TAIL PIECE

Notes on a Military Hospital in the Middle East in World War II

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In May 1942 a large convoy sailed from Glasgow under the protection of a cruiser and four destroyers. Its cargo included a complete infantry division and a considerable quantity of guns, tanks and other stores. Also on board was the 91st General Hospital RAMC, a 1,200 bedded tented hospital which derived from the 56 London (TA) Division. Two months later the convoy reached Egypt where the troops already there were in some disarray. They had taken part in two campaigns in the Western Desert only to be repulsed by Rommel who was then, it was thought, preparing an attack on Cairo. Most of them believed they had insufficient troops and equipment to stop him. The arrival of our convoy together with the appointment of General Montgomery as C-and-C and the establishment of the 8th Army transformed the situation and led to the triumphant victory at El Alamein in October1942.

On arrival in the Middle East, 91 General Hospital was hastily assembled in the desert three miles inland from the coastal town of Gaza in Southern Palestine and took its place alongside a dozen similar hospitals in Egypt and Palestine. The staff comprised 33 doctors, 80 Army nursing sisters, 250 other ranks and three parsons. Patients were soon admitted from the crowded military hospitals in Egypt and by August a train loaded with 200 to 300 of them arrived regularly at Gaza station at 10.00 pm on Mondays, Wednesdays and Fridays where patients were dumped on the platform in the dark before the train moved on. To accommodate them in our overfull hospital meant transferring similar numbers to the Convalescent Depot in North Palestine on the Tuesdays, Thursdays and Saturdays. Our three surgeons managed the whole range of traumatic and orthopaedic surgery, including battle casualties, whilst the physicians with a much larger turnover, strove to accommodate the overcrowding. With more than half the hospital admissions being accounted for by so-called tropical diseases of which most of us had had little or no previous experience, we needed to train quickly in an age before the discovery of antibiotics and other modern remedies.

Of the three disastrous epidemic diseases of former times in England, namely plague, typhus and smallpox, all were endemic in the Middle East during World War II, but none of them gained a firm foothold in Gaza during 1942-1945. In early 1943 plague struck Haifa in Northern Palestine. A swarm of rats whose fleas were infected with plague bacilli invaded the town, probably in search of food. Many died from the infection and lay in the street. A group of us was invited to a civilian hospital where 50-60 plague victims were being cared for. It was a sad sight with many of them obviously dying. About one-third were boys aged 12-14, which was easily explained. Seeing the rats in the streets, they picked them up by their tails, swinging them and dashed their heads on the ground. This gave the fleas long enough to attack the boy's hands and ankles and bite them. The bacilli spread to invade the lymph nodes in the axillae and groins which became grossly swollen into the buboes of bubonic plague. As new cases arrived they were stripped of all their clothing by orderlies in macintoshes, put in a bath and were thoroughly scrubbed to rid them of fleas and then put in a ward.

A severe epidemic of typhus broke out in Cairo in 1943, spread by infected body lice in crowded communities. The 250 bedded civilian isolation hospital was soon overfull, ward after ward containing some with the initial high fever and prostration, many of whom did not survive, but most of them were well on the way to recovery. The striking features and aids to diagnosis were the characteristic macular rashes mainly on the flanks and transient mental disturbances usually in the form of excitability.

Smallpox, among the most contagious of diseases, was troublesome. Sporadic cases occurred, due to incessant troop movements, some with virulent strains that proved fatal. A smallpox tent of 6-8 beds was maintained a hundred yards from any other tent and with a fully vaccinated staff. Even so, it managed to spread on one occasion. As a precaution, patients were retained in hospital for a week after the disappearance of the last scab and washed daily with potassium permanganate.

Amongst less exotic diseases there were two, either of which might account for over 300 of the inpatients, namely infective hepatitis and dysentery. Almost everybody, it seemed, had infective hepatitis. It struck 91 General Hospital soon after arrival in Gaza. Most of us had a few days of

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anorexia, dark urine and a palpably tender liver edge below the costal margin, but no jaundice - the sub-icteric form. On one occasion, a newly arrived medical officer from England was surprised to be ordered to find the 150 patients with the least jaundice and dispatch them to the convalescent depot as a large convoy was arriving at Gaza later that day. Of those admitted to hospital, about 1% died, their jaundice instead of beginning to improve within a fortnight became more and more deeply orange coloured, with death from liver failure.

Hardly less common at times were desert sores, almost all having arisen in the Western Desert where water was often in short supply and regular washing was difficult. Fifty or more might arrive in a convoy at Gaza. On arrival the ulcers, mainly on the legs, were meticulously tested for diphtheria by swabs and pinpricking around the ulcers for anaesthesia. About 5-10 per cent were positive and antitoxin undoubtedly saved lives from fatal myocarditis. Laryngeal diphtheria was also common, with two 30 bedded tents insufficient to accommodate them at times.

