DI JU NANA BUNSHYO-NIGHTMARE-REVISITED

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We were expended as F.D.R. predicted and thus became guests of the Emperor. As such we departed Manila on 24 July 1943 in the hold of Mate Mate Maru, 500 adjudged fit for heavy manual labor by Japanese doctors. Our cruise ship had a 155 mm cannon lashed to the bow with heavy rope, this represented our anti-aircraft fire protection in case our cruise was interruped by American air attack. Two doctors and a medical warrant officer were assigned to keep the detail in good health. En route Manila to Japan our ship stopped at Santa Cruz and took on Manganese ore, July 31st found us enjoying the beauties of Taipeh Harbor in Formosa. Jerry Okonski one of the group became very ill during the Formosa visit. The gracious Formosan and Japanese guards could not see fit to move him ashore for the necessary emergency surgery, so utilizing a hatch cover table and dental novocain in the spine, removal of a ruptured appendix was carried out in bright sun light. About 7 days later Jerry Okonski was able to walk off the ship carrying his own possessions. However, the government would not compensate him for loss of the appendix. We finally arrived in the Port of Moji 9 Aug. 1943 and after a brief delay termed a "Quarantine" we traveled by train to Omuta where the civilian population stoned us in welcome as the first contingent of prisoners of war to enter Camp 17, Fukuoka Military District. Contrary to a recent publication our trip was a safe one, we lost no men and thus buried no one at sea. As POW's we worked in the mine and foundry.....

I have chosen to review with you factual material from a medical report on Camp 17 which was compiled by the Medical Staff: Capts Ian Duncan & Richard Parker, Australian Army, Lts Harold Proff & Theodore Bronk,U.S.Army and Lt. Gerit Bras, Royal Dutch Army.

It is ironic that this report was accepted into the Australian Army Museum for its historical value. Our meager records including the death list were not acceptable to a U.S. Courts Martial since they were not typewritten. I was young and inexperienced with the system in those years so at this late date I apologize for not keeping a typewriter with me. The medical report was completed Aug. 25, 1945 while the medical staff was still together in a complete state of recall to review the period, utilizing our private records as concerned each nationality group.....

As the camp increased in population, doctors who joined us were assigned to work in their field of interest, we were young and not fully trained, as an example Dr Bras interested in laboratory work arrived in camp with a crude microscope constructed of bamboo tubing and field glass lens. Thus we gained an additional capability in diagnosis and it became possible to cross match blood.

Medical supplies for the camp was a joint responsibility shared equally by the Mitsui Corporation and the Army. Eventually hospital space increased from a combined dispensary and ward building to one adequately large clinic building and 6 ward buildings: 1 isolation ward of 9 beds, 3 medical wards of 30 beds each, 2 surgical wards, 1 of 30 beds, 1 of 58 beds, to a total of 187 beds or mats. Thru the humaneness of Baron Mitsui, a 1919 Dartmouth graduate, we did have bed space for the sick and wounded.

Those of us who remained at Camp 17 following the exodus of the guard detail in Aug.

1945, set out to scavenge the city of Omuta. Early in the exploration we found several warehouses packed with Red Cross food and medical supplies. The dates of receipt and storage indicated that these items had reached Japan prior to Aug. 1943. Thus while we suffered from lack of food, essential medicines, surgical supplies, and x-ray equipment, these items, gifts of the American people, were hoarded in warehouses during our two years in Japan. The reason we were denied these essentials remains a top secret of the Imperial Japanese Army.....

Deficiency diseases were a continuing medical problem and despite repeated pleas to the Japanese command we were never able to obtain any dietary improvement. The Allied Medical officers considered the basic problem to be total dietary deficiency while the Japanese considered it as beriberi, the so called classic patterns of Vitamin B defi-- ciency. The first case of deficiency edema (swelling) that appeared in the camp in Dec. 1944, this patient literally wasted away. Within 10 days after the polished rice was introduced into camp, edema was noted in increasing number of prisoners, as polished rice eliminated our only source of Vitamin B and reduced the major nutrients.....

