance in thinking about health investment is the new theory of location. By this is meant that in planning to build a welfare society, it would be necessary to consider all the relevant facilities, in which health investment is to be made, in terms of their locations.

Theory of Location

Unless a definite policy is formulated on the basis of such a theory of location, the success of health insurance would become dubious. For

this reason, I believe that the concepts of health investment and of the theory of location for welfare are like the two wheels of a cart. The latter, however, has not yet been established as an academic discipline anywhere in the world.

The theory of location for social welfare deserves full attention in planning social development not only in Japan but also in the Asian-Pacific region.

I strongly hope that this theory of location would be discussed during the Fifth Congress of the Confederation of Medical Association in Asia and Oceania. I also hope that assistance by foreign powers to Asia would contribute much as a health investment to the development of the region.



The 5th CMAAO

March 29, 30, 1967

Palace Hotel



Business Session

AGENDA

I. Official Business Meeting—FIRST SESSION

Date : March 29, 1967 1.00 p.m.—5:00 p.m.

Venue : Palace Hotel, Golden Room

1. Call to order and welcome address by the President, Dr. Taro Takemi, who will take the chair.
2. Introduction of delegates, and presentation of Banners to the Confederation.
3. Approval of the Proceedings of the Fourth Congress of CMAAO, held at Perth, Australia, 1965.
4. Report by the Vice-President, Dr. Haruo Katsunuma
5. Report by the Secretary-Treasurer, Dr. Victorino de Dios.
6. Finance:
 - a. Financial statement presented by the Secretary-Treasurer, Dr. Victorino de Dios
 - b. Approval of the Budget for 1967-1969.
 - c. Annual Subscription to the Confederation.
7. Report of the Chairmen of the different delegations on the affairs and problems of their respective associations.
8. Appointment of different Reference Committees:
 - a. Reference Committee on Resolutions.
 - b. Reference Committee on the Reports of different member-associations.
 - c. Reference Committee on the report of the Secretary-Treasurer:
 1. Financial report.
 2. Budget.
 - d. Special Committee for nomination and election.

II. Official Business Meeting—SECOND SESSION

1. Approval of Minutes of the First Session.
2. Reports of the Reference Committees.
3. Determination of the place of the Sixth Congress.
4. Election of the President, Vice-President for 1967-1969, and two councilors for 1967-1971.
5. Induction to offices of the newly elected officers.
6. Installation of the newly elected President.
7. Any other business.
8. Adjournment.



WELCOME ADDRESS

Taro TAKEMI, M.D.

President, JMA and the Congress

Distinguished Delegates, Ladies and Gentlemen,

It is extremely meaningful and a source of joy to us that those of us who are engaged in the same profession throughout the vast region of Asia and Oceania should come together and talk about their vocation.

As president of the CMAAO, I wish to offer my hearty greetings to those of you who are gathered here as delegates and observers from many countries. It is most unfortunate that due to an administrative error delegates from Australia, one of the most enthusiastic member of the CMAAO, could not be here in time for the opening meeting.

I believe that this region of Asia and Oceania has a close bearing on the destiny of entire mankind. Today, the disparity in culture and productivity in the various parts of the world is rapidly widening. It is a duty of the advanced nations, I believe, to eliminate areas of low culture and productivity. If such efforts should succeed, it would mean a progress

of human culture and the laying of foundations for a new civilization for man.

Man's health is a central factor for culture. Even though we physicians may have different nationalities and live in different places, our common objective is the same—maintenance and advancement of the health of the inhabitants of the areas in which we live.

In few other professions than our own, the objective is more common among its members of different nationalities.

This fact, I am convinced, makes it possible for us to make progress and cooperate in bringing greater happiness to a larger number of our fellow men in our region.

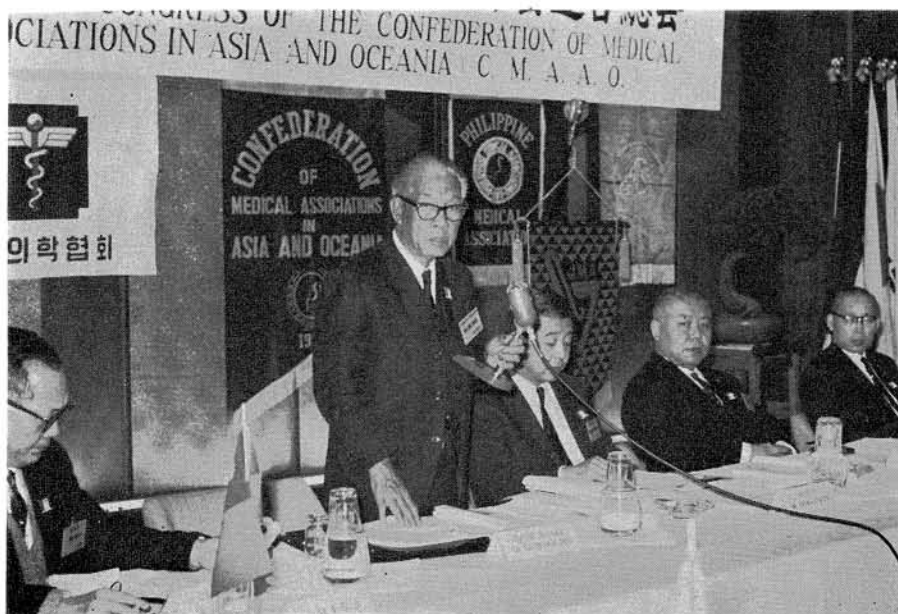
The cooperation of physicians with the CMAAO as a rallying point will play a major role in the development of health, interchange of medical knowledge and advancement of culture and welfare in Asia and Oceania.

In this region, the problem of population as a sociobiological factor deserves study with a higher priority than any other. Whether our task in our region succeeds or not depends on how we can make family planning succeed. Japan today is faced with the serious problem of how to maintain productivity. The problem has arisen because the average age of the population grows older and young labor force becomes shorter. Yet, there are areas where exactly opposite trends persist.

In many aspects of medical administration in Asia and Oceania, international cooperation is required. There are areas in which success has already been attained. In the areas which urgently require our positive cooperation, we must move forward with greater courage than ever before in giving our help to the regional development in medicine. This should be, in fact, the meaning of this conference we are holding here today.

Let us make this an opportunity for all of us to strengthen our ties of friendship and for you to have a better idea of what Japan is really like. For this reason I am particularly happy to welcome each and everyone of you to Japan.

I should like to mention with great joy the fact that Colonel Fairchild, chief of the Public Health and Welfare Department of the United States Civil Administration of the Ryukyu Islands, is with us to give a lecture on the Dynamics of Health Program Development in the Ryukus.



**Report of The Secretary-Treasurer
to The Fifth Congress of CMAAO
Covering The Period 1965-1967**

Victorino de Dios, M.D.

Secretary-Treasurer

Immediately after the Fourth Congress held at Perth, Australia, the Secretariat began to collect materials and other matters that has been considered in the Fourth Congress for the publication in the proceedings.

During the Congress, there were two business meetings and a symposium on the theme "Family Physician."

The following were approved during the last Congress, to wit:

Publication of a Newsletter:

The first issue came out of the press last August. It was sent to all member-associations and to non-members as well as to affiliate societies of medical organizations. The second issue of the CMAAO News was already released this month of March and copies were sent to all member-associations, to some individuals and medical groups.

The news published usually concern the medical groups and countries in Asia and Oceania.

Invitations to Non-Member Associations:

Letters were sent to non-member associations existing in different regions in Asia and Oceania inviting them to join the Confederation.

Dr. Taro Takemi, President of the CMAAO and of the Japan Medical Association, had also advised me to send letters of invitation to countries geographically related to CMAAO inviting them to join the Confederation and to participate in the Fifth Congress of CMAAO. But, unfortunately only Ceylon Medical Association answered my letter inquiring about the annual due to the Confederation.

Amendment to the Constitution and By-Laws:

The most important amendment is the election of the Vice-President instead of a President-Elect.

Before the election of the officers, the place of the next Congress must be decided first because the President and Vice-President must come from the country where the next Congress will be held.

As to the financial status of the Confederation, in spite of the small dues collected from the members there is still a surplus of 1,040.21 at the end of the fiscal year. This is due to the fact that the Secretariat is run in a most economical way.

As shown in the financial report, only seven medical associations have paid their annual dues.

During the XXth General Assembly of the World Medical Association I have been designated by the Philippine Medical Association to give a home hospitality to some foreign delegates. I entertained all foreign delegates from member-associations of the CMAAO during the WMA General Assembly.

A letter was received from the Yearbook of International Organizations requesting some informations about our Confederation with regards to aims, purposes and activities for publication in the Yearbook of International Organizations. All the requested matters have been sent to them.

For all cooperation, activities and advice extended to me by the officers and members of the Confederation, I wish to express my whole hearted thanks and sincerest appreciation and I hope that I could render more efficient service if only the member-associations would answer my letters immediately. But, I regret to say that some do not even reply my letters.

Report from Member-Association



THE KOREAN MEDICAL ASSOCIATION

Kunwon Park M.D.

The Korean Medical Association was established on May, 1947 and it was officially accredited as the central medical association by the Government of Republic of Korea in 1948.

In accordance with the standards of the National Medical Law the Association was legally recognized as the authoritative body of Korean physicians and medical scientists in 1952 and the Association was approved as a corporate juridical person by the Ministry of Health and Social Affairs in 1956.

The Name of Officers of the Korean Medical Association (1966 — 1967)

President: Choo Wan Myung, M.D.

Vice-President: Kyek Boo Han, M.D.

Vice-President: Dae Byuk Myung, M.D.

Member of Board of Trustees

Planning: Choong Jin Park, M.D.
 Medical Affairs: Pyung Hyun Lee, M.D.
 Science: Byung Ho Chin, M.D.
 Public Inform. and Publication: Sa Dal Kim, M.D.
 Finance: Bum Soon Lee, M.D.
 Auditors:
 Legal Advisor: Lawyer Heung Han Kim
 Number of House of Delegates 63

What K M A does:

The Korean Medical Association is to develop the medical science and promote the medical education through encouragement of medical research and investigation.

