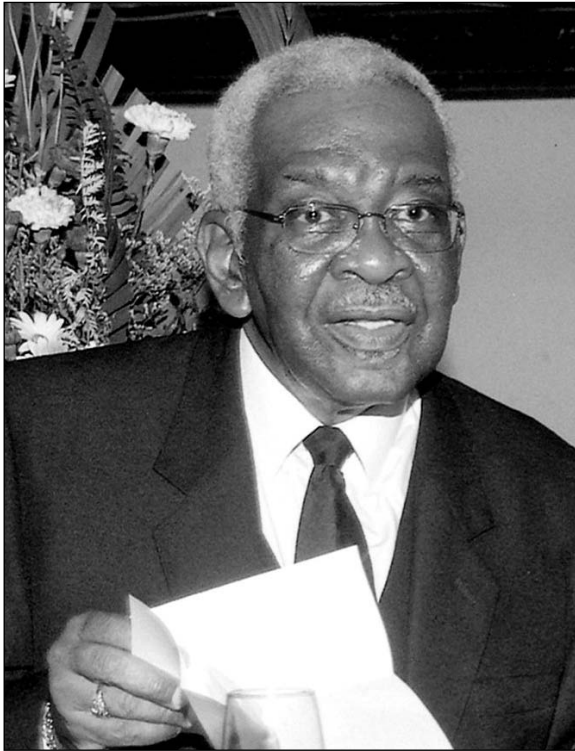


A Citation to Kenrick Orrin Evan Barrow



Kenrick Orrin Evan Barrow

Kenrick Orrin Evan Barrow called Orrin by family and friends, was born in Georgetown, British Guiana, on November 27, 1938. He was the only son and the eldest of the four children of Phillip Gladstone Barrow and his wife Ella Adolphine.

Phillip Gladstone was a British Guiana Scholar and studied medicine at The University of Edinburgh. He subsequently took the diploma of Master of Public Health at Harvard University. At the time I knew him, he was the Medical Officer of Health for the city of Georgetown and was called irreverently “Happy B” by his son.

Ella B, his wife, was by profession a pharmacist but there is no evidence that she practiced her profession after the birth of her first born. Orrin’s father was of quiet disposition and had a great sense of humour while his mother was a staunch methodist and became deeply involved in the Caribbean Conference of the Methodist Church holding high office

as a lay person. Ella B was widely known in several islands in the Eastern Caribbean because of her work in the church.

Orrin’s birth and infant nurture was normal and in due course he entered Queens College for his high school education. The most notable thing about his sojourn there is the great interest he developed in music and by age 18 years he had obtained the Licentiate of the Royal Schools of Music.

Science subjects were also studied and he graduated with marks high enough for him to be accepted for admission to Edinburgh, Howard and New York Universities and was considered for a place at the University College of the West Indies (UCWI) provided he passed the required written examination and interview.

Orrin recalls that among the interviewers were Sir Roy Augier and Professor Walter Harper of the Anatomy department. When asked why he wished to study medicine, he replied that he did not wish to do so and would prefer to study music. In spite of this, he was offered a place at the UCWI and accepted it as it enabled him to begin his studies that same year.

He joined the first MB class in 1957 and as he had studied the same subjects to the higher school certificate level, he devoted himself to music and passed the examination without additional study. Preparation for the second MB examination was a course of study over two years. Although these subjects were new to him, he pursued his musical interest with unabated zeal. In fact, he became proficient on the double bass steel pan and the bongo drums and together with like-minded students formed a group (Off Beats) playing Latin-American rhythms. The group became quite popular and played for dances and parties – some at north coast hotels. It is a matter of record that he was able to earn enough to purchase a Vauxhall Velox for £125 without having to raid the parental purse.

The effects on his studies meant that at examinations he did not achieve the desired results and he spent an additional year improving his knowledge of biochemistry, anatomy, physiology and pharmacology. His progress in the clinical phase of his studies was greatly influenced by a particular case he was involved with soon after his entry to the hospital. He was convinced that the approach of his seniors to the problem was not the correct one and by his research he was able to convince the staff to adopt a different strategy. That patient is alive and well today. This case so excited and

challenged him that he began a relentless pursuit of all aspects of internal medicine. At every opportunity, he attended the medical wards realizing correctly that the skills of clinical examination would be applicable to all branches of medicine.

He graduated in 1964 obtaining honours and first place in every phase of the examination. For his effort, he was also awarded the University of London Gold Medal.

His first four appointments were six months each in Surgery, Medicine, Casualty and Pathology. These were followed by one year as a junior registrar in Medicine. Always diligent in ensuring that the results of investigations would be available the next day, his performance during that year was of the highest calibre. Little did I know that he had another reason to visit the laboratories frequently – he had become enamoured of one of the secretaries in the Microbiology Department, a certain Miss Pauline Hayle. They got married shortly before he left for the United Kingdom for postgraduate studies.

In one calendar year, he obtained membership Diplomas of the Edinburgh and London Royal Colleges of Physicians. It was at this time too that he decided that Gastroenterology would be his particular field of study.

He returned to Jamaica and was appointed Senior Registrar in Medicine and one year later was appointed Lecturer in Medicine and Consultant Physician to the University Hospital of the West Indies. He resigned his university appointment as Lecturer in 1973 but remained a sessional consultant physician at the hospital. After 19 years in private consulting practice, he rejoined the Faculty as a senior Lecturer in Medicine until his retirement. In 2003, he was seconded by the University to act as the Chief Executive Officer of the University Hospital of the West Indies for several months and this was extended until his retirement.

