

Newsletter No.94 - October 2004

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Dear Colleagues

May I take the opportunity of opening this letter with a digest from one of our founding fathers. What follows is the experience of a generation.

“The Good, The Bad and The Ugly” by Geoffrey Walker, Hon Member World Orthopaedic Concern

This is a summary of an account of forty years of some of my ‘WOC’ activities in the developing world. It was presented to the International Council in Luxor, September 2003 and subsequently to SICOT, with whose permission this is reproduced.

My interest in the orthopaedics of the developing world started when, in 1960-1962, I was the second registrar to be sent from the Royal National Orthopaedic Hospital in London, to Kano and Ibadan in Nigeria. Later as a consultant in the UK National Health Service I was allowed and encouraged to spend a few weeks every two years teaching in several developing countries. After early retirement, I worked for the British Council in Addis Ababa for two years. I taught in many countries and started, and then edited for ten years, the WOC Newsletter. I have also served as Secretary-General and President of WOC (International) and for nearly twenty years I acted as linkman between WOC and SICOT. I have divided this autobiographical presentation into three sections: “The Good, the Bad and the Ugly”.

The Good: WOC, often in association with other similar organisations, has had some success in establishing and then developing orthopaedic training schemes in several countries. I was particularly involved with **Dr Ron Garst’s** excellent work in Dhaka, Bangladesh, which he started in 1972 in response to an appeal from the new government for help with the many amputees resulting from the recent war of Independence. When I arrived, a few months after Dr Ron Garst had transferred his attentions from Ludhiana, I found that he had already established a 150 bed orthopaedic hospital, and was training doctors in orthopaedics. Over the following years I made 13 visits to Bangladesh and am

happy to report that some 300 orthopaedic surgeons there have completed their training, of whom the majority work in their own country. Help from 'visiting general orthopaedic surgeons' has not been required for some years, and so we have met one of the basic criteria of WOC which is **'to work ourselves out of a job'**.

Similar successes have followed, notably in Indonesia with American, Australian and Singaporean help. Others include Uganda, Malawi, Zambia and Nepal. A locally established 'anchor man' is essential. From the start one has to teach surgery in general and basic sciences in addition to orthopaedics. WOC's experience has resulted in these principles that training should be: (1) in the country in need (2) on the local orthopaedic problems and (3) with the facilities locally available. University and government support is essential, as well as the creation of appropriate posts for the graduates. Once this medical ball is set in motion, it generates its own momentum.

As well as training in the arts of listening, examining and thinking we concentrate on teaching fundamental principles namely 'Doctors treat patients with fractures, they do not treat x-rays, splints, traction, plasters and, least of all, metallic implants'. 'Primary closure of compounds should rarely be attempted.' 'Post-operative care is vital and should be part of an overall plan made when the patient is first seen.' 'Avoid metal as far as possible.'

The Bad: The Ethiopian training scheme has had some success in the 14 years since it was established, but alas several of its graduates are now working 'outside'. This is always bound to be a problem when personnel are trained 'to an international level'. Their expertise becomes 'an international commodity'. The last two department heads in fact have migrated from Addis and are now in the United States.

Insurrection, civil wars, and intolerance, often over land and women, or for tribal or religious reasons, are matters beyond our (or anyone's) understanding or control. The population in developing countries seems to double every 20 to 25 years. Low gross national product (GNP) remains low often because of crushing debt and interest charges. Alas attempts to improve this often founder as a result of the population explosion and mishandling of the economy in manners quite beyond our understanding. I am often asked how the orthopaedic/medical services of an area can be improved. It seems to me

that really there is only one basic requirement; to improve the GNP. But this is very much easier to state than to bring about.

Private practice would seem to constitute a threat to the common good. When younger I used to be rather against private orthopaedic practice in developing countries, but with the passage of time, I now think that much good can come of it - providing certain criteria are met. Through it, doctors can make a reasonable living and are thus encouraged to remain in their own community and country, but it is difficult for them to manage outside the capital or other larger cities because of the lack of modern equipment with which to practice what can be read about in every journal - again largely an economic problem. Private practice results in patients being treated. Those who are wealthy would otherwise seek treatment 'outside'. The fact that successful treatment can be provided near their home inspires community pride, a self-perpetuating commodity.