* * *

The Association is to encourage the qualified and efficient members in the exercise of their medical profession through continuing medical education programs.

* * *

The Association has established the Joint-Commission on Accreditation of Training Hospitals to research on the actual condition of the hospitals for internship and residency for training.

* * *

The Association is to help the members keep informed on the modern medicine through the regular publication, the *Journal of the Korean Medical Association* which reaches free of charge to the members and the library established for an international exchange of new medical periodicals.

* * *

The Association has established the Council on Drugs and Foods which is to provide physicians with early unbiased and authoritative information on all types of new drugs and foods, prepares special reports on the current status of therapy and nutrition.

* * *

The Association enforces annual registration of the physicians in Korea for their distribution over the land.

* * *

The Association has established the Council on Medical Insurance Study with plan to bring it in Korea.

**Number of the members throughout the country
(As of 1966)**

<i>Name of Province</i>	<i>Number of Members</i>	<i>Population/one member</i>
Seoul City	3,266	1: 3,279
Pusan City	657	1: 2,161
Kyunggi Do	611	1: 4,884
Kangwon Do	273	1: 6,487
Choong-puk Do	163	1: 9,431
Choong-nam Do	372	1: 7,795
Kyung-puk Do	850	1: 5,270
Kyung-nam Do	321	1: 10,057
Chon-puk Do	260	1: 9,676
Chon-nam Do	561	1: 7,153
Cheju Do	39	1: 8,369
Military	1,257	
Abroad	106	
Country	8,786	1: 3,279

Number of Members for Age

<i>Age</i>	<i>Men</i>	<i>Female</i>	<i>Total</i>
-30	1,129	312	1,441
31-40	2,665	693	3,358
41-50	1,931	201	2,132
51-60	1,260	53	1,313
61-70	411	13	424
70-	66	2	68
Total	7,462	1,274	8,736

Number of Members by Profession

	M	F	T	%
Private Practice	3,867	1,274	4,604	52.7
Teaching Profession	485	52	537	6.2
Government Health Service	640	148	788	9.0
Health Officials	93	18	111	1.3
Government Operated Enterprise	228	43	271	3.1
Private Hospital	67	33	100	1.2
Non-Practice	17	4	21	0.2
Intern	19	2	21	0.2
Resident	621	160	781	8.9
Unemployment	90	49	139	1.6
Military	1,257	—	1,257	14.4
Abroad	77	29	106	1.2
Total	7,462	1,274	8,736	100.0
	85.4%	14.6%		

Number of the members with Specialists Boards by Profession

	M	F	T	%
Private Practice	1,144	151	1,295	58.9
Teaching Profession	341	21	362	16.5
Government Health Service	228	25	253	11.5
General Hospital	102	9	111	5.2
Military	142	—	142	6.5
Abroad	5	1	6	0.3
Non-Practice	21	6	27	1.2
Total	1,983	213	2,196	100.0

Number of Specialists Boards

	M	F	T	%
Internal Med.	433	13	446	20.3
Surgery	521	3	524	23.9
Pediatrics	194	62	256	11.7
Obst. & Gynec.	214	94	308	14.0
Ophthalmolgy	93	14	107	4.9
E. N. T.	121	9	130	5.9
Urology	23	—	23	1.0
Dermatology	24	1	25	1.1
Orthopedic Surg.	44	—	44	2.0
X - Ray	56	6	62	2.8
Anesthesiology	13	2	15	0.7
Neuro-psychiatry	44	2	46	2.1
Neuro-surgery	24	—	24	1.1
Pathology	58	4	62	2.8
Preventive Med.	52	3	55	2.5
Derm. & Urology	69	—	69	3.2
Total	1,983 90.3%	213 9.7%	2,196	100.0

32 Member Academic Societies of the Association

Name	Address	No. of Members
The Korean Association of Internal Medicine	c/o Seoul National University	790
The Korean Surgical Association	c/o Catholic Medical College Hospital	797
The Korean Academic Association	c/o Ewha Woman's University College of Medicine Hospital	693
The Korean Association of Obstetricians & Gynecologist	c/o Soo Do Medical College Hospital	587

The Korean Ophthalmological Society	c/o Seoul National University College of Medicine Hospital	209
The Korean Dermatological Association	c/o Seoul National University College of Medicine Hospital	197
The Korean Urological Association	c/o Seoul National University College of Medicine Hospital	198
The Korean Otorhynolaryngological Society	c/o Catholic Medical College St. Mary Hospital	288
The Korean Society of Radiology	c/o Seoul National University College of Medicine Hospital	124
The Korean Society of Neuro-Psychiatry	c/o Seoul National University College of Medicine Hospital	123
The Korean Society of Orthopedic Surgery	c/o Yonsei University College of Medicine Severance Hospital	203
The Korean Neurosurgical Society	c/o Seoul National University College of Medicine Hospital	69
The Korean Society of Anesthesiology	c/o Seoul National University College of Medicine Hospital	77
The Korean Gastroenterological Society	c/o Seoul National University College of Medicine Hospital	76
The Korean Cardiological Society	c/o #107, Kyunji-dong, Seoul	235
The Korean Society of Nuclear Medicine	c/o Seoul National University College of Medicine Hospital	98
The Korean Society of Communicable Diseases	c/o Catholic Medical College St. Mary Hospital	98
The Korean Society of Hematology	c/o Yonsei University College of Medicine	77
The Korean Academy of Tuberculosis	c/o Korean National Association of Tuberculosis	380
The Korean Society of Chemotherapy	c/o Seoul National University College of Medicine	221
The Korean Society of Leprosy	c/o Yonsei University College of Medicine Severance Hospital	129
The Korean Association of Anatomists	c/o Catholic Medical College St. Mary Hospital	60
The Korean Association of Pathology	c/o Seoul National University College of Medicine	170
The Korean Society of Physiology	c/o Yonsei University College of Medicine	80

The Korean Biochemical Society	c/o Seoul National University College of Medicine	96
The Korean Pharmacological Society	c/o " "	65
The Korean Society of Parasitology	c/o Yonsei University College of Medicine	112
The Korean Society of Microbiologists	c/o Ewha Womans University College of Medicine	204
The Korean Society of Medical History	c/o Seoul National University College of Medicine	89
The Korean Society of Preventive Medicine	c/o Seoul National University College of Medicine	193
The Korean Society of Physical Anthropologists	c/o Seoul National University College of Medicine	73
The Korean Society of Transportation Medicine	c/o Seoul Station Medical Inst.	226

8 Medical School in Korea

Name	Address
Seoul National University College of Medicine	#28, Yoenkun-dong, Seoul, Korea
Kyung-puk National University College of Medicine	#335, Samduk-dong, Taegu, Korea
Chon-nam University College of Medicine	#8, Hak-dong, Kwangju, Korea
Pusan National University College of Medicine	#31, 2-ka Ami-dong, Pusan, Korea
Yonsei University College of Medicine	#15, Sinchonsan-dong, Seoul Korea
Catholic Medical College	#81, 2-ka, Che-dong, Seoul, Korea
Soo Do Medical College	#4, 2-ka, Myungryun-dong, Seoul, Korea
Ewha Woman's University College of Medicine	#1-1, Daehyun-dong, Seoul Korea

Number of Hospitals and Clinics in Korea (1965)

<i>Name of Province</i>	<i>Gen.</i>			<i>Total</i>
	<i>Hospital</i>	<i>Hospital</i>	<i>Clinic</i>	
Seoul City	17	69	1,817	1,903
Pusan City	1	16	500	517
Kyunggi Do	—	16	492	508
Kangwon Do	1	17	206	224
Choong-nam Do	1	7	331	339
Choong-puk Do	—	4	136	140
Kyung-puk Do	2	15	621	638
Kyung-nam Do	—	12	280	292
Chon-puk Do	1	9	226	226
Con-nam Do	1	15	371	387
Cheju Do	—	2	32	34
<i>All Korea</i>	<i>24</i>	<i>182</i>	<i>5,002</i>	<i>5,208</i>



Main Activities for 1966 and 1967 of the Philippine Medical Association

Ramon R. Angeles, M.D.

1. Proposed or support legislations to attract physicians to render service in the rural and "doctorless" areas and the standardization of salaries of government health officers.
2. Help to solve the problems of our physicians and nurses who are in the U.S.A. (Exchange of Visitors' Program), and in order foreign countries.
3. Send Delegates to the 3rd World Conference on Medical Education held Nov. 20-25 1966 in New Delhi, India.
4. Opposed the Decentralization Act now being considered in Congress which seeks to transfer the control and supervision of Provincial and Rural Health Physicians from the Department of Health to the Provincial Officials and politicians.
5. Submitted a List of Drugs in accordance with the classification of the Food & Drug Cosmetic Act and gives full-support to the Food and Drug Administration.
6. Helped in the formulation of a "Code of Ethics on Ethical Drug Advertising" with the Food & Drug Inspection Board.



Inaugural Address

Tsungming, Tu M.D.

President

The 6th CMAAO

Thank you for your support you all agree with the 6th Congress of CMAAO to be held in Taipei.

It is a great honor to our country to invite the delegates of our member-countries to Republic of China.

We would like to do our best and to perform the 6th Congress of CMAAO successfully.

I represent the government of Republic of China sincerely to welcome you all.

I thank you.



