cerebral tissue, using MRI, as little as 4 hours after the onset of symptoms. (In comparison, approximately 50% of infarcts are not visible on CT for the first 24 hours). This has important implications if current trials demonstrate benefit from early thrombolytic intervention in patients with acute cerebral infarction.

The development of hydrophilic guidewires, smaller vascular catheters, and embolisation coils and balloons, has lead to a rapid expansion of interventional procedures performed in the CNS. Now the radiologist can freely explore where even the bravest of surgeons fears to tread, with coiling being the preferred treatment for basilar artery aneurysms, and embolisation an important therapeutic option in the management of intracranial arteriovenous malformations. Surgeons may have developed keyhole operations, but radiologists have been performing pinhole therapeutic procedures for several decades, and the advances continue apace. Trials are presently underway to assess the value of radiological intervention in many intracranial lesions, including coiling of non-basilar aneurysms, and carotid angioplasty versus surgery for the treatment of carotid stenosis. The results are eagerly awaited.

With the major methods of imaging now established, advances in the field of image integration are now emerging. Several exhibits were on show demonstrating combined images using several techniques, such as CT and MRI, or PET (position emission topography) and MRI scans in imaging the base of the skull. However, though aesthetically pleasing to look at, the production of the final images were evidently still incredibly labour intensive, and considerable development will be required before these methods are available in clinical practice.

There were a few disappointing aspects of the meeting. Though hailed as the world's forum for the presentation of new work, the content of some of the papers was poor. In several of the studies the number of subjects was small, and the scientific method rather dubious.

There was a noticable lack of awareness (or denial) of the importance of radiation protection amongst the American radiologists. The Royal College of Radiologists of Britain has recently highlighted the significant contribution of CT to patient exposure to ionizing radiation, and the importance of trying to limit this. The philosophy in the US seemed to be that of 'Why do an MRI when CT is cheaper?'—presumably the effect of the tightening financial belt on the American health service. 'Cost effectiveness' was the phrase of the week.

Memorable moments of the visit included a video trip into 'virtual CT', the audience propelled into a 3-dimensional image of a patients body which could be examined from any position. There were examples of virtual bronchoscopy, guiding the physician to the optimal site for biopsy of an occult submucosal lesion, and aortography, viewed as if one were sitting in the lumen of the vessel.

There was one exceptional exhibit, and that was a computer reconstruction of 'virtual man', created from a cadaver sliced into 1 mm sections and digitally imaged. Exquisite high resolution images of the entire body could be viewed in any plane (with CT correlation, of course). To use the word 'beauty' of someone cut into 1 mm thick slices may seem rather macabre, but the exhibit was a radiologists' dream—the ultimate aid to anatomy teaching.

I am grateful to the Royal College of Physicians for their generous support from the Myre Sim Fund.

Letters to the Editor

TROPICAL MEDICINE IN THE TWENTIETH CENTURY

Sir, This article, Power H. (*Proceedings*, 1995; **25:** 427–35) gives a full account of the development of tropical medicine, with 47 references. The author refers to the founding in Britain of two schools of tropical medicine, in Liverpool in 1898 and in London in 1899. Although it is literally true that only two 'Schools' of tropical medicine have existed in Britain, it is strange that there is no reference to Edinburgh.

In 1857 a course of lectures on 'Effects of Climate on Health and Disease and Hygiene' was given by A. W. Pinkerton (1829–1861) in the Edinburgh extra-mural School of Medicine. Pinkerton was elected FRCP (Edin.) in 1857 and died, aged 32 years, of a 'fever' in Aden. The University of Edinburgh founded a Lectureship in Diseases of Tropical Climates in 1898, the first lecturer being Andrew Davidson (1836–1918), and in 1899 he also lectured on tropical diseases in the extra-mural school. Edinburgh instituted a Certificate in Tropical Medicine in 1899 and in 1905–1906 the course for the diploma in Tropical Medicine and Hygiene (DTM & H.), shortly after a similar diploma (but after a shorter course) had been started in Liverpool and Cambridge, while specialised teaching in tropical medicine was also being given in London.

As Professor Alan Woodruff of London (FRCP London and Edinburgh) pointed out, when the unification of the membership examinations of the Royal Colleges was under discussion, with the consequent abolition in Edinburgh of 'selected subjects', the Edinburgh College was the only academic body which had been conducting, as a selected subject, an examination in tropical medicine more advanced than for a DTM & H. Since the abolition of the 'selected subjects' a number of courses and examinations of limited aspects of tropical medicine have been instituted by various bodies. There is a professor of tropical medicine in Birmingham, and research in specialised fields is carried out elsewhere in Britain, notably in Oxford and Glasgow, sponsored by the Medical Research Council through its Tropical Medicine Research Board.

With my retiral, in 1972, the Senior Lectureship in Diseases of Tropical Climates in Edinburgh and the DTM & H. (Edin.) fell into abeyance. The University departments which formerly contributed to the DTM & H. Course, viz. those of protozoology, entomology, helminthology, bacteriology, paediatrics, public health, etc., continued as formerly, but clinical practice in tropical medicine was taken over by the Department of Infectious Diseases, and *ad hoc* arrangements were made for lectures in tropical medicine. Probably correctly, the concept of tropical medicine is tending to be absorbed into that of global medicine. However, the Royal Society of Tropical Medicine and Hygiene (RSTM & H.) continues through its Scottish (formerly Edinburgh) Branch to foster tropical research in Scotland, the results being reported at Laboratory Meetings of the Society. In Britain, in addition to the organisations mentioned by Power, it should be noted that the RSTM & H. has its headquarters in Manson House in London and publishes a scientific journal. Also the Government sponsored Bureau of Tropical Diseases and Hygiene publishes the *Bulletin of Tropical Diseases* and *Abstracts of Hygiene*, surveying the world literature of these subjects.