GASTRO INTESTINAL DISEASES: There was a consistently high disability rate from diarrhea. To clarify one point, Amebic dysentery was never a problem in Camp 17, only 7 cases were diagnosed by microscoptic exam and 3 of these were under treatment in Aug. 1945. Medically we used 4 classifications for gastro intestinal diseases:

1) FOOD DIARRHEA-(HIROHITO'S CURSE): On at least 3 occasions 75% of the prisoners were struck by an epidemic, in the fall of 1943 following questionable fish soup thru the mess hall, whale blubber, or the rare issue of clams always produced such a temporary epidemic, usually these outbursts tended to recede in 48-72 hours. These patients always demonstrated undigested food in the stool. Purgation and total abstension from food were effective in handing such epidemics.

2) ACUTE ENTERITIS-(BENJO BOOGIE): These patients gave a history of 3-4 days of diarrhea, with as many as 15 stools per day. They did not respond to an aniline purgative available in small amounts from the Japanese Army. Bed rest was our only successful mode of treatment.

3) ACUTE COLITIS: This condition was undoubtedly bacillary dysentery, it was prevalent during the summers of 1944 and 1945, at which time 30 hospital beds were constantly utilized for its treatment, during both periods Japanese denied the existence of the disease outside camp bounds: Yet prisoners employed in the mine reported Japanese miners suffering with it. One Japanese civilian employed in Camp 17 died of the disease in the early summer of 1945. Sanitary public health measures with-in the camp were instituted, but no public health measures were taken in the Japanese guard housing area and none in the surrounding civilian areas.

4) CHRONIC INTEROCOLITIS: Required long hospitalization and bed rest and a strict diet of lugao with warm tea enemas. The could be a terminal disease in severe malnutrition cases.

RESPIRATORY DISEASES: PNEUMONIA: Our most dreaded killer, pneumonia continuously maintained the highest mortality rate of any of the infectious diseases. In the winter of 1943-44, among the men of the first detail, the morbidity rate was 8%. The same group, during their second winter in Japan, showed a morbidity rate of 3%. Both the Australian and Dutch details who arrived in camp for the second winter showed the higher morbidity and mortality rates. It should be noted that the second Australian detail which arrived Jan. 1945, showed the highest morbidity and mortality of any group in this camp. They arrived from the tropics during the wintertime. In considering the Pneumonia in this camp, one cannot ignore certain living conditions which contributed to the development of this disease:

1) Starvation diet.

2) Continuous exposure to extremes of temperatures 32°-105° in the mine; some men worked in water.

3) Persistent upper respiratory irritations in all miners as a result of the irritating gases encountered.

4) Lack of adequate heating facilities within the camp.

Diagnosis of pneumonia depended upon the physical findings. The lower lobes were the most constantly involved.

Total pneumonias for the period reached 250 cases and were classified as follows: 1) Broncho-pneumonia-------20% 2) Lobar-pneumonia-------80%.....

Due to the limited supply of drugs available, treatment was not instituted in any patient until positive consolidation could be demonstrated. X-ray was never available.

Total deaths from pneumonia were 48, of these, 10 were in a state of extreme emaciation when they contracted this disease. The highest incidence of the disease occurred during the winter of 1944 and spring of 1945. During these periods 50 to 60 were in the hospital. In March of 1945, there were 14 deaths from pneumonia. This was the highest total for any month. The average period of hospitalization was 20 days, followed by 30 days of convalescence in quarters.

TUBERCULOSIS: Most Americans with even minimal tuberculosis died early in Philippine Island prisons. Pulmonary tuberculosis first appeared in the first detail of this camp in March 1944, after 7 months of mine work. It was impossible for this prisoner to have had contact within the camp bounds with a case of active tuberculosis. One of the Japanese overmen assigned to his group apparently was troubled with a chronic productive cough. This overman stated that he was troubled with consumption. This case was diagnosed by stetoscope and later confirmed by x-ray. There have been in the camp a total of 11 proven cases and 4 suspects. Of the 11 cases, 8 were from the American group and 3 of the 8 lived in the same room during the first winter in Japan. Treatment of these patients was limited to hospital bed rest. Six of the 11 proven cases died prior to Aug. 23,1945.