**The Roster of the Attendants from
Abroad to the 5th Congress of the CMAAO**

I. Member-Association:

China (13)

Councilor;

Chi-Fu, Wu

Delegates;

Tsungming, Tu Chan Ching, Wu Yung Hui, Tsai

Observers;

Ta-Luan, Peng Tai Wu, Wang Ching Chung, Lim

Cheng Koan, Ti Chia Ten, Guo Hwai Yu, Wang

Ji Kei, Kyo Ying Fui, Tsai

Family; (Mrs.) Pi-Ren, Tsai

Korea (1)

Councilor; Kunwon, Park

Philippines (6)

Secretary-Treasurer;

Victorino de Dios

Councilor; Gregorio Dizon

Delegates;

Ramon Angeles Ricardo D. Ibanez Hilarion de Dios

Family; (Mrs.) Gregorio Dizon

Thailand (6)

Delegate;

Polpatt Talalak

Observers;

Narong Nimsakul Pallobh Charuvanit Apichat Kong-
kananda Boosaba Poottasiri Thavorn Ratanasiri

II. Non-Member-Association

Afghanistan (2)

Noor Armed Loynab Rokay Kamyar

Okinawa (1)

Seiki Kinjo

Malasia (1)

Joseph Napoleon Anthony

U.S.A. (3)

John P. Fairchild Carl L. Bauer John L. Nerness

**The Total of Attendants from Abroad
to the 5th Congress of CMAAO**

Country	Officers	Delegates	Observers	Families	Total
(Member-Association)					
Australia	0	0	0	0	0
Burma	0	0	0	0	0
China	1	3	8	1	13
Indonesia	0	0	0	0	0
Iran	0	0	0	0	0
Korea	1	0	0	0	1
Pakistan	—	—	—	—	—
Philippines	2	3	0	1	6
Thailand	0	1	5	0	6
(Non-Member-Association)					
Afghanistan			2		2
Malasia			1		1
U.S.A.			3		3
Okinawa			1		1
Total	4	7	20	2	33

Officers of the 6th Congress of the CMAAO

Officer

President: Tsungming, Tu, M.D. (China)
Vice-President: Chi-Fu, Wu, M.D. (China)
Secretary-Treasurer: Victorino de Dios, M.D. (Philippines)
Immediate Past President: Taro Takemi, M.D. (Japan)

Council

Chairman: Tsungming, Tu, M.D. (China)
Vice-Chairman: Chi-Fu, Wu, M.D. (China)
Secretary: Victorino de Dios, M.D. (Philippines)
Councilor: Haruo Katsunuma, M.D. (Japan)
Councilor: Gregorio Dizon, M.D. (Philippines)
Councilor: Kunwon Park, M.D. (Korea)
Councilor: Hiroshi Kumagai, M.D. (Japan)

Official Delegates



Chinese delegates

Official Delegates**China**

Chi-Fu, Wu

Councilor, CMAAO

Chairman, Board of Trustees

Taiwan Provincial Physicians' Association

No. 225, Shin Chung 1 Road,

Kaohsiung

Tsungming, Tu

President, Formosan Medical Association

Chan Ching, Wu

Member, T.P.P.A.

Yuong Hui, Tsai

Member, T.P.P.A.

Korea

Kunwon Park

Councilor, CMAAO

c/o Korean Medical Association

International P.O. Box 2062

Seoul

Philippines

Victorino de Dios

Secretary-Treasurer, CMAAO

2114 Juan Luna, Manila

Gregorio D. Dizon

Councilor, CMAAO

Professor, University of Santo Thomas

Ramon Angeles

Member, P.M.A.

c/o Philippine Medical Association

P.M.A. House, 1850 Taft Ave.,

Manila

Ricardo D. Ibanez

Member, P.M.A.

Hilarion de Dios

Member, P.M.A.

Thailand

Polpatt Talalak

Assistant Professor

Siriraj University Hospital

Dhonburi

Japan

Taro Takemi

President, JMA and 5th CMAAO

Japan Medical Association

5-2 chome Kandasurugadai

Chiyoda-Ku, Tokyo

Hiroshi Kumagai

Vice-President of JMA and chairman of the Organizing

Committee for 5th CMAAO

Haruo Katsunuma

Vice-President of 5th CMAAO and

Executive Member, Board of Trustees, JMA

Professor, University of Tokyo

Kohei Toyokawa

Secretary of the Organizing Committee for

5th CMAAO

Professor, University of Tokyo

Yoshiaki Miura

Member, Organizing Committee

Professor, Chiba University

Ayao Yamamoto

Member, Organizing Committee

Professor, Institute for Medical Sciences,

University of Tokyo

Nozomu Takemura

Member, Organizing Committee

Professor, Tokyo Jikei-Kai University

Tadashi Yamamoto

Member, Organizing Committee

Professor, Institute for Medical Sciences,

University of Tokyo

Hiroshi Muroya

Member, Organizing Committee

Director, Department of Medicine

Taito-Pfeizer Co. Ltd.,

Yushichi Minamizaki

Member, Organizing Committee

Secretary-General of JMA

Business Session



from left to right

- Dr. Wu
(China)
- Dr. Wu
(China)
- Dr. de Dios
(Philippines)
- Dr. Katsunuma
(Japan)
- Dr. Takemi
(Japan)
- Dr. Muroya
(Japan)

from left to right

- Dr. Wu
(China)
- Dr. Park
(Korea)
- Dr. Wu
(China)
- Dr. Dizon
(Philippines)
- Dr. Toyokawa
(Japan)
- Dr. Katsunuma
(Japan)
- Dr. de Dios
(Philippines)



The Banners
and
Dr. de Dios

The Contact Address of the Member-Associations

(As of April 1967)

- Dr. Edgar F. Thomson
Secretary-General
Australian Medical Association
77 Arundel Street, Glebe,
N.S.W.
- Dr. Ba Than
Burma Medical Association
No. 249, Theinbyu Road
Rangoon
- Dr. Chi-Fu, Wu
Chairman, Board of Trustees
Taiwan Provincial Physicians' Association
No. 225, Shih Chung 1 Road,
Kaohsiung, Taiwan, Republic of China
- Dr. Sofjan Lamid
Secretary-General
Ikatan Dokter Indonesia
(Indonesian Medical Association)
Djalan Dr. Sam Ratulangie 29
Djakarta
- Dr. Said Hekmat
Iran Medical Association
c/o Dr. Said Hekmat Boit Postale 179
Teheran, Iran
- Dr. Yūshichi Minamizaki
Secretary-General
Japan Medical Association
5, 2-chome Kandasurugadai
Chiyoda-Ku, Tokyo
- Dr. Choo Wan Myung
President
Korean Medical Association
International P.O. Box 2062
SEOUL

- Dr. H. R. Khan
Secretary-General
Pakistan Medical Association
P.M.A. House Garden Road,
Karachi-3, Pakistan
- Dr. Elpidio L. Gamboa
Secretary-Treasurer
Philippine Medical Association
P.M.A. House 1850 Taft Ave.,
Manila
- Dr. Sanong Unakul
President
Medical Association of Thailand
3 Silom Street
Bankok

Reception

given by Dr. Takemi

President, JMA and Congress



from left to right

Dr. Miura
(Japan)

Dr. Fairchild
(U.S.A.)

Dr. Katsunuma
(Japan)

Mrs. Miura
(Japan)

Dr. Dizon
Mrs. Dizon
(Philippines)



Foreign Minister Miki (right)
and
Dr. Takemi



Foreign Minister Miki (right)
and
Dr. Tu (back), Mrs. Takemi (center)



from
left to right

Dr. Takemi
Dr. de Dios
Mr. Miki



Teacher &
Student

Mr. Loynab
(Afghanistan)
Dr. Miura
(Japan)
Mr. Napoleon
(Malaysia)
Dr. Kawana
(Japan)
Mr. Rokay
(Afghanistan)



Dr. and Mrs.
Dizon
and
The Miss
Takemis



from left to
right

Dr. Kase
(Japan)
Dr. Park
(Korea)
Dr. Takemi
(Japan)



Dr. Katsunuma
(Japan)
Dr. Fairchild
(U.S.A.)
Miss Takemi
(Japan)
Mrs. Katsunuma
(Japan)



Dr. Kikuchi
(Japan)
Dr. Park
(Korea)
Dr. Wu
Miss Wu
(China)



from left to
right

Dr. de Dios
(Philippines)
Mrs. Takemi
(Japan)
Mrs. Katsunuma
(Japan)



Dr. Toyokawa
(Japan)
Dr. Wu
Miss Wu
(China)



Dr. Minamizaki
(Japan)
Dr. Kase
(Japan)
Dr. Park
(Korea)

Scientific Session



Paper

1. Mycotoxins of "Yellowed Rice."
Dr. Kenji URAGUCHI (Japan)
2. Acatalasemia
Dr. Shigeo TAKAHARA (Japan)
3. Dynamics of Health Program Development in the Ryukyus
Dr. John P. FAIRCHILD (U.S.A.)
Dr. Seiki KINJO (Okinawa)
4. Medical Security in the Philippines
Dr. Victorino de DIOS (Philippines)



Dr. T. YAMAMOTO
(Chairman)



Dr. URAGUCHI, (Japan)

Mycotoxins of "Yellowed Rice"

Kenji URAGUCHI, M.D.

Prof. University of Tokyo

I. Mycotoxin as Rice Pollutant

In Asia and Africa, in a high incidence occur various diseases of clinically important, but etiologically unknown. Beriberi has been often cited as a historical example of such cases, although it has been generally considered that the cause was almost worked out. As the second example, liver diseases like liver cancer or cirrhosis are still on discussion mainly from the standpoint of etiological factors like nutrition, virus or toxin.

Today I am going to cast a spot-light first on beriberi, and next, on the liver diseases, both from the toxicological view point of mycotoxins derived from the fungi polluting rice grains and cereals, in order to figure out the potential environmental hazards in Monsoon Asia. The scientific concept of "mycotoxin" has been established by our research group during the World War II, and the term "mycotoxin" became familiar recently even to the European and American specialists, because some 100,000 young turkeys died at poultry farms in the United Kingdom in 1960 and then Aflatoxin was isolated from *Asp. flavus*-infecting peanuts, and it produced hepatoma in mammals.

