A HISTORY OF ELECTRONICS IN MEDICINE

THE USE OF ELECTRICITY FOR medical purposes dates back to the Ancient Greeks who used the electric eel to treat various maladies. In 1759 Wesley collected case histories of the use of electricity. The first recorded use of electricity for treatment in a hospital in London was in 1767.

Not quite 200 years ago, in 1786 to be precise, Professor Luigi Galvani — an anatomist at the University of Bologna, Italy — discovered by chance that the muscles of a dead frog contracted under the influence of an electrical quantity.

He wrongly assumed that animal electricity stored within the muscle caused this to happen. It was, in fact, the result of dissimilar metals forming a primary electric cell which energised the nerves of the muscle. Volta of the University of Paris proved it and subsequently gave the world the voltaic battery, in 1800.

The contribution of these two men provided, in the simple primary cell, a workable basis for using electricity in practical ways not previously possible with the electro-static form of electricity. Galvani's work on "animal fluid" was amongst the earliest electro-medical studies. The apparatus he used was crude by today's standards — see Fig. 1.

Fig. 1. Artist's idea of Galvani experimenting with frogs' legs in the 1780s. Note the friction electrostatic generator on the left and the Leyden jar on the right (Funk and Wagnells).

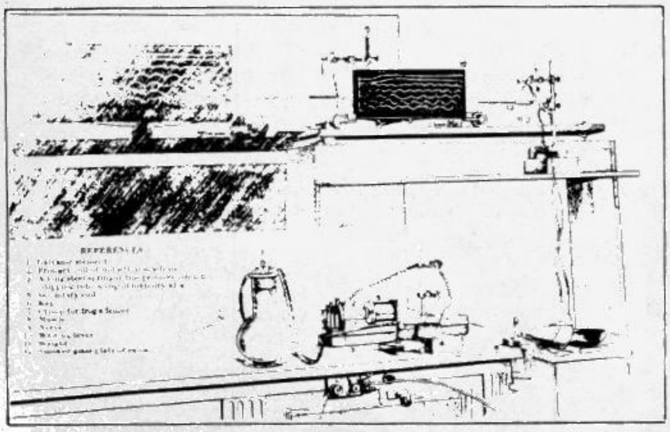


Fig. 2. Apparatus used by McKendrick to give lectures on life in motion to Royal Institution, London, audiences around 1890.

Body Electric?

Research into physiological electric quantities gradually became more sophisticated as the 19th century passed. This development, however, had to wait for suitable experimental inventions such as the electromagnetic galvanometer which became available in its crudest form around 1830. A typical laboratory electro-medical instrumentation set-up of the 1890s is shown in Fig 2. A smoked glass plate moved steadily across the end of a mechanical pen secured to the end of a frog's leg muscle. The muscle was energised by high-voltage generated from a vibration induction coil which was energised by a chromate primary single cell of the Grenet kind. Smoked screen recorders are still in use today in some medical research measurements, blood flow parameters being one example.

The sphygmometrograph (as a pulse measuring instrument was known in that time) was originated by Marey in 1860. A later design by Verdin is shown in Fig 3. Electronic method was little used in medicine in early times, as powerful electric signal amplification was not obtainable until the beginning of the 20th century —

Electricity has long been used for medical purposes, here's the story of the past and a look into the future. By Peter Sydenham.

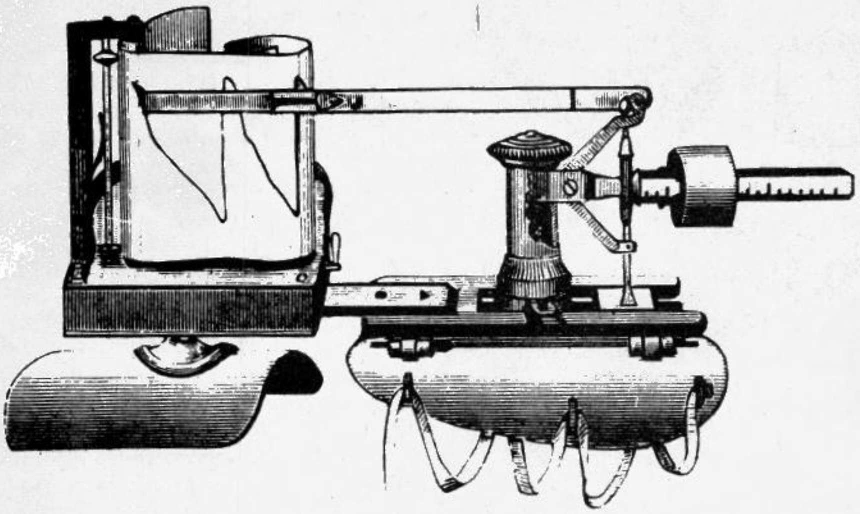


Fig. 3. Verdin's apparatus of the 1890s for recording action of the pulse.