After El Alamein, the 8th Army departed on its triumphal advance across North Africa and on to Italy, taking about half the tented military hospitals in Egypt and Palestine with it. Those of us who remained were soon fully occupied in organising care for the many thousands of troops who poured into Egypt in the following months. They included prisoners of war from the Western Desert, the remainder of the 200,000 African troops who had been serving in the Mediterranean theatre and others from the various Eastern European countries. Many were severely ill or injured and it fell to the British Army to resolve most of their difficulties. By 1944, the disposal of non-British troops with pulmonary tuberculosis and psychiatric disorders posed a major problem. They were scattered in small pockets all over the Middle East. An option on a recently vacated thousand bedded tented hospital some three miles into the Sinai desert east of Kantara on the Suez Canal was accepted. As the only fully trained chest physician in the Middle East Forces, I organised the large tuberculosis wing and commanded the hospital.

Surprisingly the new hospital, named The Mixed Hospital, was full within a month with 400 Italian prisoners of war, 200 Greeks, 200 African soldiers and about 50 Germans and 50 Russians together with a mixture of Yugoslavs and others from Eastern Europe. The British staff comprised 3 physicians, 3 psychiatrists, 12 Army nursing sisters and 30 other ranks. The Italians and Greeks supplied their own doctors. With such a motley collection rapidly thrown together, there were bound to be disturbances from time to time. They were quickly dealt with by a detachment of east Africans with two British officers who were stationed near by.

The Italians, usually in one or two adjoining tents, repeatedly threatened to strike over the quality of the food, but stopped at once when their rations were withdrawn. The Greeks, who were Royalists, took a little time to settle when about fifty Communists arrived from a sanatorium near Athens. Soldiers who had taken part in affrays elsewhere were sometimes labelled psychiatric and sent to us for disposal. Of the half-dozen or so murderers we usually accommodated, one killed a patient before he could be stopped. The others were found berths in ships passing through the Suez canal on their way to South Africa. The Germans were well behaved and gave no trouble. The Russians, many with advanced tuberculosis, had mostly enlisted in one of the foreign armies in eastern Europe. They appeared to be frightened and the difficulty with language was not overcome. One day, a group of high ranking Russians came on an official visit and took them all away.

With the coming of peace in 1945, the patients that remained were returned to their various countries.

Comment

This article describes events that occurred during wartime over 50 years ago, when there were no antibiotics or antituberculosis drugs. Yet the diseases that prevailed then are still widespread. If the experiences of World War II did little to enhance the understanding of them, they certainly concentrated the minds of many people on their diagnosis and treatment. For doctors posted to the Middle East, the need to acquire basic knowledge of the diseases with which they were suddenly confronted was essential, in order that they might understand the contrasting demands that each made on the medical services. For example, consider malaria, dysentery and infective hepatitis.

Almost all the malaria that came to Gaza was acquired in Egypt or the Western Desert where it was diagnosed by a simple blood test and started on standard QAP treatment (Quinine 5 days, Atebrin 3 days and Plasmoquin 3 days) which had been devised and recommended at GHQ Cairo and for which pamphlets on dosage were freely available. All that needed to be done for them was to continue the QAP and send them on to the convalescent depot when they were fit to go, hoping that none would develop signs of a cerebral malaria; from which, incidentally, two soldiers had died on our troop ship after calling at Freetown, Sierra Leone, West Africa on the voyage out.

The general adoption of QAP greatly facilitated transfers from one unit to another and reduced paperwork considerably; the issue of similar pamphlets for other common diseases was also successful.

Coping with 100 or even 50 patients with 'dysentery' was an entirely different matter. The first requisite was the collection of labelled stools in bedpans which were conveyed to the pathology laboratory, maybe a quarter of a mile or more away, usually by nursing orderlies with little English. When the diagnosis had been confirmed, with or without sigmoidoscopy, the identity of possible cases of amoebic dysentery was essential and indeed could be life saving at a time when effective remedies were beginning to appear. For infective hepatitis, the diagnosis was simple and there was no special remedy.

Working at the Mixed Hospital was a memorable experience with most of the doctors Italian and Greek and few of the patients other than the Africans able to speak much English. Yet, with more than 700 patients suffering from pulmonary tuberculosis, many of them with advanced disease, the atmosphere was that of a hospital despite the bizarre setting.

Among the amenities that were passed on by the previous occupiers of the site was a brothel, a solitary concrete building resembling a two up and two down residence about a mile into the desert beyond our barbed wire perimeter. With no other units in the vicinity, it claimed to be ours and, judging by fresh foot prints in the sand, it appeared to be fairly busy. My first instinct was to shut it, anticipating letters from Cairo headed 'Ref your brothel' and asking for any costs involved including its supply of electricity, but I was persuaded to let it remain for the time being. Later, it was responsible for its own demise in curious circumstances. A very large package arrived at the hospital, unexpectedly, containing no less than 1,000 fine woollen blankets, a gift from the Canadian Red Cross. They were welcomed and distributed around the wards. Soon, the QA Sisters noticed that they were disappearing. By chance, I looked into the brothel and there were a 100 or more of them stacked against the wall. I retrieved the blankets and shut the place down.