II. Neurotoxic Yellowed Rice

In Japan, historically the first animal experiment with moldy rice was reported by Dr. J. Sakaki in 1891, disclosing the neurotoxic action, but the fungus has been left unknown. At that time, around 70 years ago, acute cardiac beriberi or "Shoshin-Kakke" was still rampant in Japan. According to the latest statistics published in 1966, the number of the beriberi autopsied in the Univ. of Tokyo during the past 80 years (1883-1937) was highest (26/116) in 1889, and it began to decrease actually around 1910, a few years before the outbreak of the World War I (1914-1918). The slide shows a sharp descent during the 1910's. This fact and its meaning were not disclosed for many years, but I think the reason of epidemiological decline should be scrutinized. As generally known, vitamin was discovered in (1911-1912), but, in Japan, the concept of vitamin deficiency as well as the therapeutic application to the clinical cases were not accepted until 1919 by the specialists and practitioners in Japanese medicine. This is the

point to emphasize. Acute beriberi was quick, not only in clinical figure, but also in its epidemiological behavior, and in turn, the disappearance of beriberi was beforehand with the entry of vitamin B. What is the actual reason for beriberi disappearance? According to my opinion, the epidemiological prevalence of acute beriberi in Japan was ascribable, if not entirely, to any other factor than the generally accepted avitaminosis. There must be some unknown factor beside the avitaminosis in the etiology. In this respect, I take sides with the skeptic opinions expressed by many Japanese experienced clinicians and pathologists in the past. As the above mentioned unknown factor, the most suspectful is the fungus pollution of rice grains. This opinion has two supporting evidences; the one is the socioecological fact and the other is our own experimental data.

a) Rice is the staple food in Japan, and it served the governmental allowance and taxpayment in kind under the feudal system, but rice was degraded to one of the commodities in the market after the Meiji Restoration in 1868, when the transport and storage system fell into a disorder lasting for many years. Just at that period, the acute beriberi prevailed among the citizens of Tokyo and other large towns, sacrificing collectively seasonal labourers, wage-earners, students far from home, soldiers in barrack and prisoners in jail. Fear of infection with beriberi spread, and the etiological ambiguity cast suspicions on rice. However the rice-conditioning was not conducted before 1898 and it came in effect in the prefectures covering 30 per cent of the country in 1909 and 60 per cent in 1911. Thus, underqualified rice was shut out from the domestic market at an increasing tempo during the 1910's. This coincide with the aforementioned 1910 sharp descent of beriberi incidence. I put emphasis on the possible role of rice-pollution in the epidemiological appearance and disappearance of the beriberi prevalence in the past.

b) The idea of "rice, fungus and toxin" was survived by I. Miyake, the late Professor of mycology. After his 20 years painstaking screening, a toxic fungus polluted rice was detected from the Formosan rice in 1938. He named it the yellowed rice. The fungus was *Penicillium toxicarium* Miyake, which was later identified as *P. civeoviride* Biourge, and it was detected also from the Japanese domestic rice as well as the foreign rice imported from the Asian countries. According to the animal experiment conducted by us since 1940, the moldy rice and its alcohol extract contains fat soluble mycotoxin, fatally affecting mammals and other vertebrates, when given orally or parentally. Acute poisoning forms a progressive ascending paralysis with cardiovascular failure and respiratory damage. The clinical features resembles closely to the reported acute cardiac beriberi "Shoshin-Kakke" in man, and, to some extent, to Landry's paralysis in man. Site of action is the motor neuron of spinal cord, and the cause of death is the paralysis of the respiratory center. The mycotoxin is thermostable and fluorescent, but unstable to the sun light. The chemical structure of the compound, civeoviridin, was recently determined by Prof. Y. Hirata, although LD₅₀ has not been reported.

III. Hepatotoxic Yellowed Rice

Since the idea of "rice, fungus and toxin" had turned to an experimental truth during the World War II, it spurred us to turn attention to the possible role of mycotoxin

in pollution of rice and other foodstuffs in Asia and Africa. In the postwar period, Japan suffered from a shortage of rice crop and imported various rice from the countries of the world. Many fungi have been detected. According to our research team, *P. islandicum* Sopp widely distributing over the countries is to produce two mycotoxins, luteoskyrin and chlorine-containing peptide, both fatally affecting mice and rats, developing acute liver injury in their respective forms. On long term feeding, liver cirrhosis, adenoma or carcinoma were observed in their liver. Biochemical investigation revealed that, with mitochondria, luteoskyrin is to inhibit phosphorylation as uncoupler or inhibitor (I. Ueno), and with nucleus, the compound is to form a complex with DNA and Mg^{++} , and also to inhibit the RNA synthesis. (Y. Ueno).



Dr. Y. MIURA
(Chairman)



Dr. TAKAHARA, *(Japan)*

ACATALASEMIA

Shigeo TAKAHARA, M.D.

Prof. Okayama University

“Acatlasemia” is a new term which means “the deficiency of catalase enzyme in the blood” and it is a new type of inborn error of metabolism which was first described by Takahara in 1947. The lack of catalase activity in the acatalasemic cases was initially noted in the whole blood, but subsequent studies of the tissues of other organs such as the nasal and oral cavities, pharynx, bone marrow and liver have revealed similar absence of the activity for this enzyme. For this abnormality some scholars suggest that “Acatlasia” may be a better name. However, up to date we have not had a single autopsy case to prove definitely that catalase is lacking in all the organs of the body and therefore, for the time being, we prefer the term Acatlasemia.

To date, 77 cases of acatalasemia from 39 Japanese families and 3 cases from a pure Korean family have been found in Japan. Recently, 11 Caucasian cases from three Swiss families and 1 from Israel were added to these cases, amounting to a total of 92 cases in the world. It is noteworthy that most of the acatalasemics are the offsprings of consanguineous marriages and acatalasemia is sporadic in distribution and not restricted to any limited area of Japan.

In acatalasemia the following five points seem to be interesting and worthy of further discussion:

1) Characteristics of Acatlasemic blood:

Acatlasemic blood shows no different in the gross appearances when compared to normal blood, but it has peculiar and striking characteristics when exposed to hydrogen peroxide. The color changes instantly from red to brownish black without emitting any bubbles of oxygen. This happens owing to the lack of catalase in the erythrocytes and the blackening of the blood is caused by the formation of methemoglobin. When excess peroxide is added, oxidation continues and within 20 or 30 minutes the color changes to lemon yellow and then becomes colorless. This clear liquid contains the final decomposition product, propentdyopent, which gives a positive pentdyopent reaction.

1. This study is supported by the Grant from the Ministry of Education of Japan and aided by the United States Public Health Service Research Grant, AM 06793-03 GEN, from the National Institute of Health.
2. This paper was presented at the scientific session of the 5th Congress of the CMAAO (The Confederation of Medical Associations in Asia and Oceania) in Tokyo on March 30th, 1967.

2) On oral disease specific to Acatalasemia:

Reviewing the reported cases statistically, about one half of the acatalasemic individuals has a peculiar progressive gangrenous disease of the mouth (Takahara's disease) which occurs in childhood. This disease usually originates as a small painful ulcer from the crevice around the neck of a tooth or sometimes from the tonsillar lacunae. In severe cases the inflammation develops into a far advanced gangrene of the maxillae or may develop in the soft oral tissues. As a whole, these findings are similar to textbook descriptions of so-called Noma. After healing, a remarkable recession of gum which is characteristic of this disease, or a scar of the mouth which causes difficulty in opening the mouth, is likely to occur. Pathogenesis of the oral ulceration can be attributed mainly to the lack of catalase in the blood. That is, the bacteria in the crevices of the tooth or tonsillar lacunae produce hydrogen peroxide during their metabolic proliferation and as there is no catalase in the patient's tissues to decompose the hydrogen peroxide so produced, hemoglobin is decomposed by oxidation by the hydrogen peroxide, thus causing ulceration and decay of the oral tissues. An early, radical removal of diseased teeth or tonsils and application of antibiotics are very effective to check the progress of the disease. In the healing rate of the wound, however, there is no difference from normal individuals.

The other half of the acatalasemic individuals do not show any such oral lesions and are designated as asymptomatic acatalasemia.

3) On the genetic aspects:

In 1958, the catalase activity of the blood of acatalasemic family members had been tested very carefully by our Okayama group in a close collaboration with ABCC* group in Hiroshima and Nagasaki in Japan and it was revealed that there are two types of individuals in the family members of the acatalasemics, in one type catalase activity is normal and in the other it is clearly intermediate between normal and acatalasemic values. This intermediate group was designated as "Hypocatalasemia". As there is no overlapping of catalase values between the hypocatalasemic group, normal and acatalasemic group, it is easily understandable that we can differentiate clearly hypocatalasemics from the normal and acatalasemics with biochemical assays.

By plotting these hypocatalasemics to their respective family trees, we have verified the next four combinations of mating following the Mendelian recessive law in their offspring. The combinations are: hypocatalasemia with hypocatalasemia, normal with acatalasemia, normal with hypocatalasemia, hypocatalasemia with acatalasemia. These findings suggest that this acatalasemia is of incomplete recessive monogenetic inheritance and hypocatalasemia is heterozygous and is a carrier state for the acatalasemia gene.

4) On the incidence of hypocatalasemia:

These hypocatalasemic individuals have catalase enzyme in their blood, though its amount is only one-half of the normal person, accordingly, they have no particular disease

* Atomic Bomb Casualty Commission.

to speak of and live a normal life. So, I think the gene of these individuals has been handed down from one generation to the next over a long period of time. Therefore, if we can check closely the frequency of hypocatalasemia over wide geographic areas, we shall be able to know gene flow or the flow of races.

With this view in mind, for the past seven years we have checked the frequency of hypocatalasemia in about 83,000 individuals among peoples in Asia as shown in the table; among the Japanese and Koreans residing in Japan, residents of the Ryukyu Islands, Chinese living in Taiwan—both those living there for generations and those who migrated there recently from their main-land during the war.

As the results the frequency of hypocatalasemia has been found to be the highest among Koreans, followed by the Chinese of Northern China, Central China, Southern China, and those Chinese in Taiwan residing there for many generations. The frequency in the Japanese followed this. The lowest rate is found in the Okinawans, namely, only one hypocatalasemic person among about 13,000 persons we examined as illustrated in the map.

I believe, therefore, Okinawans have had little relation with other peoples in Asia as far as their acatalasemic gene is concerned.