FUKUOKA FEVER: Dengue type fevers are endemic in all far eastern countries. Navy personnel will remember Cauite Fever of the Philippines. For want of a better name a local endemic fever encountered in this camp was termed "Fukuoka Fever". Very little satisfaction was ever obtained from the Japanese concerning this condition although the disease ranged from 60% to 70% of the entire camp. It may be described as an atypical aching, profound malaise, loss of appetite, and profound weakness. There is no rash and the length of the disease varied from 6 to 15 days. The prevalence of the disease coincided with the mosquito season. The temperature showed a tendency to run high the first 2 to 3 days of the illness returning to a low level for a period of 5 days, to rise again for 2 to 3 days prior to cessation. The severity of the symptoms varied with the temperature, the response to salicylates and codine was only fair. The disease conferred no immunity and 1 recurrence was likely during the season. It was impossible to keep these patients from duty status except when temperature was demonstrable. Subjective symptoms had to be ignored. This condition was developing a high morbidity rate during August 1945.

MALARIA (BLACK WATER FEVER): Of the population in this camp, 88% had suffered from malaria in the tropics. Increased numbers of malaria cases were noted within 2 to 3 months following the arrival of the respective details from the tropics. It was noted that the Estivo-autumnal type died out after about 3 months in this climate. The tertain type was persistent but was rare after 2 years. Many patients received their first complete course of malarial theraphy in this camp. No treatment was instituted without positive blood findings. Quinine-Atebrin routine was used in this manner;7 days of 30 grains followed by 7 days of 20 grains with 3 tablets of Atebrin per day.

A severe form of malaria in which the urine is black with blood is termed "Black Water Fever". Three patients developed Black Water Fever within 3 months afer their arrival from the tropics. During the period they were hospitalized with Black Water Fever, no parasites were demonstrable in the blood. The treatment consisted of rest and support with intravenous fluids & transfusions. Recovery was complete in each instance. Dr. Bras from Java had great knowledge of malaria & took personal care of the Black Water patients.

Although from time to time the morbidity rate for malaria was high, the only fatality from this disease was one patient with cerebral malaria.

SURGERY: Just prior to the departure of "A" detail from Cabanatuan instruments were requested from the senior American medical officers, having spent a year on Corregidor with a 500 man labor detail I was well aware of the need for surgical instruments, and the fact that the Japanese did not furnish instruments for use on prisoners. My re-
were refused by the senior American officers, they were naive enough to believe that all essentials would be supplied once we reached Japan. The instrument kit that I had

put together on Corregidor was minimal at best, my friendship with certain enlisted men working in medical supply at Cabanatuan made it possible to supplement my kit to the point that at least we would be able to handle emergency surgery while enroute to Japan. The individual instruments were placed in the baggage of a number of prisoners; thus they escaped detection during the inspections we were subjected to. The instruments were reassembled after we settled in Camp 17.

Our only available anesthesia consisted of several vials of dental novocain tablets. Two of these tablets dissoved in a small amount of the patient's spinal fluid, and injected into the spine gave about 45 minutes of anesthesia, giving us time to perform most operations that had to be done.

Dutch torpedo technicians, who eventually came to Camp 17, were able to make surgical knives out of old British table silverware.....

As a general rule if a prisoner suffered an injury in the mine some physical punishment was administered underground before he was brought to the surface. This punishment was handled by the civilian Japanese overmen. If the patient suffered a broken bone in the mine, x-ray examination might be carried out at the mine hospital, we might get to see the films 2 to 3 weeks later, so we treated fractures without x-ray.

Japanese surgeons operated in cotton gloves, since rubber gloves were not available. We operated bare handed, the fingernails of the surgical team stayed black as a result of our using bichloride of mercury and 7% iodine in preparing our hands before surgery. Despite our primitive equipment and environment our infection rate in surgical patients never exceeded 3%.