However private practice must be kept in perspective. I am very much in favour of a certain amount being encouraged in university and other hospitals, providing that the practitioners honour their contracts and perform their teaching and other duties. For visiting surgeons to encourage and support the resident surgeon in his private practice will have a beneficial effect in these situations. He must never appear to be taking private work from the local man.

The Ugly: Late arrival and late presentation of penetrating wounds is to some extent inevitable, the result of distance from medical centres and poor road communication. The use of noxious materials, both internally and externally, add unknown morbidity. We only see the bad results of the work of traditional healers. The orthopaedic problems from too tight plasters, result in gangrene or contracture; and yet all is not lost. An Ethiopian colleague working outside Addis Ababa has succeeded in organising a well attended short course for traditional healers (112 participants), explaining the danger of 'too tight splintage', and how to avoid it. This has resulted in a dramatic decrease in patients presenting with iatrogenic gangrene and contracture. The details of this work await publication in the Journal of Bone & Joint Surgery.

But traditional healers are very secretive about their work and the treatments they use. It is practically impossible for a 'foreigner' to see them at work, but this is something which

our host colleagues should be able to influence, as their own personal reputation increases.

In conclusion it is salutary to realise that many of the orthopaedic problems now encountered in developing countries, were our own “bread and butter” not so long ago (70 - 100 years perhaps). Most if not all are now rare in the ‘West’. At least in theory, they should also be eradicated throughout the entire world.

For those with an interest in spreading our hard won experience, my final comment is that working in the developing world may at times be frustrating, but is always immensely rewarding. The effect of passing on our own lessons, sometimes bitter ones, is instantly apparent. Successive visits to one hospital always reveal improvements in which the visitor may feel some pride. Principles are absolute; standards may be relative, but we are too long in the tooth to let them slip.

Further information can be obtained either from any of the regions of WOC (via the Web) or from me at Geoffrey.Walker@Bigfoot.com

MESSAGE FROM THE PRESIDENT OF INTERNATIONAL WOC

Mr Kenneth Tuson, the President of WOC, is pleased to welcome the representatives of two new chapters, **WOC (Sri Lanka)** namely **Dr Sritharan** as President of WOC (Sri Lanka) (e-mail: dr_sritharan@yahoo.com), and **Dr Iqbal Qavi** who is the linkman for WOC (Bangladesh) which held its inaugural meeting on the 14th February 2004 (e-mail: qavi@bdonline.com). Both countries are enjoying periods of peace and growth, but both with significant shortages in their peripheral towns.

Mr Kenneth Tuson goes on in his recent letter: “Although it seems a long time away it is only 12 months to the next International Meeting of World Orthopaedic Concern to be held within the **Triennial Meeting** of SICOT in **Istanbul** in **September 2005**. After discussion with the Secretary General we have agreed to organise a whole day meeting for WOC on a date yet to be decided.

“The day will consist of a clinical meeting and the General Assembly. The reason for my writing now is that the clinical symposium will contain presentations by orthopaedic surgeons, on research projects carried out by themselves during or following their visits

to underdeveloped units. We particularly encourage trainees who have been teaching, and indeed learning, in the Third World, to present their experiences; not of course a travelogue, but clinical research. Papers from trainees who have been to “Centres of Excellence” either in their own country or in the so-called developed world and have found work which has led to publications or presentations would be particularly welcome. As you know the SICOT meeting is an opportunity for us all to meet and to share experiences of global orthopaedic pathology and management. I hope that this notice will stimulate submissions from colleagues to present to the international meeting in Istanbul. Papers, in summary form, should be sent to myself at the Nuffield Hospital, Kingswood Road, Tunbridge Wells, Kent TN2 4UL, UK, or e-mailed to me at k.tuson@nuffield-woc.freeserve.co.uk. The final selection of papers will be made by an executive committee of WOC International.”

REGIONAL REPORTS

Bangladesh

Under the auspices of WOC (India) together with the SICOT Regional Training Programme **Professor T K Shanmugasundaram** and **Professor N S Laud** have visited Dhaka. They participated in a 4 day CME programme of musculoskeletal disorders organised by the Department of Orthopaedic Surgery, Dhaka and the Bangladesh Orthopaedic Society. The participants included rheumatologists, traumatologists, physicians and orthopaedic surgeons. In all 40 papers were presented included 15 by the visiting professors covering important conditions relevant to Bangladesh. Over 300 doctors and medical students attended the lectures and participated in lively discussion. The inauguration of the Bone & Joint Decade chapter for Bangladesh was a significant event in the proceedings.