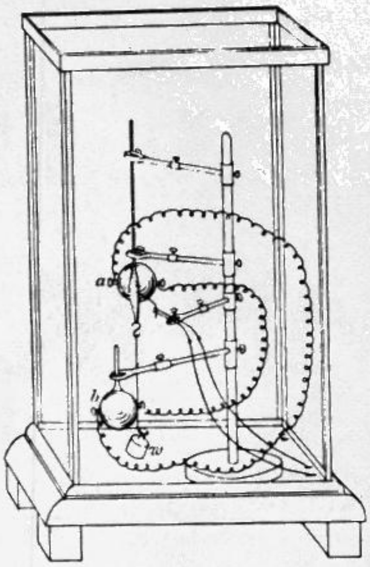


Fig. 4. Schematic of McKendrick's 1891 method for measuring heat generation in muscle.

when the thermionic valve was invented by Fleming (in 1904).

Figure 4 shows experimental equipment for measuring heat production of muscular contraction around 1880. Thermocouples, forming a thermopile, drive the crude galvanometer.

Ion Therapy

Another aspect of medicine where electricity is used is for therapeutic treatment. Since the very early 1800s output of the various kinds of electric current generator, namely the Faraday induction coil, the galvanic chemical battery, the sinewave rotating generator and the friction statical generator have been applied to appropriate parts of the body to provide a cure for all sorts of ailments.

X-ray equipment was born in 1895 when Roentgen discovered X-rays in a chance situation using photographic plates. There is probably no case in instrument history where application was more rapid. Edison, and others, had equipment in use in hospitals within months. Figure 5 shows contemporary American X-ray plant of 1899.

Measurement and recording of heart performance also began around 1900. Professor Einthoven of Holland devised a rapid response, high sensitivity detection instrument in 1903 — the string galvanometer. Soon after this was coupled to a photographic recording system, by the Cambridge Instrument Co., to produce an electrocardiograph. The first installation of this was made in 1909. By 1945 cardiographs were available in portable form. Figure 6 shows the interior of a 1930s Both Brothers portable electro-cardiograph invented and made in Adelaide, South Australia — possibly one of the first portable units devised anywhere. It used a loud speaker drive unit (right) to mark a rotating smoked disk. The record was viewed by the physician using an optical magnifier. Amplification to drive the stylus from skin electrode signals was obtained by thermionic tubes.

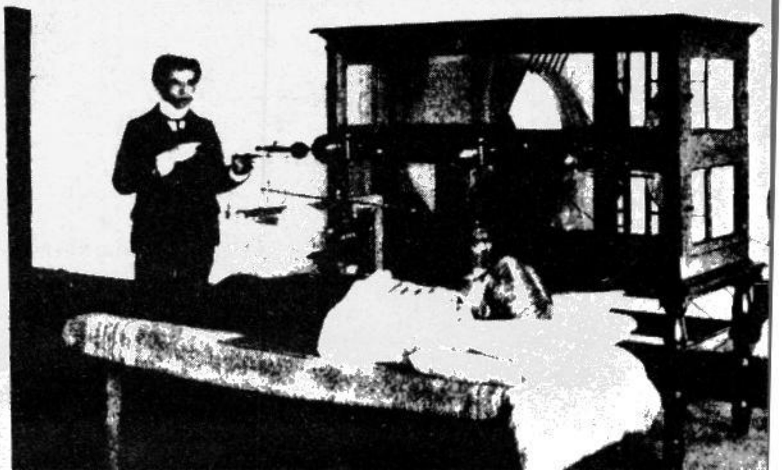
As with all disciplines, electronic method opened the door to new accomplishments. In medical electronics it happened from the 1920s onward. Equipment for researching physiology at Oxford University, in 1949 is shown in Fig 7 The unit, advanced for its time, incorporated amplifiers, a temperature control unit, stimulators to induce responses, a time base and a cathode ray tube display unit.