5) On biochemical and immunochemical aspects:

The test for determining the anomalous state of catalase has been conducted by assaying the catalase activity in erythrocytes using the modified method from von Euler and Josephson. However, there are important questions relative to whether the catalase protein is actually deficient or highly altered or whether its activity might be inhibited by some unknown factors. In order to clarify these points, we conducted a series of studies by spectrophotometric, electrophoretic and immunochemical methods. From these approaches, particularly by the quantitative precipitin method, it was demonstrated that the proportions of the quantities of catalase proteins in normal, hypocatalasemic and acatalasemic hemolysates were 1.0: 0.5: 0.07, while the catalase activities showed nearly the same proportions of 1.0: 0.5: 0.

From this finding it can be said that hypocatalasemic blood shows one-half catalase activity of normal blood due apparently to one-half quantity of catalase protein, and the acatalasemic blood lacks catalase activity due evidently to the absence of catalase protein. These findings strongly suggest that substances suppressing or inhibiting the enzyme activity in these blood samples do not play an important role. Probably acatalasemic individuals have a deficiency, or a high alteration in the configuration of the catalase protein molecule, thus denoting a defect in the biosynthesis of the catalase enzyme in their blood.

* * *

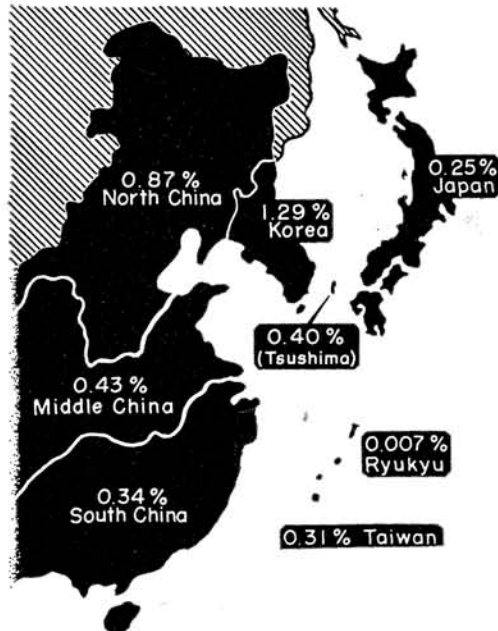
In conclusion, I would like to add that for the past several decades it has been thought that in all living beings hydrogen peroxide is produced during normal metabolic process and this is broken down by catalase enzyme in blood and tissues; thus we have been led to believe that catalase is an indispensable enzyme for life. However, acatalasemic

individuals, with the exception of occasional oral lesions, appear to carry on the normal life routine without any serious disturbances. From these facts it can safely be said that catalase is not a so important enzyme for human life as has been generally believed. Now, supposing hydrogen peroxide is produced during metabolic processes, there arise questions about what is there to compensate the function of catalase in acatasemia, and just what is the actual physiological role of catalase in human life. For the solution of these questions, there remain further works to be done.

FREQUENCY OF HYPOCATALASEMIA

Race	No. of exam.	No. of hypocat.	Frequency(%)	Year
Japanese	46878	116	0.25	1960-66
Ryukyans				
(in Miyako)	10083	1	0.01	1965
(in Okinawa)	3297	0	0	
			0.007	1965-66
Koreans	922	11	1.29	1960-62
Chinese	20644	66	0.32	1966
Aborigines (in Taiwan)	1145	1	0.09	1966
Total	82969	195		

FREQUENCY OF HYPOCATALASEMIA IN FAR EAST





Dr. TAKEMURA
(Chairman)



Dr. FAIRCHILD (U.S.A.) and Dr. KINJO (Okinawa)

Dynamics of Health Program Development in The Ryukyus

Colonel John P. FAIRCHILD

Captain Carter L. MARSHAL

USCAR's Public Health and Welfare Department

Seiki KINJO M.D.

President

Okinawa Medical Association

This presentation is a discussion of the more pertinent influences of the present program as we see them. It is not intended to be an exhaustive study of all of the factors in all areas of public health program development in Okinawa.

The problems of the past are history and will not be discussed except those that are pertinent to a better understanding of the present. Geographically the Ryukyu Islands are the southern most of the Japanese island chain just north of Taiwan, warmed by the black current, and are at the edge of the Nansei Shoto Trench rising out of the sea—as age-old coral. These islands are an anthropologist's delight; incorporating racial lines from all parts of the Orient with polynesian influence most evident in the southern islands and an occasional occidental influence considered by many authors to represent the genetic contribution of an occasional shipwrecked sailor. Customs and dialects have been influenced by visitors, but nurtured in relative isolation. The population, limited by the sea, restricted by limited natural resources, and adjusted to a limited protein source have had two choices: (1) Emigrate or adjust. Adjustment has produced courteous, happy personalities and strong family ties. Their customs, love and respect, continue as an advantage. Hungry for outside contacts, they accepted newcomers. They also accepted their diseases. The more venturesome youths who were most vulnerable to, for example, tuberculosis, hastened the spread of the disease they contacted in their travel and in their employment. Drawn to return to their native land they brought their problems with them and introduced them into a susceptible population with little racial immunity.

Although no new cases of malaria have developed in the Ryukyus since 1961 that haven't been imported—maintenance of eradication is made easier as the population is relatively compact, well defined and relatively stable. Twenty years of experience in disease control works as a positive factor in eradication. As time

passes, eradication is maintained and as the acute problem of malaria fades in individual memories, the less concern the health service and the individual worker has. This apathy might lead to the missing of the first cases. However, we feel the apathy we might expect in other cultures is balanced by a cultural characteristic in the pride of the local people in the job they are doing. To maintain alertness in the lab technician who reads the blood smears, positives are inserted among the routines. The third factor that seems to favor maintenance of the malaria free situation is the popularity of mass campaigns. That is with the support of the village leaders, the villagers turn out almost to a man to be checked for the disease of the day.

On the other side of the ledger however, a constant threat to the introduction of the plasmodium into the vector is an increased contact with the endemic areas of the world. The dwindling importance of surveillance as we get further away from the years when the disease was a problem will be an increasingly significant factor as the years increase. Public health problems in the past and necessarily, unfortunately, into the future will, to some degree, be the stamping out of the biggest fire or disease that is recognized, and where there is a fire extinguisher to be used.

This approach to budget, manpower, popular concern and therefore, cooperation, will always exist to a greater or lesser extent.

The recognized number one public health problem in Okinawa is tuberculosis. Recognized as a problem—a significant fire—in the late 40's, an organized program was initiated—with case finding and home care as the key stones for control. Beds, manpower, budget were mobilized and using reported annual death rate as a criterion produced results that can be compared not unfavorably with the BCG program that was simultaneously being conducted in Japan. Having embarked on a country-wide program based on case finding and home care, it is understandable that there is a desire to maintain the same direction and not abandon a program that appears to be holding its own after making some very real gains. Almost 3/4 of all of the public health nurses' time is devoted to the care and supervision of these patients and the maintenance of the home care program and contact tracing. Pride in their job makes it difficult for them to accept single purpose workers to assist in good surveillance and home care. It is becoming increasingly difficult to assure proper isolation at meal times and 24 hours a day. The large number of cases makes timely administration of the program inherently difficult. There are administrative delays at both ends of the course of disease, i.e., from case finding there is a delay to isolation and initiation of treatment, and on the other end of the disease there is a delay from the biological cure to removal of the case from the care program. To provide the best treatment for the greatest number in face of a shortage of TB beds—an arbitrary hospitalization of 6 months was set, this sends a fair number of communicable cases back into the community which could be acceptable only if home care was ideal. This group finds itself without the government subsidy for

livelihood they received while hospitalized which tends to drive them back into the labor market with all its connotations, that is, regards spread of disease, both externally, and internally. A strong and continued effort by individual physicians brought BCG into use as research projects by some and for high risk contacts by others. The first concerted effort to use BCG will be this spring when the 8th graders will be given BCG throughout the school system. This age group was selected primarily as past surveys indicated a significant increase in incidence after leaving school and to allow for a year's follow-up and re-check on tuberculin skin test. The administrative advantage of using the school system is obvious.

LEPROSY

Leprosy has been endemic in the Ryukyus for centuries, but it was not until 1938 that an institution for the care of leprosy patients was erected in the village of Yagaji in northern Okinawa. This facility and a sister hospital in Miyako can accommodate over 1,000 patients. While the true prevalence of leprosy is unknown, it is estimated to be approximately 1.5 cases per 1,000 population. With the advent of sulfone therapy in the late 1940's, the prognosis of even the most severely afflicted victims has brightened considerably, and we believe it is entirely accurate to say that in 1967, leprosy in the Ryukyus is more a social than a medical problem.

Public fear of this disease is the main obstacle to its eradication. It leads directly to delays in seeking medical attention and a high rate of deformities, most of which could be avoided by early diagnosis and prompt treatment. From the public health standpoint, this tendency of leprosy patients to temporize and procrastinate exposes vast numbers of people to the disease. If patients are often lethargic in seeking care, most are still more lethargic about leaving the institution and returning to a productive role in society. A large part of this problem is the patient governing council at the institutions which, in its efforts to make living more comfortable within the institution and establishing group identity and support for the individual ego, has unwittingly tended to defeat efforts to discharge and rehabilitate patients to society as productive citizens. Unfortunately, a really adequate program to rehabilitate leprosy patients and to develop in them marketable skills remains on the planning board and in the minds of a few. Little is done in this area outside of providing them with a place to live and the creature comforts, a practice which reinforces their segregation.

On the positive side, much has been accomplished in leprosy control since the late 1940's. The institutions themselves are entirely adequate for patient care and the quality of care is good and getting better with the combined assistance of the USPHS Hospital for leprosy at Carville, Louisiana and GOJ leprologists. The number of persons discharged has been rising steadily and a small home care program has developed over the past 4 years and now serves about 400 patients, some of whom have never been admitted to either leprosy hospital. Thus, there is grow-

ing emphasis on out-patient and home oriented care and a de-emphasis on institutionalization. The ultimate aim here is to reduce leprosy to the status of infectious diseases generally and to strip it of its unique aura of despair.

There is considerable activity and equal concern in the area of Hansen's disease. However, the great unknown is the actual extent of the disease. This cover of under-reporting is in some cases the sympathetic physician not wanting to burden his patient with the potential social stigma—neither the patient nor the physician willing to serve as the fulcrum to change popular concepts.