Professor Laud gave lectures on joint replacement surgery and UMEX external fixation techniques, and performed an operation. The participation of such large numbers in spite of the devastating floods ravaging the country in the month of July, demonstrated the value of such visits. The visitors were humbled by the kindness and exceptional hospitality of the host department.

Professor Amjad Hossain has recorded the feedback and gratitude of the participants at Dhaka, and requested WOC (India) to support such visits every year. He had discussions

with office bearers of WOC (Bangladesh) who wanted more slots for “hands-on training” for their surgeons under WOC (India) - SICOT Regional Training Programme.

TKS assured them of his continued support. He went on to visit the Centre for Rehabilitation for the Paralysed, run by **Ms Valerie Martin** and came away with admiration of the many activities of the Centre. TKS recalls the event during which he presented the Sir Arthur Eyre-Brook Gold Medal to Ms Martin at the SICOT meeting in Amsterdam in 1996. He saw the Department as a living monument to her determination in the service of humanity.

John Lourie and **David Jamieson-Evans** continue their regular visits to the hospital ship, Jibon Tari. The surgical work continues unabated in spite of the floods in the delta south of Dhaka, which regularly destroys crops and damages dwelling places. Jibon Tari meanwhile rises and falls with the flood. It remains in good repair with a new electrical generator and an extra upper deck increasing the accommodation. **IMPACT (UK)** have shouldered the running cost of this free surgical service, so far. They are now anxiously looking about for financial support from the Great and the Good in Bangladeshi business, to adopt the vessel.

Singapore

We are proud to announce from Singapore, a Lectureship set up in honour of the eminent orthopaedic surgeon, **Professor V K (Kanda) Pillay** with additional support from the Education Ministry of Singapore. The aim is to bring each year a renowned overseas orthopaedic surgeon to Singapore for a week to teach postgraduate and undergraduate students and interact with local surgeons. The Lectureship has been set up by the Lee Foundation and the Shaw Foundation. World Orthopaedic Concern has added \$50,000 (Singapore) which has been matched by the Pillay family itself. This Singapore University Lectureship recognises the contribution made by Dr Pillay in founding the postgraduate programme in Orthopaedics in Singapore and WOC internationally. The first lecture of this new establishment was given by **Professor Surya Bhan**, from the All India Institute of Medical Services for which he is head of the Department of Orthopaedics.

Health Volunteers Overseas

The Executive Director, Nancy Kelly, sends us the following message, reporting that HVO is pleased to announce that the American Orthopaedic Foot & Ankle Society (AOFAS) has joined as a sponsoring organisation. The Chair of Orthopaedic Overseas, **John P Dormans MD** reflected on the AOFAS sponsorship as follows: “Having AOFAS as a new sponsor extends the breadth and depth of our organisation and creates new avenues and opportunities for the members of AOFAS to use their expertise and help those who are less fortunate.” In a Presidential message, **Mark Myerson**, urged AOFAS to give their most precious commodity, namely time, to engage in humanitarian work. “In addition to the successful programmes already underway in Vietnam we plan to expand volunteer programmes for education and surgery to countries in need of help. I encourage you to assist in this endeavour with your time and financial support.” He went on to refer to 57 active programmes in 25 developing countries which include Bhutan, Cambodia, Costa Rica, Ethiopia, Nicaragua, Peru, Philippines, Tanzania, Uganda and the Caribbean.

HVO also sends a plea for urgent help from a hand surgeon in **Honduras** (e-mail: n.kelly@hvousa.org). The hand surgery programme is based in Tegucigalpa at the Hospital Escuela, a large teaching hospital and university medical school. Volunteers are invited to provide lectures, make rounds, participate in surgery and demonstrate any special expertise. The volunteers would act as consultants in the outpatient clinic for continued training of residents.

HVO also describes their hand surgery programme in **Peru** centred on the country's Society Security Health System (EsSalud). Assignments are regularly arranged for two weeks or more. Hand surgeons interested are invited to contact the HVO website where similar programmes are described in **Uganda** and **Ethiopia**.