Electronic equipment used in medicine has come a long way during the past 50 years. This can be seen by comparing the apparatus pictured above, which covers the 1800s to 1930s period, with modern equipment such as that used in pathological testing and nuclear medicine.

Future

Against this background let me now suggest developments we can expect to experience over the next quarter century.

Fig. 5. Complete X-ray apparatus in use in America around 1900. Note the lack of safety devices and precautions.



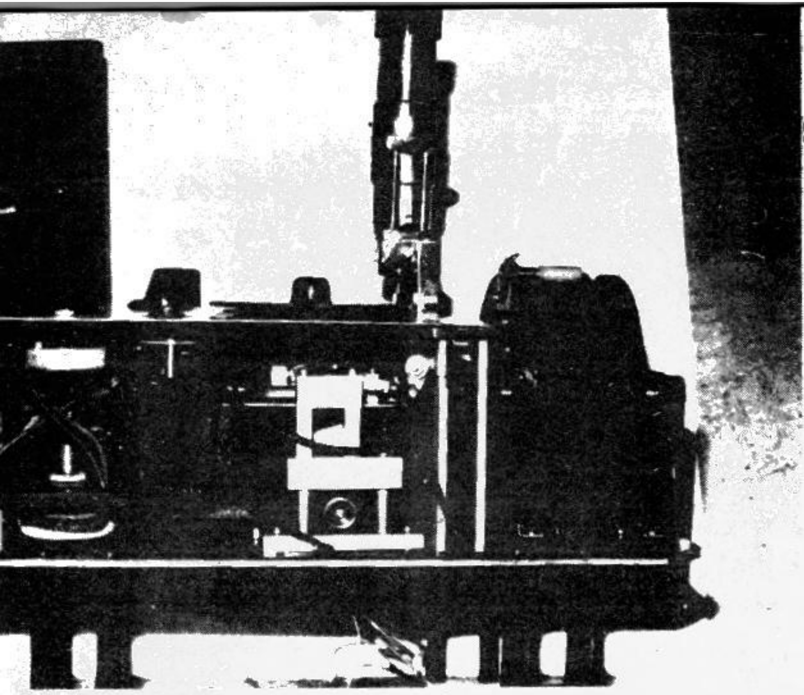


Fig. 6. Interior view of a Both portable electro-cardiograph machine made in Adelaide around 1930.

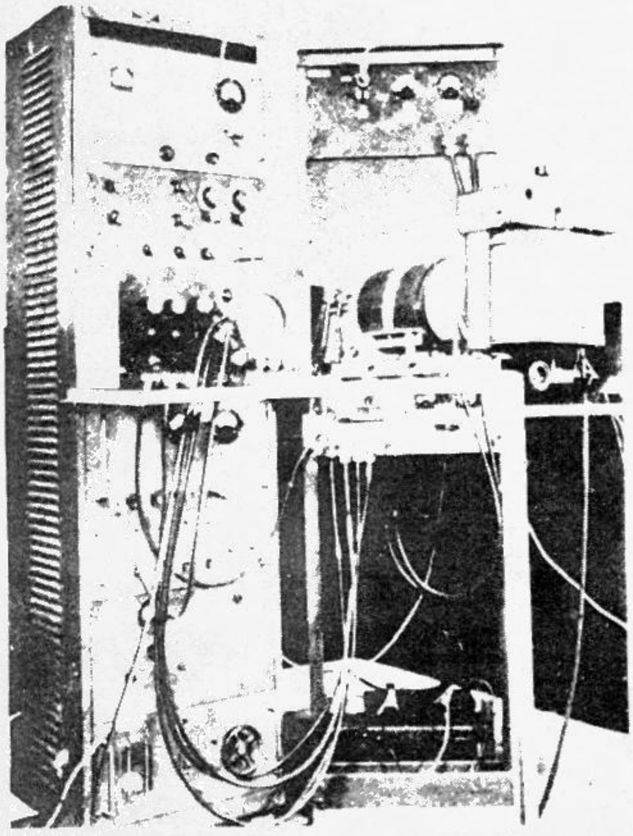


Fig. 7. E Electro-physiological research equipment used by Dickinson at Oxford University in 1949.

Monitoring

The largest proportion of electro-medical equipment is concerned with measurement; for detection of abnormal states. At present comparatively few of the incredibly great range of medical measurements needed can be made in situ on the body and without disturbing its functions. Samples of tissue, blood, urine, etc. are removed for analysis in the pathological laboratory. This process, although performed faster today than ever before, can still take several hours before a diagnosis is available to the physician in order that he or she can decide corrective action. Analysers now exist that handle many measurements of a sample entirely automatically once the sample is loaded into the analyser. But the sample must first be extracted from the body and then be transported to the machine, processes which consume time and in some circumstances alter the sample from its original state.