During our first 2 months in Japan several prisoners underwent surgery in the mine hospital, these operations were done either without anesthesia or with very weak local anesthesia and the patients were returned to us in rather severe shock.

Hand injuries which were repaired at the mine dispensary required thorough exploration as soon as the patient returned to camp, usually such wounds were filled with coal dust and severed tendons had to be repaired. Eventually after a number of these mismanaged wounds were demonstrated to the Camp Japanese Army doctor, he ordered that injured prisoners be returned immediately to the camp hospital.

Sharpened bicycle spokes were used as traction wires in the treatment of hip and leg fractures. Plaster of Paris was never available. We observed that simple fractures healed in approximately 2 months in the first year, by the second year in Japan the same type fractures required 4 to 5 months healing time, this we attributed to our worsening nutritional state.

PSYCHOLOGIC & SOCIAL PROBLEMS: I am troubled that the V.A. can recognize a broad range of psychologic and social problems in our current society, and not be cognizant of the fact, that some of the patterns they encounter in former P.O.W.'s are long term results in individuals who had no help available when the emotional or psychic traumas occurred during long confinement. The philosophy of the prisoner of war is a strange one, individually developed to make survival possible in the most hostile environment. He first learned to laugh, at the tragedies that comprised the every day life, he completely obliterated the pangs of hunger. The starving man would willingly trade his meager ration for a few cigarettes. In many instances he would risk his rations gambling with professionals, who pursued their trade without compassion for any life except their own.

The language problem was ever present, interpreters either Japanese or English speaking tended to put themselves in a command position so they created an atmosphere of distrust.

One prisoner of the A detail was executed for attempting to learn to read Japanese, he was utilized as the target for a bayonet drill by the guard detail, his body when examined showed over 75 stab wounds.

Early in the course of starvation hunger is overwhelming and the theft of food by such a person is not a criminal act. The Greek "Pavlokos" was starved to death in the guardhouse for stealing food, it took them 62 days to accomplish this execution, benefit of trial was denied.

For a minor infraction of rules a 19 year old Australian soldier named David Runge, was forced to kneel in front of the guard house for 36 hours, during the period he developed gangrene of both feet: bilateral amputation was carried out 10 March 1945. He was carried on the backs of comrades to keep us reminded of the benevolence of the Japanese. Runge has only recently retired from an active life.

In camp the prisoners life was subject to the individual whims of the guard on duty, the prisoner could be aroused from rest to undergo punishment or humiliation, which ever met the sadistic needs of the guard.

Underground the prisoner was faced with falling walls and ceilings, blast injuries and entombment, he lived each day with the possibility of sudden death or permanent disabling injury.....