We are eager to announce the World Congress on External Fixation to be held in May 2005 in **Lima, Peru** and the principles of its use. The two day symposium, 26th - 28th May would concentrate upon the development of systems of external fixation. It will include conferences, workshops, and/or post presentations, geared specifically towards instruction and biomechanical technique. Abstracts for a free presentation are invited and should be sent to the organising committee at the follow e-mail address: externalfixation2005@cycexpoeventos.com The deadline for such abstracts, either for podium presentation or posters, is the 1st December 2004. The programme will include

important contributions on new developments and more particularly towards simplification of much of the technique. This will allow flexibility in difficult problems and encourage simultaneous collaboration with plastic surgeons.

HVO also announces an education training programme in Orthopaedic Surgery at Managua, **Nicaragua** aiming to provide clinical and didactic education in arthroscopic surgery of the shoulder, surgery of the elbow, surgery of the cervical spine and paediatric training for foot and limb lengthening, together with general orthopaedic management. The Hospital Antonio Lenin Fonseca receives referrals of complex cases from throughout the country included complex injuries. There is no certification programme for orthopaedics in Nicaragua. Residents are selected on the basis of merit during the final year of medical school. The Republic of Nicaragua comprises approximately 5.5 million people of whom one million live in the capital city, Managua.

Orthopaedics Overseas' programme in the **Philippines** has expanded from its original site at the Philippine General Hospital to include a second hospital in Manila, Jose Reyes Memorial Medical Centre; assignments are offered for two weeks. Volunteers for this programme should have teaching experience, academic or otherwise, and must be comfortable and confident about instructing other physicians. To learn more about the programme, visit the HVO website or contact the HVO programme department (e-mail info@hvousa.org)

The Lonely Planet website is currently featuring HVO and several other non-profit organisations under the "make a difference" heading in the left hand column. You should click on "Refresh" until the HVO logo reappears to access travel information.

South America

In a previous letter we gave forward information about World Orthopaedic Concern activity in South America quoting correspondence between **Dr Xavier Martin** in Cataluna, Spain and **Dr L Lorenzo** who works in Tarragona. The trail seems to have gone cold at present but there is no doubt that large sections of South America, outside the centres of excellence in the great cities of that continent, have a continuing and urgent need for orthopaedic expertise. Any information relating to prospects or retrospects will be gratefully received and passed on through these pages.

Cambodia

A cry for help has come from the Shinouk Hospital Center for Hope in **Phnom Penh** due to the unfortunate cancellation of orthopaedic 'locum tenens'. Volunteers with experience in amputation, internal fixation, foot and ankle surgery and polio deformities are required. This is both for surgical performance and more importantly to teach Cambodian doctors in hands-on fashion in both patient evaluation and surgical technique. Moderate cost housing is available (info@hvousa.org)

Nepal

Dr Pieter de Bruijn has been good enough to send his full report relating to his visit to Kathmandu together with a surgical team at the invitation of **Professor Lakhon Shah**, Director of the Department of Orthopaedics at Tribhuvan University Teaching Hospital. The visit was organised through the Rotatory Clubs of Thiel (Holland) and Kathmandu with local organisation by the Health Volunteers Overseas.

This project was briefly reported in an earlier Newsletter, as it appeared in a much abbreviated form in Orthopaedic Project News, with the promise that a full report would be published later. A full version has never been published, and it was the opinion of this Newsletter that the brief report in the trade journal did not give a fair representation of Dr de Bruijn's work.

In his full report Dr Pieter de Bruijn describes the list of equipment brought out from Holland, which included 3 complete arthroscopy cameras and instruments, 2 complete sets of laminectomy instruments, 8 sets of external fixation systems amongst a host of other simpler and essential pieces of equipment. The surgical team's work over a period of 6 weeks from the beginning of March 2002 coincided with a period of unusually intense Maoist activity in Kathmandu Valley. But apart from many and varied injuries, they were able to assist in the management of congenital deformities, skeletal infections including tuberculosis, paraplegia, amputations, tumours and road traffic accidents. Delayed transport from the mountainous areas meant that compound fractures were assumed to be infected. An external fixation was the ideal system of management allowing skin cover using plastic surgical techniques.