It is realistic to expect the transport step to be eliminated in the future with most local clinics having their own units for analysis of samples. The next stage in progress will come about by the invention of units that measure parameters such as blood count, albumin, etc, by contact externally to a suitable vein or artery. Direct measurement like this would also provide more accurate measurement as the blood would be in its normal working state. Furthermore, it would then be possible rapidly to optimize drug dosage and to investigate changes in parameters as they happen. The concept of in-situ measurement will apply to numerous other tests.

In special cases some people have already been equipped with sensors of critical body parameters. The outputs are telemetered to a remote observer. Examples of this are in space-medicine, in fitness studies and in a few heart disease cases.

Microbody

Considering the low-cost data processing power already available, and coupling this with inexpensive micro-miniature sensors we can expect to see developed in the future, it is possible that individuals will one day be able to obtain self-monitors that provide warning when body parameters exceed allowable limits.

Better measurements always leads to better control. As an example, respiratory tract problems, such as hay fever and asthma, are hard to combat effectively because of the lack of detailed data about each individual's characteristics in the various circumstances encountered. Not all people are allergic to the same pollens — we could benefit greatly if an easy way existed that determined the allergic pollens involved.

At present, a pollen count is usually taken by drawing the ambient air over a sticky surface for many minutes — hours sometimes. The surface is then observed with a microscope, the technician counting all pollen grains together to obtain the total pollen count. This process is now sometimes carried out using computer-controlled video TV camera systems, but the systems are still barely able to group the various kinds of pollen grain. (They are typically a micrometre in diameter or smaller — counts of a few grains per cubic metre can cause unwanted symptoms.)

A development that could help is a sensor that provides a virtually instant count of the individual kinds of pollen grain present — a real-time sampling analyser.

With such a device the sufferer could test for the hostile situation *before* symptoms arise and take remedial action in time. Technologically such an instrument appears feasible. It is, however, cost and physical size that holds up its development and its practical everyday use at present.

A likely parallel already existing is the Coulter counter that analyses the size and number of cells in a blood sample. Blood-cell counting of several years ago required the blood to be smeared on a microscope slide and the cells counted by eye under a microscope. Today the machine makes the measurements in a few seconds by counting particles as they pass a small orifice — but it is neither portable nor inexpensive. Figure 8 shows a Coulter counter installation as used in the larger pathological laboratories.

Development of personal monitors will almost certainly pass first through a telemetry method in which a central computer processes the data, perhaps with the help of the trained physician to begin with. A direct self-contained method will then be developed in which the specific data processing requirements that have emerged from experience, are integrated into the unit.

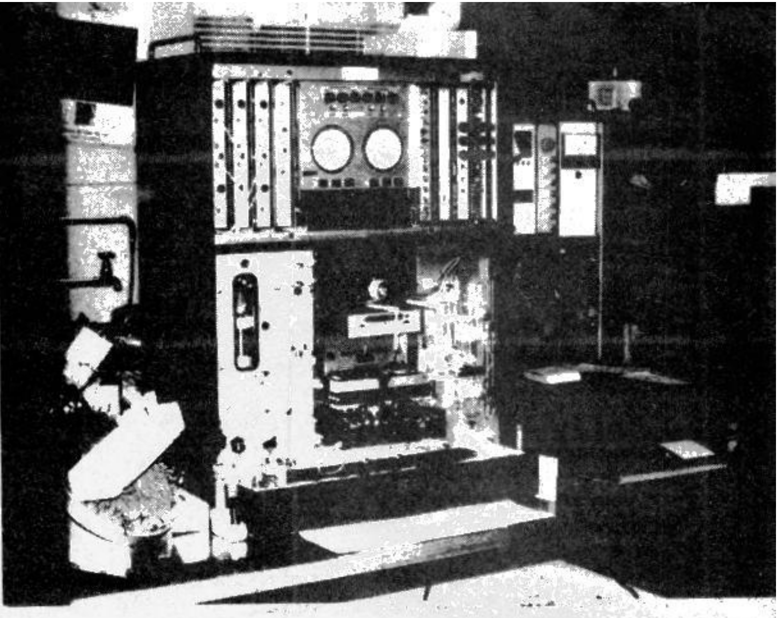


Fig. 8. Coulter counter unit of today that analyses blood sample particles providing a printout (IMUS, Adelaide).