VENEREAL DISEASE

Venereal disease, like leprosy, is primarily a social problem. These diseases should have, in theory, been eradicated long ago. They are completely curable by a regimen of drug therapy which does not place excessive demands on the patient. In the Ryukyus, treatment facilities are readily accessible to the patient and a newly developed contact tracer system exists to ferret out secondary and tertiary cases. With all these pluses, it seems odd indeed, that this problem has actually changed little over the years.

One frequently voiced explanation is the large transient troop population. However, a serologic survey of bar and teahouse girls in Miyako in 1963 revealed positive serologies in 38%, yet the foreign population in Miyako is negligible. More important than the presence of soldiers is a general public tendency to regard the disease as unimportant, easily treated, and self-treatable. Penicillin, tetracycline and other antibiotics are available in low dosage tablets without prescription and legion are the numbers of V.D. patients who simply treat—i.e. undertreat—themselves. This inadequate therapy contributes to the emergence of resistant organisms, and the spread of infection to contacts, and the under-reporting of the disease. Contact tracing is widely regarded as an invasion of individual privacy and the inauguration of the GRI contact tracer program was vigorously opposed on these grounds. Another factor contributing to the persistence of V.D. is the lack of a standardized treatment routine. Each physician treats each case as he chooses and inevitably some patients are under-treated. The exact prevalence of V.D. is not known without certainly because of under-reporting. In 1965, 1,096 cases of GC and 1,791 cases of lues were reported although actual cases were perhaps 3 times higher.

FILARIASIS

Filariasis control began in January 1965 on the island of Miyako where almost 20% of the population was found positive for microfilariae. At present, after 27 months of control work, only 3% of the population remains positive and there ap-

months of control work, only 3% of the population remains positive and there appears to be every reason to expect this disease to be wiped out in the rather near future. A similar program has just started in Yaeyama and tentative plans call for the program for Okinawa to begin in 1968. Without exception, this program has been a most successful one. However, it is operating in a population accustomed to and fond of mass campaigns. The anti-filarial drug, diethylcarbamazine, while far from ideal, is adequate, and the vector control aspects of the program are well known to both the technicians and general populace because it is identical with methods used in malaria control. In addition, an added stimulus has been an academic interest by scientists from all three participating governments, GRI, GOJ and the U.S.

There have been few problems of consequence encountered. The largely asymptomatic nature of the disease in its quiescent periods has not impeded efforts to examine people; the examining rate has been about 99% since the program began. The great inherent weakness of the program is the island-by-island approach necessitated by limitations of manpower. This approach carries the danger of reintroducing the disease, but even this has not been an apparent problem yet.

TRACHOMA

The control of trachoma has proven to be one of the great challenges in modern public health. Unfortunately, control is very difficult in spite of a variety of effective antibiotics. All too often, cured patients simply become reinfected in a short period of time. The ultimate control of this disease depends not on drugs but rather on improved personal hygiene and community sanitation. To make matters worse trachoma is a difficult disease to diagnose and examination of the patient is often unwelcome because the condition is asymptomatic until quite late, and in many cases runs its entire course without pain or even significant itching.

Trachoma control in the Ryukyus is hampered by limited trained manpower. Present efforts encompass children of primary and junior high school age in Okinawa. U.S. Special Forces personnel are responsible for the program in the offshore islands where an attempt is made in the smaller communities to examine everyone. In urban Naha, the prevalence of trachoma among school children is 4.6% and is more common in children of junior high school age than in younger children. The rate among school children in the rural offshore island communities is much higher, about 28%. Tetracycline ophthalmic ointment is curative for trachoma and is being used in our program, but it stings and requires active participation. Although limited in scope, the program is well organized and well received by the people. The great hope of this program is that cured patients will remain so long enough for advances in sanitation (sewer system) to catch up and hopefully assist in the disease control effort. With basic sanitation improvements and education, and training, this program can show its effects.

JAPANESE B

Because of the severity of this disease (the crippling residuals combined with the fatalities) a considerable portion of the budget is designated for its control. Efforts in research go unrecognized as an influence in eradication until the expended effort is fruitful of information and that information can be translated into a practical control measure.

Although Okinawa's rate is lower than that of the islands north and south of us, we can claim no credit for this low rate as it has been low for years. Inferentially from the distribution of cases it is expected that there is an early immunity established that is not as yet discernable in either complement fixation or agglutination studies. An effort has been made to keep the arms and legs of the children covered when they are out of doors at dusk or after dark, however, there is no evidence that this either has had an effect in the incidence of the disease.

On the other hand, the factors working to increase the incidence of the disease are equally evasive. The reservoir, if it is the pig, obtains the virus in the first 3 months of its life. Work continues to produce a vaccine that crosses the placental barriers of the sow and protects the piglet. If this can be worked out and if the pig is a significant source of the disease, then the control of the disease in the pig will decrease the incidence of the local disease.

POLIOMYELITIS

In any disease where the tools for eradication are available, the actual eradication depends on getting the treatment to the patient. In the case of polio, eradication means getting the vaccine to the susceptible. An epidemic in 1957 provided the impetus to join all factors in adequate quantities to produce the desired results. It was fortunate timing that an effective vaccine was available. The other factors involved were manpower, cost and population acceptance. The popular survey and mass campaign were instrumental in reducing the incidence to near zero for the last several years. On the other hand there are encumbering efforts to incorporate polio immunization and all other immunizations in a total care plan for the individual. Until recently, when refrigeration was available in all sub-health centers, the health centers couldn't keep biologicals that required refrigeration for longitudinal individual total patient care. Using the live attenuated oral vaccine in the infant has secondarily immunized at least some of the other susceptible family members. This leaves an unknown number of the population at risk. Immunization of infants with Diphtheria, Pertussis and Tetanus presents the same problem, so all infants are immunized in September, October and November in an annual mass campaign. This leaves the infant born in December at high risk the following fall of Diphtheria, and indeed, this is borne out in reports. Tetanus in the newborn will remain a problem in the remote areas until all deliveries are attended by trained professionals.

As a multi-island community, this facet of care ties in with adequate transportation, communication and the economy of the smaller and more isolated communities. Tetanus is not only a problem of the remote areas, but remains a significant medical problem that will be eliminated only when health care and health education is improved. As pertussis has always been a weak antigen, as available in commercial vaccines, I look to new developments here before we can speak with assurance of eradication.

Measles vaccine will be included in the budget as soon as the Health Department can Persuade those who control the budget on its necessity, this pressure unfortunately must include to some extent, popular demand.

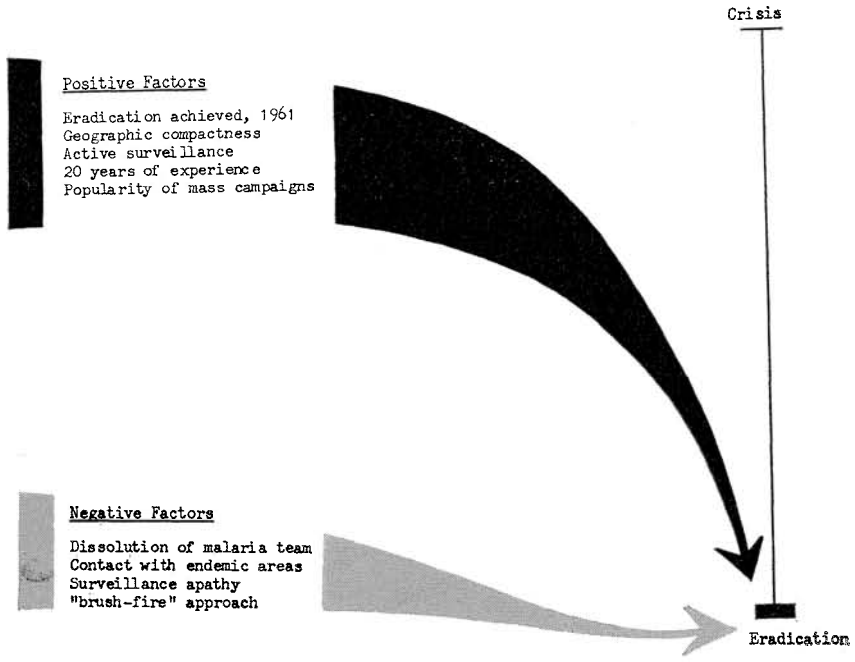
INTESTINAL PARASITES

As the incidence of parasitemia relates inversely to basic sanitation and effective health education, it is of interest that the impetus of concern is from the medical profession rather than the health department. Our present program is given significant guidance and assistance from Japan's Nagoya University, particularly Dr. Katoh. This program has been economically a drain (individually and collectively). There has been considerable world wide effort expended in treatment prevention and public recognition of the problem. These same factors apply to Okinawa with the greatest effort toward public recognition of intestinal parasites as a problem which is the first step in eradication. This is being done in conjunction with diagnosis and treatment surveys.

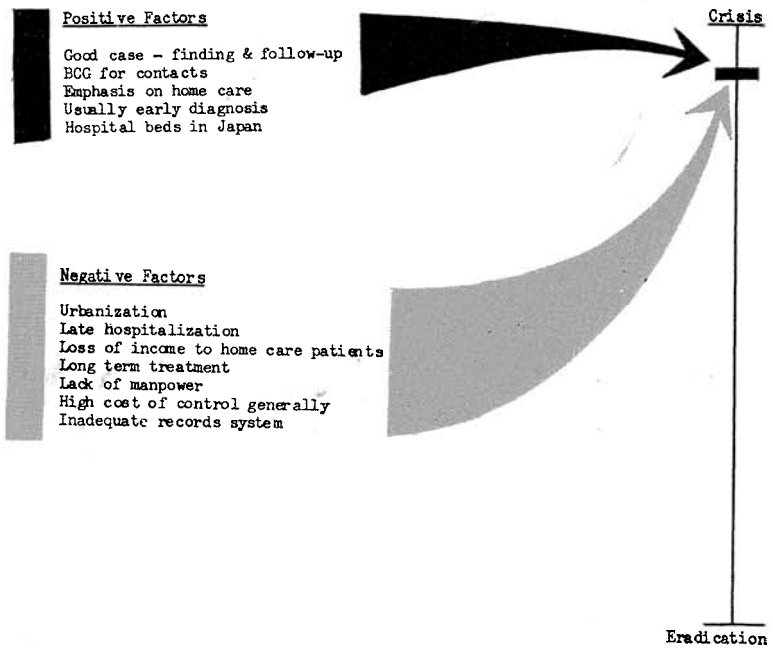
SUMMARY

I've presented the factors influencing the more significant public health programs as we see them in the Ryukyus. These are the same factors influencing health in comparable areas throughout the world, however, with different weight and priorities and at different stages of success.