Dr de Bruijn gives a graphic description of Kathmandu itself and the circumstances of life for its million citizens. Careful and constructive points regarding surgical

management, particularly in regard to sterility, are described in his report with constructive suggestions about the programme of technical teaching. He made helpful observations about the paucity of instruments necessary for many surgical procedures. Some of the needs were corrected by the generous donation from the Rotary Clubs.

In his conclusions and recommendations, Dr de Bruijn says that 4 weeks is the minimum period during which one could make a significant contribution to the surgical work. He noted that surgical equipment and up-to-date literature were important requirements. He realised the paucity of funds and felt that world wide sponsors must be sure that what is brought and given, is appropriate and in working order. He suggested that local donors and sponsors must be encouraged and involved, with perhaps the Embassy of each visiting team taking the lead. He felt that any monetary help should be brought and personally given to the person in medical authority.

Dr de Bruijn felt deeply about the difficulties the nursing and other ancillary staff worked under and made constructive suggestions as to how best the charitable bodies who funded this work, could most usefully deploy their benefaction.

This editor compares this most helpful visit to the Premier Teaching Unit in Kathmandu (TUTH) with the circumstances that obtain in the small towns far from the capital city.

A team from WOC (UK) is due to make one of its annual visits, not to the capital city but to the provincial town of **Nepalgunj**, in November 2004. These surgical camps have previously been supported (travelling expenses) by IMPACT (UK) but this has now been discontinued. In response to local entreaty the team, which will include **John Fixsen** and a senior registrar from Plymouth, will be paying their own way and take part in lectures, teaching sessions and surgical demonstration, appropriate to the conditions of the Terai far from the tourist attraction of the mountains. The current team and those of the past six years wish to convey their gratitude to IMPACT (UK) for their encouragement and support to date.

India

IMPACT (India) continues with the hospital train, the Lifeline Express. The 10th project, in March 2004, covered the state of **Madhya Pradesh**, centred on Gwalior. The report records details of surgical treatment on patients with paralysing polio and included

release of contracture, tendon transposition and orthodeses to correct deformity. New developments include the most exciting project of running the train into Parkistan, across the most sensitive international border. We look forward to hearing details of their adventure.

Malawi

Malcolm Swann writes from somewhere between Zambia, Sierra Leone and Malawi. His surgery has been mostly neglected trauma, untidy traumatic amputations and children's conditions. He expresses a special interest in the mode of open reduction and stabilisation of long standing dislocations of the elbow. From a base in Lilongwe (which has no established resident lead surgeon) he travelled to visit and encourage the "Orthopaedic Clinical Officers", reconstituted by Lavy. These he refers to as "the backbone of the Orthopaedic Service". He is anxious about young surgeons in the West who are so highly trained nowadays as to be "lost without a scope in one hand and an MRI request form in the other". Swann fears he may be one of a race facing extinction through longevity. He emphasises the need for those of a certain age and still in active surgical practice, who can remember poliomyelitis and traumatology. He invites correspondence via swannm@aol.com which will reach him anywhere in the Third World.

PAROCHIAL MEETINGS

The Seddon Society

Our Newsletter does not usually report proceedings of individual orthopaedic clubs, of which there are many, but the 13th annual meeting of the Seddon Society was held in London under the chairmanship of Geoffrey Walker who spoke at length of his work beginning in Nigeria, through Ethiopia, Bangladesh and Laos (*cf* his autobiographical report on page 1).

Geoffrey thought it was unimportant that he no longer provided active surgical work but felt that he was able to inspire the student, both pre- and post-qualification on how to listen, to examine and then to think in regard to therapeutic options. This must be followed up by careful planning of post-operative care which is difficult for someone visiting for a very brief spell, but is absolutely essential in the cause of good results. Third World pathology remains that of diseases which have largely been controlled or even eradicated in the West, for example poliomyelitis. But the injuries from explosive

devices are to be found in every part of the world. The breadth of general orthopaedic expertise is beginning to fade in western medicine because of the pressure for extreme specialisation, but it remains the essence in the Third World from where the abundant experience across many anatomical fields will fuel the advances of the future.

He saw the effect of super specialisation as being stultifying on freedom of thought. The field of external prostheses was now dominated by cybernetics whereas the multitude of lost limbs, particularly as a result of ferocious civil aggression, produced a desolate procession of amputees for whom no device would ever be economically available. He spoke warmly about such old-fashioned procedures as the Krukenberg reconstruction of the forearm for amputations of the hand.