The Wellcome Museum in London gives an excellent informative display of Tropical Pathology.

Power rightly notes that medical research also took place in tropical countries outside the British Empire, but does not mention that from the beginning of the twentieth century medical schools for the special study of tropical diseases were set up in Paris, Bordeaux, Antwerp and Hamburg. She describes the efforts of the United Nations Organisations to promote health and to prevent and treat disease in the tropics. She rightly records the disappointing results of the antimalarial measures, but does not mention the great success of the eradication of smallpox, or, regrettably, the emergence from the tropics of new pathogenic viruses to affect mankind, notably causing AIDS with its social implications.

Frederick J. Wright
75 Barnton Park View, Edinburgh EH4 6EL

MECHANISMS OF ASTHMA

Sir, The review by Holgate (*Proceedings* 1995; **25**: 360–79) clearly shows that the lung is a complex immune organ with a remarkable degree of autonomy in the manifestation of immunological reactivity; hence the discrepancy between the behaviour of lungs transplanted from non-asthmatic subjects versus the behaviour of lungs transplanted from mildly asthmatic donors to non-asthmatic recipients, the consequence being amelioration of asthma in the former instance and its persistence and progression in the latter.[1] What is even more remarkable is the immunological autonomy of the airways *vs* the alveoli within the same individual, rendering the co-existence of asthma and fibrosing alveolitis a clinical curiosity reported only once,[2] even though the immunological repertoire of cytokines, eosinophils, mast cells, and lymphocytes is available throughout all lung tissues.[3,4] How does this segregation come about, and why does it seldom break down even though the association of fibrosing alveolitis and elevated serum immunoglobin E is common?[5]

O. M. P. Jolobe
Tameside General Hospital, Ashton-under-Lyme

REFERENCES

[1] Corris PA, Dark JH. Aetiology of asthma: lessons from lung transplantation. *Lancet* 1993; **341:** 1369–71.
[2] Jolobe OMP, Asthma with cryptogenic fibrosing alveolitis could arise from altered immunity (letter): *Care of the Elderly* 1994; **6:** 346.
[3] Kay AB. T cells, cytokines and asthma. *J R Coll Physicians Lond* 1994; **28:** 325–31.
[4] Du Bois RM. Diffuse lung disease: combined clinical and laboratory studies. *J R Coll Physicians Lond* 1994; **28:** 338–46.
[5] Marsh P, Johnston I, Britton J. Atopy as a risk factor for cryptogenic fibrosing alveolitis. *Resp Med* 1994; **88:** 369–71.

College Affairs

Obituary

JAMES WILLIAM HOWIE

JAMES WILLIAM HOWIE

James Howie died on 17 March 1995 aged 87. He had been professor of bacteriology at the Glasgow medical school and director of the English Public Health Laboratory Service and had received many honours. He held the fellowships of the Colleges of Physicians of London, Glasgow and Edinburgh and of the College of Pathologists which he served as President in the 1960s. He was President of the British Medical Association in 1969–70 and BMA Gold Medallist in 1984. In 1972–73 he was President of the Association of Clinical Pathologists. He was appointed an Honorary Physician to the Queen and he was knighted for his outstanding services to Medicine in 1969. In the same year his alma mater honoured him with an honorary LL.D. He was notable for his quiet wisdom, his style and his enthusiasm, tempered always with thoughtfulness and caution. He had a flair for words and writing. He was a man of sincerity and integrity, who did an enormous amount in his lifetime for medical microbiology, for pathology in the wider sense and for his Church.

He was born on 31 December 1907 in Oldmeldrum, Aberdeenshire. His father, an auctioneer at Laurencekirk, was seemingly a hard man. James did not have an indulged childhood but he had the great advantage of an education at Robert Gordon's College, Aberdeen, and thereafter at Aberdeen University medical school where he graduated MB ChB in 1930 and MD with honours in 1937. In 1935 he married Winifred Mitchell who held a first-class degree in agriculture. Their homes were always warm and welcoming. He was an earnest golfer and was hugely encouraged when, at the age of 77, he got a hole in one at the 15th at Bruntsfield, Edinburgh, and repeated the feat 3 months later at the same hole. He made one of his sons very anxious by phoning him (to give him the news) 20 minutes before the starting time for the cheap rate. His politics, when they showed, were well right of the fairway. Once, as James came off the tee at Hampstead, Harold Wilson complimented him on his drive and asked how he did it. The answer was, 'By keeping a firm grip on the left, Prime Minister', and James looked round with his inimitable hint of a smile. A man of emphatic likes and dislikes, he loved the music of Beethoven, Bach, Wagner and Schubert.

From Aberdeen he went to Glasgow, where he obtained clinical microbiological experience. He served during World War II with the RAMC in Nigeria and then at the War Office in London. His early experience of the Civil Service in London was to stand him in very good stead in his later career. He

Photograph reproduced from the portrait by Sir William Hutchison with permission of the Royal College of Pathologists.