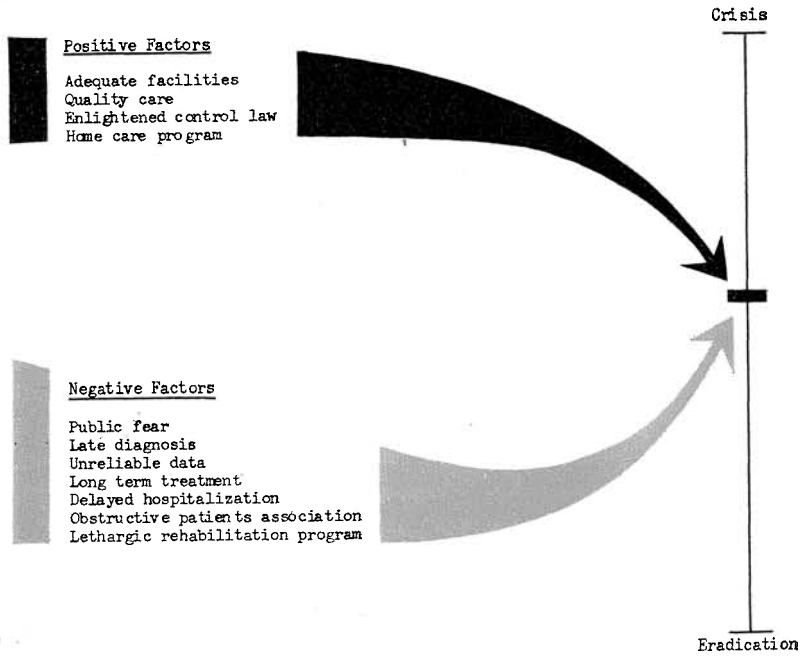
DYNAMICS OF MALARIA CONTROL



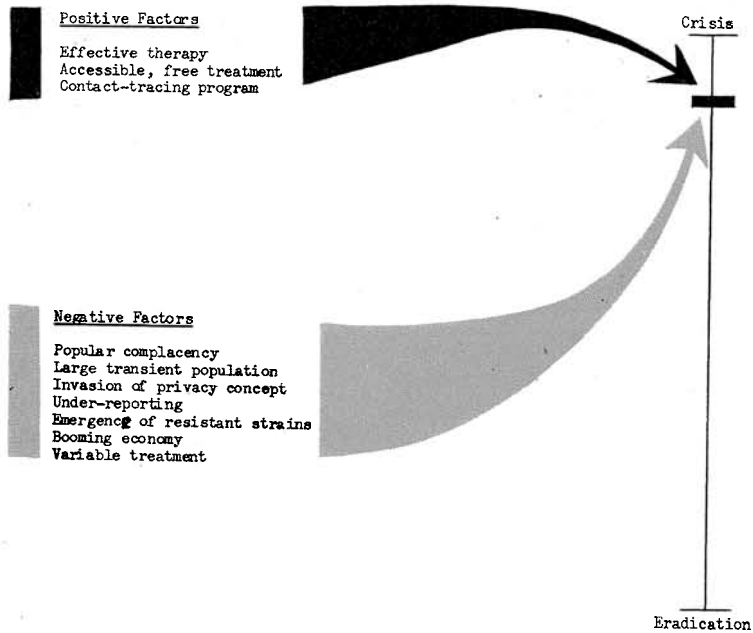
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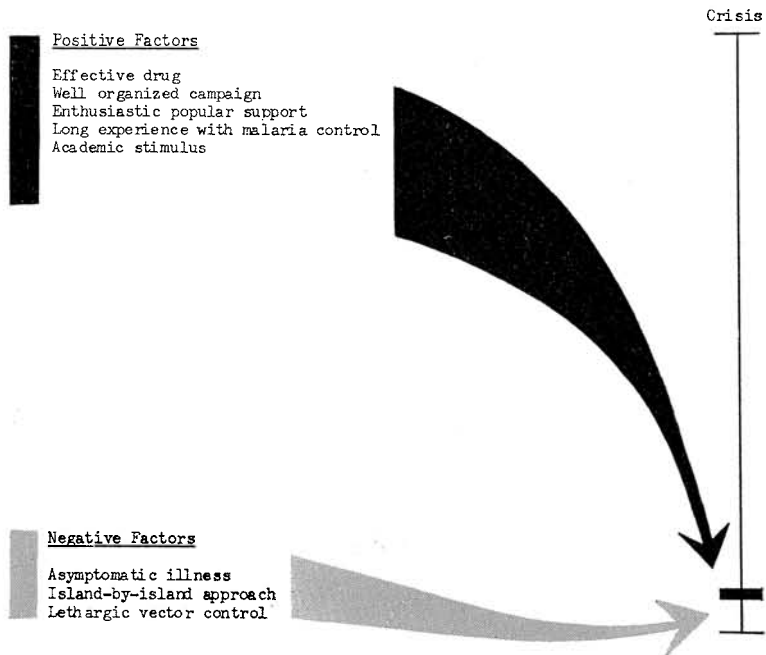
DYNAMICS OF LEPROSY CONTROL