Sensors

The human body is a vastly complicated chemical process plant. It has sensors feeding information to the brain for central processing. In turn, the brain sends signals to actuators — the muscles which cause the body to function and to do work. Nerves are the hardwired data channels for receiving and sending control information.

Slight deficiencies in the senses of sight and hearing have been aided using instruments — spectacles and hearing aids. The latter began as acoustic horns which provided sound pressure gain without active amplification. The advent of the telephone led to amplifierless hearing aids in the 1900's which used several mouthpieces coupled to the ear pieces (Fig 9). Then came electronic units which provided active signal gain from miniature thermionic tubes. Today we have integrated semi-conductor circuitry. We have still a way to go, however, before we are able to compensate for a failed action of the inner ear mechanism.

Vision, until very recently, was aided only by optical lens compensation. But this applies only where the eye is still largely operative as an optical-to-electrical transducer. Quite recently experiments have been reported in which a miniature video camera provides electronic signals that drive cells in the brain to provide illusion of sight. The method is still crude compared with the performance of natural process. Given time for research it seems reasonable to assume that quite compact and useful artificial eyes will soon be available for blind people. Bionic man is not so fantastic! Interestingly, once the bionic eye is developed it is an easy matter to provide greater than natural visual acuity and to offer sensitivity to other than the visible light band — infra-red for instance.

Providing electronic replacements for the sense of smell will most likely be a much later development. We know too little about the olfactory senses and have no really compact and cheap smell sensors at this time to expect great progress to occur in the near future.

Fig. 9. 1900's hearing aid. The three receivers, which fit into the case, provide signal to the two earpieces. No active amplifier was involved. (Birdwood Mill Museum, S.A) ▶

Animals, such as dogs, possess a sense of smell vastly much more sensitive than humans. Ants track each other by a scent trail! Yet man has not yet produced small and inexpensive chemical analysers (smell is a largely chemical process) that can meet the complex sensing requirements of smell detection.

Scanners

X-ray and nucleonic diagnostic methods have the valuable feature that certain internal structures of the body can be seen. But all such methods lack the spatial resolution we obtain by visual examination with the unaided eye or through a microscope. A nuclear radiation source set-up within the body privides a rather diffuse output picture. Resolution is improved by increasing the number of individual elements at the sensing stage. The gamma camera, for example, provides two-dimensional pictures using over thirty scintillometers connected in such a way as to provide many more picture elements. The latest development senses the body area by scanning multiple sensors thereby collecting yet more data in a given time. Sophisticated processing is then used to provide video screen outputs which contain much more useful information than ever before. Similar techniques apply to X-ray, nucleonic and ultrasonic signal transmission. Now that vastly more powerful data processing capability exists the future development will be to incorporate many more sensors of the same kind and make more effective use of three-dimensional data. Other variables, such as, say, thermal emission will also be incorporated along with systematic experience gained into the processing, all this to providing data conversion for a more meaningful measurement process.

Surgery

Electrical methods in surgery traditionally include endoscopes with which to see into inaccessible places and cauterizing probes for sealing blood flow, cutting and destroying cells where need be. The recent introduction of the laser as a cutting tool has most valuable properties. Selection of the appropriate wavelength decides which kind of body tissue will be cut. For example, it is possible to weld the retina of the eye through the pupil without need for surgery. The radiation is only absorbed by retinal material, the pupil and fluid of the eye ball being transparent to the wavelength used.

The selective property of narrow-band radiation will enable some highly precise surgical operations in the future. An operation might go as follows: a rigid framework holds the patient fixed with respect to an x-y-z translating pulsed laser operating head. Wired to the control unit of the translator are electrodes fixed to the body. These sense when low-power sensing pulses are energising the specific part of the body required to be operated upon. The unit scans until sensing signals (operated by a non-cutting wavelength source) verify the location of the beam. Once at such a point the laser is switched to full cutting power continuing to cut as the time-multiplexed sensing signals indicate position is satisfactory.

Looking back, electro-medical apparatus has only been with us for a mere 50 years. In the last 10 years of that time we developed inexpensive and very powerful data processing methods. The next 25 years are likely to unfold undreamed of aids to medicine many of which we would regard as miraculous if we heard about them today. ETI