EDITORIAL

CARDIOLOGY IN SINGAPORE

On May 21st, 1960, the first local attempt to do a repair of atrial septal defect under direct vision was made successfully. To those who are keen on diseases of the heart, this must indeed appear an important landmark in local cardiology; and indeed this case but signified the beginning of a new field, namely, that of open heart surgery; for within a matter of days, two more cases, one an atrial septal defect, and the other a pulmonary valve stenosis, were operated successfully. To achieve this success, it means that physicians interested in cardiology must learn to diagnose accurately and assess correctly, so that suitable cases might be selected for surgery; the radiologists had to master new technique, particularly with regards to angiocardiography; the anasthetists were faced with fresh problems in hypothermia; and the surgeons must acquire new skill in cardiac repair. A team work, which begun many years ago in sporadic individual effort, has resulted in the achievement to-day, for there would be no cases for operation without the diagnosis, and no purpose in diagnosis if surgical treatment was not forthcoming.

It is profitable to recall that the first attempt to ligate a patent ductus locally was in 1950, and the lack of success reduced cardiac surgery to pericardectomy and occasional suture of traumatic injuries of cardiac muscle. In 1952, attempts were made to introduce angiocardiogram as it was realised that without a definite diagnosis, surgical intervention would be both hazardous and foolhardy. It took four years before the first satisfactory picture was obtained, and it took another two years before the technique could be made reliable enough to be of definite diagnostic value. Much of this delay could be ascribed to two factors: firstly, the lack of proper equipment, and a great deal had to depend on the improvisory ingenuity of the staff, and secondly, the lack of team work so that each investigator had to grope about on his own, relying on foreign reports, and a painstaking evaluation of his own hard-earned experience.

Nevertheless, these poorly coordinated efforts produced results, and in 1958, a case of tricuspid atresia, probably the oldest on record, was diagnosed premortem; and before the year was out, first, the ligation of patent ductus, and then, the splitting of valve in mitral stenosis were attempted; and by 1959, two cases of Fallot's tetrallogy were submitted to Blalock's operation successfully.

Thus the moment was opportune and the setting correct for a new venture to be made. All that was needed was a new impetus, which came in the guise of a visitor, Dr. B. Eiseman, who came as a visiting professor of surgery from Harvard. It would be painful to recount the discussions, the animal experiments, the improvisation of apparatus, and even the ironing out of personal differences, but finally, the difficulties were overcome, and local doctors launched into a new field with happy results. This success at a period of increased demand for the services of the doctor, and even greater increase in the shortage of staff must indeed be a refutation to those local malicious libels let loose against institutional specialists a couple of years ago; for without the elbow grease that spelt many hours of work over and above what was normally accepted as office hours and demanded as routine work, and at the expense of individual rest, recreation, and even food, it might take another ten years before the present success could be achieved.

However, it should be remembered too that beyond open heart surgery, there are still fields galore. The physicians still have a long way to go to achieve the objective of prevention of congenital and acquired anomalies, the surgeons still have to aspire after extra-corporeal circulation so that a leisurely and more perfect repair can be made, and the technical-minded still have to begin cardiac catheterisation, and studies in cardiac haemodynamics. What is needed now is a realisation of the value of team work so that interested individuals can come together to evolve special services of cardiac units, neurological units, and whatever else that is necessary for the service of the local sick. We need hard work, more staff, more money for equipment and staff training, and more enthusiasts; but above all, we need that appreciation of the need of teams if local medicine is to make rapid progress. May 21st should not mark the end of a professional quest, but the beginning of a new academic venture.