Orrin and Pauline have three children, Philip who like his father and grandfather studied medicine, Paige, a Chef

and Peter, an Advertising and Marketing Executive. It must also be recorded that in 1970 he became a freemason and has obtained high honours in many orders of Freemasonry. Many honours have been bestowed on him, Fellowship of the Edinburgh and London Royal Colleges, Fellowship of the American College of Physicians and Fellowship of the American College of Gastroenterologists. He was the founding President of the Association of West Indian Gastroenterologists, has been chairman of the Medical Council of Jamaica and is past president of the Medical Association of Jamaica – a position he filled with distinction for three years.

He was External Physician to the late President of the Republic of Guyana, Forbes Burnham, accompanying him to many countries worldwide. He is also physician to the Most Honourable PJ Patterson, Prime Minister of Jamaica. For his services to Guyana, he has been honoured with that country's third largest decoration – the Cacique Crown of Honour.

From all that has been said, it is clear that Orrin Barrow is no ordinary man. Whatever institution he is associated with becomes the beneficiary of his high intellect and organizing skills. We commend him for his commitment to the training of younger minds, his devotion to the practice of the art and science of medicine and his refusal to accept mediocrity and ineptitude.

Thank you Orrin for your many years of service to The University of the West Indies and the University Hospital of the West Indies, to the people of Jamaica and to the people of the wider Caribbean.

May you be granted many years to bask in the glory of your achievements.

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***Helicobacter pylori* – Aspects of the Epidemiology in Jamaica**

Helicobacter pylori infection is one of the commonest chronic infections worldwide. It is estimated that about 30% of the population in developed countries and over 60% in developing countries are infected. In developing countries, infection commonly occurs during childhood. In contrast, in developed countries, infection tends to occur in adult life. An increase in prevalence occurs with age.

In Jamaica, an endoscopic study revealed *H pylori* infection in 55% of 102 patients using gastric biopsy and the urease test for confirmation. In a subsequent endoscopic study, 60% had active infection, by direct testing on gastric

biopsy, but 70% had positive serology which indicated previous exposure to *H pylori*. In an urban community in Kingston, 69% of 202 randomly chosen persons had positive serology for *H pylori*. In this study, 27% of children under five years of age and 93% of adults 45 years of age and over, had infection. Several factors were associated with infection including: older age, large yard size and the presence of domestic animals in the home environment.

Specific virulence associated with *H pylori* genotypes may influence the development of clinical disease. In Jamaica, of 15 isolates of *H pylori* in symptomatic patients,

80% were cag A positive and all were genotype Vac A-ml strains with 80% having s1b genotype. The predominant genotype in symptomatic patients in Jamaica is therefore; cag+ vacA s1b-ml, iceA2.

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Gastroesophageal Reflux Disease, a Nightmare Is it the Patient's or the Physician's?

ABSTRACT

Gastroesophageal Reflux Disease (GERD) is a common disorder requiring effective management. It accounts for 15–20% of all consultations in a gastroenterological practice. This effortless movement of gastric contents from the stomach to the oesophagus normally occurs multiple times per day but becomes pathological when there is an incompetent anti-reflux barrier referred to as the Lower Oesophageal Sphincter (LES). This in association with the irritant effect of potent refluxed material, alterations in gastric clearing or emptying and a failure of defensive factors (eg, decreased saliva production) contribute to the aetiology of GERD. Gastroesophageal Reflux Disease is not age dependent. It becomes chronic if oesophagitis is present. The quality of life is reduced considerably in patients with long-standing disease. Negative Endoscopy Reflux Disease

(NERD) should be reserved for individuals who satisfy the definition of GERD but who do not have either Barrett's oesophagus or definite endoscopic oesophageal mucosal breaks. The management of GERD involves primarily lifestyle changes and medical interventions. Acid suppression using H₂ antagonist remains the principal therapy. Anti-reflux surgery is used only if medical management fails and the patient fulfills the strict criteria for this procedure.

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Diverticular Disease: Oh the Pain of it all!

Diverticular disease of the colon represents a condition wherein sac-like protrusions of mucosa occur in areas of muscle wall weakness associated with the penetration of blood vessels. The condition is very common, particularly in the older population where the prevalence at 70 years of age approaches 50%. The majority of patients remain asymptomatic of their condition. The most common complication of diverticulosis is diverticulitis. Painful diverticular disease represents an under-diagnosed condition. Predominant symptoms revolve around cramping abdominal pain in the absence of clinical or biochemical evidence of inflammation. Theories surrounding the generation of discomfort related to diverticulosis are multifactorial and involve the colonic structural changes associated with ageing (increased collagen deposition, neuronal loss in the myenteric plexus) coupled

with altered colonic motility (uncoordinated motility, increased segmentation and excessive meal stimulated propulsive contractions postprandial). Animal studies suggest that colonic tissue in older animals exhibit abnormal apoptosis, defects of mitochondrial metabolism and inadequate levels of neurotrophins. These have not been borne out in human models to date. Treatment consists of increasing dietary fibre, avoidance of aggravating drugs and patient education. Serious underlying disease has to be excluded.

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