I was first asked to provide copy for a dispatch from the Pacific Basin over 12 months ago. Despite modern communication the editor might well say that it takes as long to get an answer from the 'colonies' as it did when Cook first ventured here in 1776. I will try to convey to you in these columns something of rheumatology 'down under', but remember that the Pacific Basin forms a vast circle, both south and north of the equator, so will also give you some idea of the rheumatology in the other countries of the ASEAN region. Some of you will already have visited Japan, the site of the 6th SEAPAL (South East Asia and Pacific Area League), and by the time this article is published the 2nd ASEAN meeting will have been held in Manila.

Active rheumatology societies operate in most countries of the area and there is tremendous enthusiasm for exchange of ideas on rheumatological practice and research. The Chinese Rheumatism Association is in its infancy but is already establishing links within China and setting up exchange programmes, particularly with North America and Australia. We all hope that these will continue, given the recent political events. Having made two visits to China and established an exchange programme with the Second Medical University in Shanghai, I can appreciate the enormous potential for scientific interaction with Chinese rheumatologists. One of the more interesting projects being undertaken in Shanghai is an epidemiological survey of rheumatic complaints at the Shanghai No 1 steel factory. Professor Chen Shun-le and his colleagues in Shanghai are carrying out the study with great enthusiasm and it will no doubt produce useful information. The steel factory itself is like a separate city with its own hospital, railway, and cargo vessels used to carry the finished product to the West. I spent a fascinating day watching the steel being produced and being provided with a 22 course meal at the end of it!

Rheumatology is a major specialty in Japan with over 5000 members of the Japanese Rheumatism Association. This includes over 2000 registered rheumatologists and a number of orthopaedic surgeons. In 1989 the Welfare Ministry decided to spend 1500m yen on research into arthritic complaints, and there is considerable public awareness of the problems of rheumatic diseases. A great deal of basic research into immunology and immunotherapy is being carried out in the country's many medical schools and scientific research institutes. Certain rheumatic conditions such as Kawasaki disease and HTLV-I associated arthropathy occur more commonly in Japan, the reasons for this being uncertain. Many new drugs are in an early phase of development, including a sulphydryl compound Bucillamine, which is a penicillamine-like antirheumatic agent now widely used in Japan. Its comparison with D-penicillamine has still to be assessed and is the subject of a proposed multicentre trial between Japanese and Australian rheumatologists to be undertaken in 1990. Of great interest, at least in the media, is the ultracold cryotherapy unit, where patients spend three to five minutes in a chamber into which is pumped liquid nitrogen at –180°C. This is repeated two to three times daily for months and has patients flocking from as far afield as Australia. I can comment on this personally as two years ago I had the opportunity to visit the cryotherapy unit along with one of our local investigative television journalists. We had a fascinating day discussing the scientific basis of cryotherapy with the Unit's director with the high (or low if you are thinking of temperature) point being a first hand experience of the treatment. Although the experience of spending two minutes running around a 10×10 chamber in a cloud of frosty fog with an ex-Sumo wrestler might be said to be invigorating, I suspect that it was the intensive physiotherapy that was the key to the moderate success of the treatment programme. The opinion of the Japanese Rheumatism Association would also seem to be that it is the physical therapy that is important with no evidence that the –180°C cryotreatment is of any benefit. However, it was certainly an experience.

The Philippines Rheumatism Association has made major inroads in undergraduate curriculum development and public education since its inception in 1964. It has close links with the Arthritis Foundation of the Philippines, which is active in public education programmes. Members of the Philippines Rheumatism Association have recently organised the 2nd ASEAN congress of rheumatology, which was held in December 1989. The Philippines has also been the site of the initial COPCORD project jointly supported by the World Health Organisation and the International League Against Rheumatism. COPCORD (Community Oriented Programme for the Control of Rheumatic Diseases) has three components—an epidemiological study of arthritic complaints in a rural population, education of health personnel, and the development of improved health services. The project has been coordinated by Dr Ken Muirden with local help from Dr Lourdes Manahan and
support from Dr R D Wigley of New Zealand and Professor Hans Valkenburg of Holland. The project has already shown interesting data on the incidence of various forms of osteoarthritis and soft tissue rheumatism, particularly of the shoulder and neck. The simple approach using questionnaires, physical examination, and a series of x rays has now been used in rural Indonesia by Dr John Darmawan and in Melbourne, Australia by Ken Muirden.

The Singapore Society of Immunology and Rheumatology has been active since its inception in 1976. The modern Singapore of high rise hotels, wide streets, with the scent of frangipani in the air has joined the international meeting circuit in a major way. Delegates can rapidly make the transition from the air conditioned meeting to taste the Asian fare, though it is a little more expensive than it used to be.

Malaysia has been the last country in the Asian group to form a Society of Rheumatology, which occurred at the end of 1988. Most patients with rheumatic complaints are seen by general practitioners and orthopaedic surgeons, but, recently, an increasing number of doctors with training in rheumatology have started to emerge.

Some of you will still remember the beauty of Bangkok, site of the 5th SEAPAL congress of rheumatology in 1984. The Society Against Rheumatism of Thailand was founded in 1970 and continues to promote medical education and services in the field of rheumatology. A number of Thai science students are currently carrying out postgraduate work in Australia, and it is hoped that they will return to Thailand to stimulate scientific research in the rheumatic diseases.