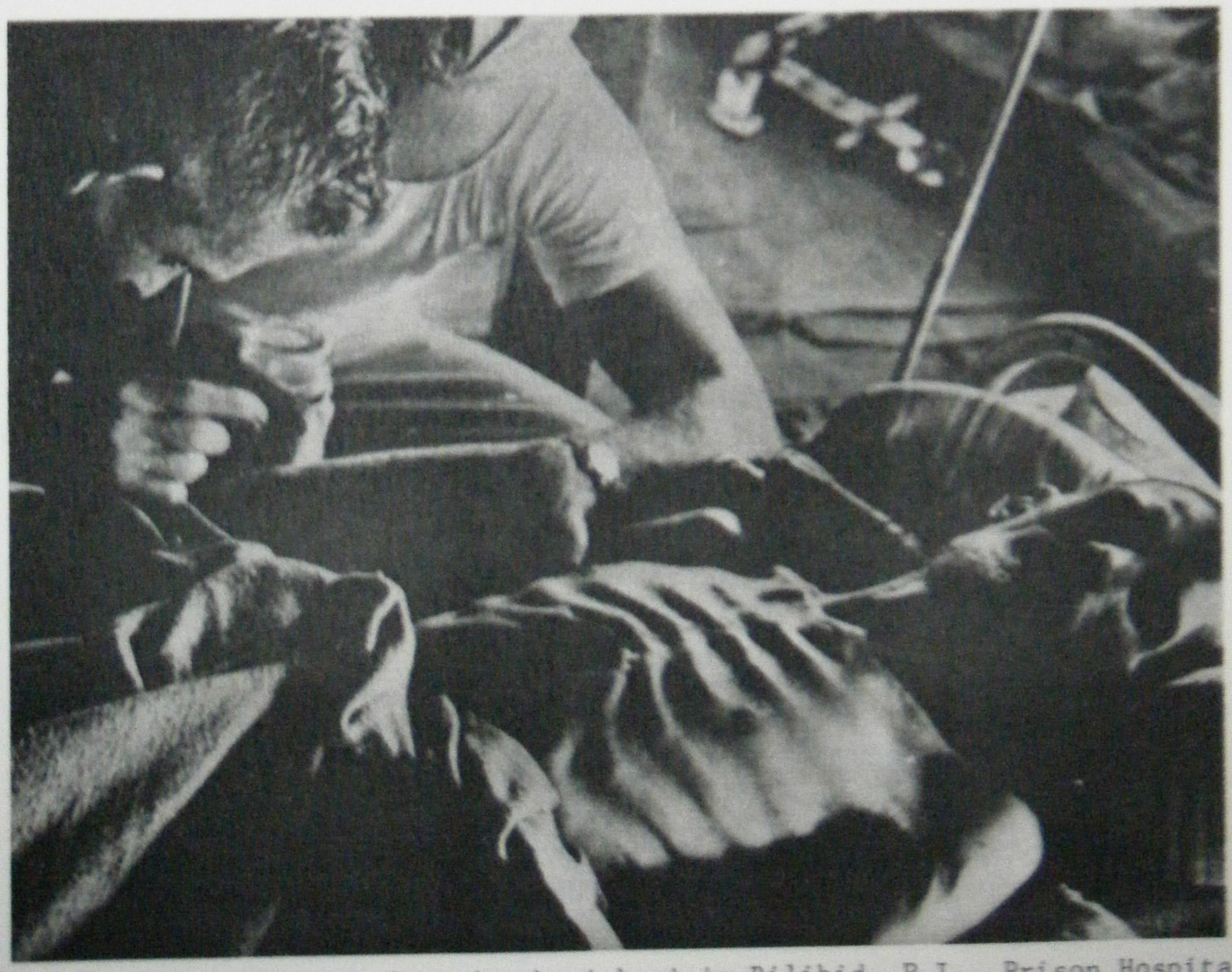
MORTALITY: Our mortality is recorded, and I might comment that it is lower than Dr. Proff and I predicted it might be after our first two months in Camp 17. One hundred twenty six men died in the 2 year period; 48 deaths attributed to pneumonia, 35 to deficiency diseases, 14 to colitis, 8 to injuries, 5 to executions, 6 to tuberculosis, and 10 to miscellaneous diseases.

MORTALITY RATE

			mortality rate
Total population	1859	(126)	6.7%
American	821	(49)	5.9%
Australian	562	(19)	3.3%
British	218	(17)	7.7%
Dutch	258	(41)	4.2%
("A"	500	(21)	4.2%)

What has just been presented to you is not documented elsewhere in the medical annals of this country, the proverbial land of plenty. Certainly no human would knowingly submit to a controlled laboratory study aimed at duplicating this experience. I believe along with Dr. Jacobs, that we survivors still face disabling physical and emotional problems which can be traced to our experience. Medical computers and the young physicians of the V.A. are I believe, completely confused when called upon to evaluate our problems. Medicine is not an exact science, it has chosen to deem the profession an art and a science; our hope must then lie with those physicians who evidence art in dealing with the whole patient.

There is no summary to a nightmare that was permanently tatooed in our brains, but that is how it was for those who were "expended".....



American POW suffering from dry beri-beri in Bilibid, P.I., Prison Hospital