The Society's Guest Lecturer was **Professor Lavy**, from Malawi, who described the problems he had identified in setting up an orthopaedic practice in a tropical country. He saw it both as a science and a romance. The aftermath of polio was still very much part of African practice. In a busy clinic he would see ten new cases of congenital talipes equinovarus and had grown to appreciate the importance of a scrupulous programme of constant stretching, massage and splintage, which could only be perpetuated through instruction and support for the mother. Late and totally neglected club feet were a different problem, never now seen in the West. Local realisation of the possibilities of correction, even at that late stage, added to the understanding by the local population that to accept deformity was not necessary. The lessons of Ilizarov have shown the value of persistent, gentle forces but the equipment is very unlikely ever to be available, nor should it be until the expertise is acquired.

Chris Lavy spoke at some length on the difficulties imposed by a workload which is far too great for the small band of surgeons available in his particular country. He was often obliged to make the painful decision that certain conditions could not be treated on the basis of the likelihood of success and the time taken to achieve a result.

In spite of all these difficulties, Professor Lavy was able to demonstrate the enormous expansion of his work in Blandtyre. When he came to the country there were no orthopaedic surgeon; now there are four. The inspirational work of **Ed Blair** had faded when he left, but his plans remained and Chris Lavy has done much to reactivate them.

In particular the training of “clinical officers” was restarted in 1997 with a programme of three years of basic training.

He described the inauguration and his Chairmanship of the East Africa College of Surgeons, emphasising the importance that the ruling politicians had given to it, and about the impossibility of it being appropriately funded locally. He reiterated the message from Geoffrey Walker about the essential value of training on site.

British Orthopaedic Association, Manchester

Again we do not usually comment upon major professional meetings; the exception in this case is for the first day of the Annual Meeting of the BOA. It was given over, at the instruction of the President (David Jones) to presentations from India. It was taken on as an opportunity for the Indian “Centres of Excellence” to demonstrate their expertise. Presentations of the highest quality were given. The subjects were for the most part on pathological conditions to be found in abundance in the subcontinent.

Dr G Anderson (Vellore) impressed the audience with the breadth of his experience of brachial plexus avulsion and the possibilities for repair. **Dr S Rajesekeran** (Ciombatori) separately presented advances in the management of compound tibial fractures, and of spinal tuberculosis. **Dr A Johari** (Mumbari) presented a comprehensive study on club foot, starting with its aetiology, clinical fractures, the various modes of stretching and splintage, and finally the many surgical approaches. From the same institution **Dr P Bhosale** analysed the particular problem of replacing the hip joint in ankylosing spondylitis, demonstrating how fully the concept of replacement arthroplasty had been adopted and perfected in India. These five papers will of course be more fully reported in future academic journals. Suffice to say at this point that the eminence of Indian Orthopaedics is apparent. WOC acknowledges the considerable contribution that the quoted Centres of Excellence have made towards the training of East Asian surgeons who serve the townships and rural areas of the continent.

Lastly the day concluded with the eponymous lecture in the memory of Professor Lipmann Kessel given by **V K (Kanda) Pillay**. He gave honour to **Professor Kessel’s** career including his distinguished war record, as a surgeon at Arnheim, and his later elevation to the Chair at the Institute of Orthopaedics, London. There Kessel set up the first unit devoted entirely to structural defects of the shoulder joint, so conforming to the

modern trend toward specialisation. He had to that date been the most general of orthopaedists with a particular devotion to Africa where he was born and grew up.

In parallel Professor Pillay showed the changes that had occurred in Singapore over the past sixty years, with photographs of ever greater antiquity. Contrast could hardly be more striking, from impoverished fishing and trading port, to Grand Metropolis; and with it, the no less impressive changes in the management of injury and disease of the skeletal system during this brief period of time. Professor Pillay concluded with descriptions of his teaching principles, their application to WOC's philosophy in particular and clinical orthopaedics in general.

AFTERWORD

Together with our usual request for reports, information, even anecdotes of WOC experiences to publish in these Newsletters, we would be grateful to know by which means you receive this letter? The object of this request is to learn which of you are happy to read it via the internet, making expensive postage perhaps unnecessary.....

(All news please to: **Michael Laurence** at mlaurenc@netcomuk.co.uk)