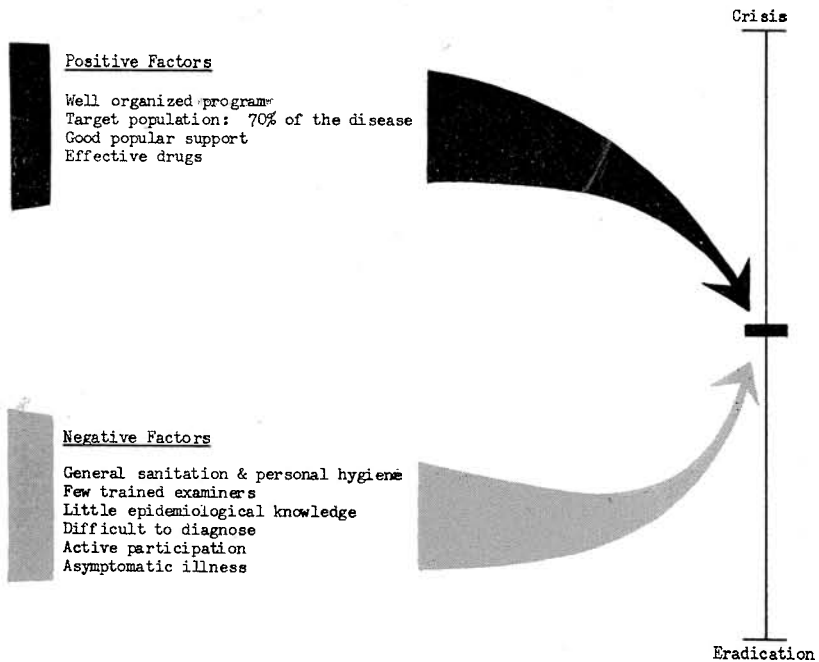
DYNAMICS OF VENEREAL DISEASE CONTROL



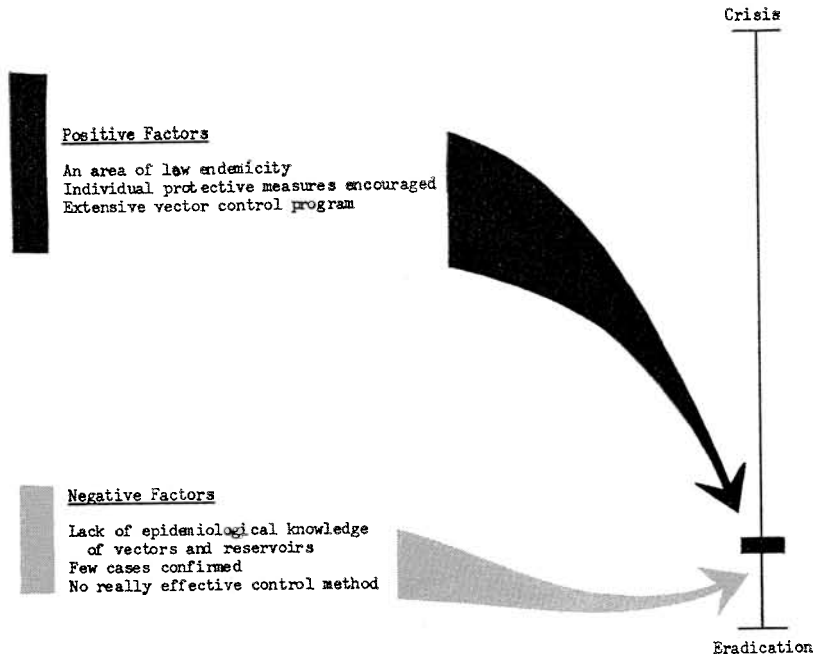
DYNAMICS OF FILARIASIS CONTROL



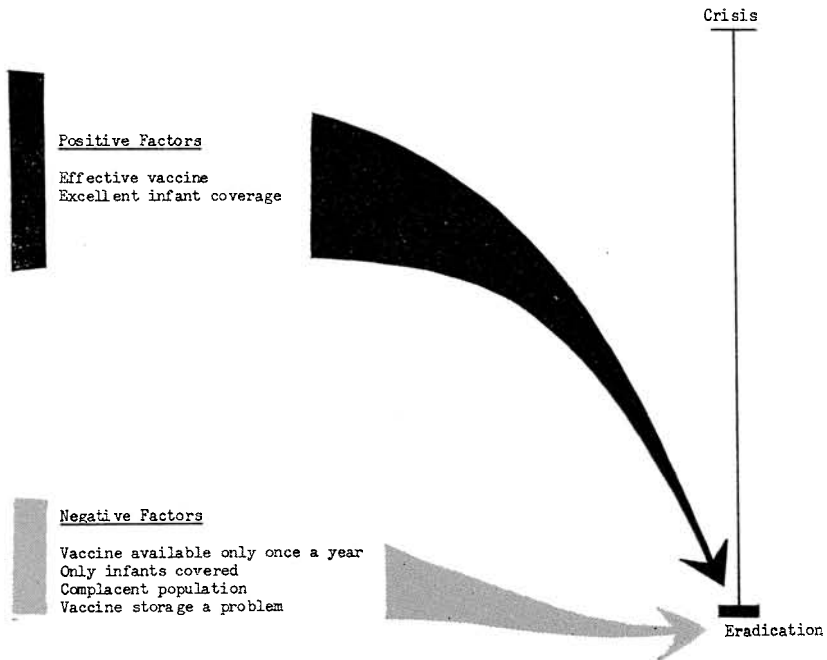
DYNAMICS OF TRACHOMA CONTROL



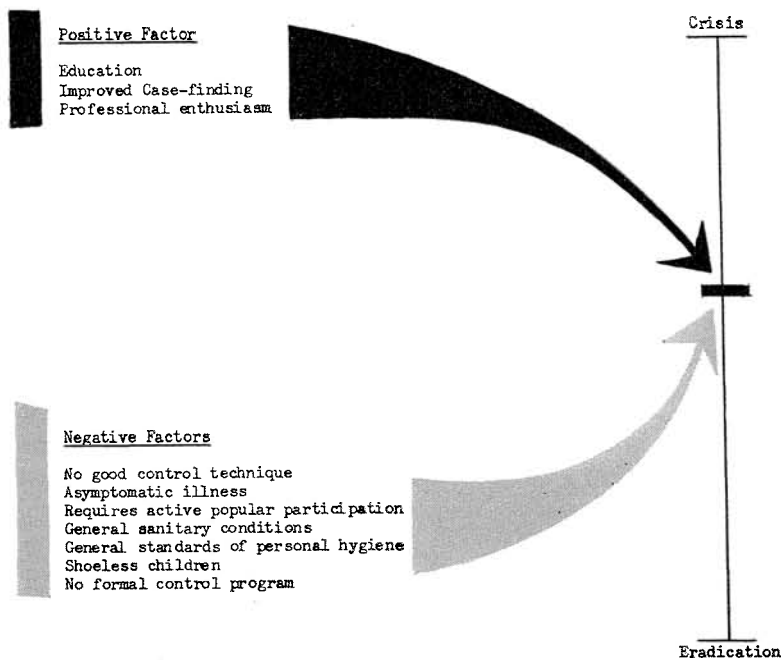
DYNAMICS OF JAPANESE B ENCEPHALITIS



DYNAMICS OF POLIOMYELITIS



DYNAMICS OF HOOKWORM





Dr. KATSUNUMA
(Chairman)



Dr. de DIOS *(Philippines)*

Medical Security in The Philippines

Victorino de Dios, M.D.

The medical security for the people can be divided into

1. Government Medical Agencies;
2. Semi-government Institutions or Voluntary Medical Institutions;
3. Private Medical Institutions;
4. Different Medical Associations;
5. Individual Medical General Practitioners.

BY THE GOVERNMENT

A. The Government Service & Insurance System (GSIS) and The Social Security System (SSS)

The GSIS is a life security dealing with all government employees while the SSS is a life security dealing with employees in private establishments and companies.

The GSIS and the SSS Provide sickness, retirement, disability and death benefits.

Retirement: Upon reaching the retirement age of 65 he will receive a monthly pension for life.

Sickness: When a member become sick, he is entitled to 15 days sick leave and if sickness is more than 15 days the system pays only one-half of his salary for the period of four months.

Death: Beneficiaries recorded in the book of the system shall be entitled to a benefit equivalent to 100% of the average monthly salary times the number of years in service.

B. Government Hospitals:

Ninety percent of the total bed capacity of government hospitals is for indigent patients with free medicine and other medical services while the remaining ten percent bed capacity is for paying patients. These hospitals are holding free dispensaries and domiciliary services daily.

C. The Provincial, City & Municipal Governments Health Centers and Chest Clinics:

The provincial, city and municipal governments are maintaining health centers and chest clinics in different strategic regions, giving free consultations and medicines especially to children and mothers. They also extend obstetrical domiciliary services. While the chest clinics are giving free chest x-ray and consultations.

D. Rural Health Units In Different Barrios:

There are about 1,400 health units in different barrios where there is no practicing doctor. If physicians employed in these health units is able to establish his own clinic he can resign from the government. The purpose of this health clinics is to induce doctors to practice in places where there is no physicians and at the same time make the people health conscious.

E. Leorosaria In Different Regions:

Patients suffering from leprosy are confined for treatment but in some cases due to the nature of his illness, the patient can stay with his family and go to the hospital only for treatment.

F. San Lazaro Hospital:

This hospital is for infectious diseases. All patients admitted in other hospitals suffering from infectious diseases are immediately transferred to the San Lazaro Hospital. There are only few beds for paying patients. It is compulsory that all infectious diseases be confined in this hospital.

G. Labor Compensation Act:

All private and government establishments shall give emergency medical treatment to any of its employees who become sick during his employment and the corresponding compensation for any occupational injury causing temporary and complete disability or permanent and complete disability. The employees are also entitled to 15 days sick leave and 15 days vacation leave within a year, to pension at retiring age, likewise female employees are entitled to maternity leave of 4 weeks before delivery and 8 weeks after delivery. Some companies even attend the medical services to families of their employees.

SEMI-GOVERNMENT INSTITUTIONS OR VOLUNTARY MEDICAL INSTITUTIONS

A. The Quezon Institute:

This institute is for tuberculous patients only. Its present bed capacity is 1,375

only, and 1,725 beds more in different regions or a total number of 3,100 beds which is inadequate to cope with the present number of TB patients. Ninety percent of the total bed capacity is set aside for charity and the remaining ten percent is for paying patients.

B. The Philippine National Red Cross:

The PNRC, through its different committees, renders important services to the public. The most important committees are the Blood Bank and the Disaster Relief Committees. The PNRC is giving away to the public 65,000 to 70,000 bottles of blood (250-500 cc) a year. The actual public need is 120,000 bottles a year. There are four regional Blood Bank Centers in the Philippines which supply the public demand.

C. The Philippine Cancer Society:

The Philippine Cancer Society maintains free cancer clinics for diagnosis, treatment and research.

PRIVATE INSTITUTIONS

A. Far Eastern University, College of Medicine:

On a voluntary basis interns in this university are sent to clinics of some private practitioners in the provinces or in remote areas. They stay there for two weeks to one month. They attend surgical and medical cases in a rotating basis. Their accommodation and food are provided by the local officials and civic-spirited families in that region. These interns are assigned from one place to another so as to acquire as much experience as possible.

In this university a certain group of faculties and students also form a unit to render medical services in the remote places on a voluntary basis and the drugs are supplied by some drug companies.

B. Manila Central University, College of Medicine:

The M.C.U. has created the Community Medical Program wherein interns are required to go to health centers every day to observe environmental sanitation and the prevailing communicable diseases in the region. They make a final report to the government officials concerned. This system is compulsory and it is included in the curriculum of the college.

C. U.E.R.M. Memorial Hospital:

This college send interns to clinics of some medical practitioners in the provinces to practice and observe for a period of two weeks so as to accustom them to rural practice with the hope that after graduation they may establish their own

clinics in rural areas. This system is compulsory for every interns, for this is included in the curriculum of the college of medicine.

D. University of Santo Tomas: (U.S.T.)

Its project is a medical mission sending students and doctors to remote regions or to mountainous areas and stay with some hospitals for 1-2 weeks giving medical or surgical services to the poor people. It is a voluntary service on the part of student interns and doctors of the hospitals.

E. Family Planning Association of the Philippines:

Recently birth control was advocated in the Philippines by the Family Planning Association of the Philippines, because of the fast growth of the population which is not in proportion to the food production and socio-economic condition of the country. Therefore, certain remedial measure are being implemented to regulate the birth rate by using contraceptive pills or other medical divides to limit the number of children or spacing the pregnancy.

Clinics are establish in different regions giving advises to married women the manner of preventing or spacing pregnancy. This method will ameliorate the poverty of the family and promote the well-being of the mother as well as the children. This plan also gives advises to couples who has no children.

All the above mentioned medical services, to certain extend, is a form of socialized medicine. But its volume of service is very insignificant to coup with the need of the population. The greater volume of services about 80% is rendered by private medical practitioners especially the general practitioners or family doctors. But, unfortunately, the private medical practitioners are crowding in big cities and urban areas which causes the mal-distributions of doctors which is the main cause of the situation wherein 60% of the population died without any medical assistance.

But, it is hoped with the present new concept on medical care, we need more general practitioners or family doctors.

The government as well as private sectors concerned with medical service are trying to develop socially and economically the rural areas and to promote the welfare of the people. Then the new graduates will be attracted to practice in rural areas.

In the Philippines, any form of socialized medicine is being opposed by the medical profession as it will endanger the freedom of the medical practice. The close-knitted relationship between patients and doctors will disappear and it will retard the progress of medical science. And besides, the Filipino costume, tradition and the socio-economic life of the people are not adoptable to socialized medicine.

JAPAN MEDICAL PUBLISHERS, INC.

1, 2-chome, Kanda-Nishiki-cho,
Chiyoda-ku, Tokyo
Tel: (291) 8832, 5033

President: Takashi Okada

Directors: Fumio Miyasaka

Printed by Japan Printing Co., Ltd.

Subscription Rates: Single issue, US\$1.00
£0-7-2 ¥360; 12 issues US\$12.00, £4-6-0
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