Indonesia has seen the establishment of its own COPCORD project in both a rural and urban population in Central Java. This has been coordinated by Dr John Darmawan. The 28% prevalence of rheumatic complaints is similar to that seen in the Philippines. Seventy five per cent of the rural population have not received medical treatment. As in other Asian countries, over the counter anti-rheumatic drugs, which are often shown to contain corticosteroids and other potent agents, are often used. John Darmawan has also adapted the popular entertainment of the rural areas—the wayang (leather puppet) shadow play as a vehicle for community arthritis education. The shadow play invariably portrays one of the 200 or more stories of the two great Hindu epics, Mahabharata or Ramayana. During the breaks in the story the darlang or puppeteer can present the arthritis community mass education programmes, teaching posture, positioning, joint and back protection techniques, and stress reduction. In this way many thousands of Indonesians have learnt to look after their joints in a more effective way.

For years young Australian rheumatologists have gone to Britain to experience the tremendous clinical material of the National Health Service. Active clinical rheumatology units now exist in nearly all teaching hospitals in Australia and rheumatology registrars are encouraged to get their basic training in Australia before travelling overseas for postdoctoral research or other clinical activities. The Michael Mason Travelling Fellowships allow exchange of ideas between Britain and Australia and allow registrars to see how the ‘uvver arf’ live. The Sydney ILAR meeting of 1985 allowed many overseas rheumatologists to see the uniqueness of Australia (in spite of the imported English weather). Rheumatology input at a university level is improving with two Chairs (both in Sydney) and a third recently advertised in Perth. A significant and increasing amount of clinical rheumatology is carried out in the private sector, however, away from the teaching hospital. Although this might have advantages in patient acceptance, it does mean that the clinical material is often lost to teaching and research activities. An increasing number of investigators are showing that it is possible to combine some private practice with at least clinical research. Australian rheumatologists are involved in a whole range of research activities from psychological determinants of disability and angiogenesis (Royal North Shore Hospital), pharmacokinetics of antirheumatic drugs (St Vincent’s Hospital, Sydney), antinuclear antibodies and seronegative arthritis (St George Hospital, Sydney), epidemiology (Royal Melbourne Hospital), synovial fluid physiology and the effect of fish oils on arthritis (Royal Adelaide Hospital), and immunogenetics of rheumatic diseases (Royal Perth Hospital). Dr John Hamilton of the department of medicine, Royal Melbourne Hospital has achieved a prestigious five year programme award from the National Health and Medical Research Council for his studies on molecular biology of cytokine regulation. The Arthritis Foundation of Australia has recently awarded grants of over $120 000 for research in 1990, including the first Heald Fellowship to allow a young Australian researcher to study in the United States of America. We hope that this will develop into a bilateral exchange, as the Michael Mason Fund provides. The Arthritis Foundation of Australia also supports young rheumatologists from Asia, allowing them to spend short periods of time in research and training in Australia.

We gather from various sources that one of our greatest exports, repetitive strain injury, is now catching on in both Britain and America. Interestingly, since being referred to as a regional pain syndrome and treated as a pain problem it seems largely to have disappeared from this country, though we wait with bated breath for the next stress related phenomenon.

In the land of the long white cloud, rheumatologists seem to have been one of the major exports over the last few years. Despite this, active rheumatology units exist in Auckland, Palmerston North, Wellington, Christchurch, and Dunedin. The New Zealand Health Services have undergone considerable devolution over the last few years with the setting up of area health boards responsible for most aspects of health care. It is hoped that this will allow better integration of the community with hospital care and achieve a greater efficiency in the use of resources. This sounds like a little bit of deja vu, but we are still all looking forward to seeing it in action when the New Zealanders host the

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combined Australia and New Zealand Rheumatism Association meeting in Queenstown—the ski centre of the southern Alps—in August 1990.

One of the rheumatological highlights of the year for me was a two week visit to Papua New Guinea, our immediate northern neighbour. The spectrum of clinical medicine was fantastic from tuberculous joints, Pott’s disease, tuberculosis, meningitis to leprosy and cerebral malaria. Funding for health care services has a low priority and the university department of medicine in Port Moresby does a tremendous job with few resources, teaching medical students to a general practitioner level. A trip to the Highlands introduced me to a young English doctor, Dr John Richens, who has developed a major interest in reactive arthritis. The prevalence of HLA-B27 is extremely high in the local community with some villages having in excess of 90%. John is doing some very interesting work with the local medical research institute in Goroka and is now collaborating with groups in Australia. Any rheumatologist who wants to have a working holiday with a difference should think seriously about contacting John as the time spent in the tropical grandeur of Papua New Guinea with its medical curiosities would be well worthwhile.

Looking out from where we do (under the globe), we sometimes feel the weight of it on our shoulders. I must say it only took two weeks in Papua New Guinea to realise that the problems that I had with various hospital and university committees paled to insignificance when faced with the life and death issues of an emerging nation. Medicine is in crisis in Australia as it seems to be in most other countries, though the crises that we face are slightly different. Looking back, however, they seem to have occurred before and I suspect that there will be crises in the future. What is important is to maintain a sense of humour and some optimism and, as we look to the future, I am reminded of the words of Lewis Thomas (in *The Medusa and the Snail*) that ‘there has never been a period in medicine when the future has looked so bright. There is within medicine, somewhere beneath the pessimism and discouragement resulting from the disarray of the health care system and its stupendous cost, an underlying current of almost outrageous optimism about what might lie ahead from the treatment of human disease if we can only keep learning’.

In preparing this report I would like to thank Dr John Darmawan, Indonesia, Professor Masashi Nobunaga, Japan, Dr Clemente Amante, Philippines, Professor Chen Shun-le, P.R.C., Dr Peter Moller, New Zealand, and Dr Ken Muirden, Australia.