

complication. The frequent movement of these fractures for dressing, etc., are, of course, both painful and surgically bad.

Wounds of the upper third of the thigh with fracture of the femur may commonly be put up in a Thomas's leg splint (slung and abducted) quite satisfactorily, but too often the ring of the splint covers some area of the wound, and it is not easy to transport cases thus put up by ambulance train without much harmful and painful movement of the fracture.

The various modifications of the Thomas we have found quite unsatisfactory. The half-ring, for instance, may not press on or cover the wound area, but the splint is extraordinarily difficult to keep in position when the patient is in a bed; during transport it is nearly impossible.

A Jones's abduction frame meets the difficulty when there is an anterior wound only, but when, as generally happens, there is a through-and-through wound, of which entrance or exit is posterior, this is in contact with the padded frame, and is difficult or impossible to dress. The frame has other disadvantages from the army point of view—it is cumbersome and takes up much space in supply trains, and it is expensive.

Experience of these difficulties raised the consideration whether it was not possible to devise an apparatus that should be efficient as a splint and yet be comfortable for the patient; allow free access to the wound and facilitate nursing; be simple of structure and application, easy of transportation when in use; cheap, light, and portable when packed.

We claim that all these requirements are met by the Hodges-Lockwood combined suspension and extension apparatus described below, which was elaborated by Captain A. L. Lockwood, R.A.M.C., and myself, with the very able assistance of Mr. Price, of Down Bros., by whom the splint was made to order of the War Office.

1. As a splint good extension is obtained and also fixation, the loin sling tending to prevent slewing of the body, while abduction can be made to any extent required. It can be adapted to either side.

2. It is perfectly comfortable.

3. Its advantages in dressing and draining of posterior wounds are obvious, and as these are not pressed upon there is an improved chance of rapid healing and less pain to the patient, especially as he does not require moving for any purpose. The use of the bedpan, etc., is easy.

4. Once the patient is in the splint he can be moved on to an army stretcher, which the splint is made to fit, and to which it can be firmly fixed. In this way he can be transported by ambulance or by train to the base, or by ship to England without in any way disturbing his fracture.

5. Packed, the splint measures 36 in. by 36 in. by 9 in. Its lightness, simplicity of structure and application, will be obvious from the following description, which is issued with the splint.

The splint consists of an iron cradle which is passed round the patient at about the level of the umbilicus. At right angles to this cradle is attached a second cradle which passes vertically between the patient's thighs. To this again is fixed (1) a cross-bar to give support when the apparatus is on a stretcher, and (2) a modified form of Thomas's leg splint supported at the foot end by a folding upright. This leg splint (made to fold for purposes of packing) is attached to the transverse cradle on the outer side by a short bar, adjustable as to length, and to the second cradle by a slotted bracket and thumbscrew. A stout canvas sling is attached to the transverse cradle by straps and buckles, and suspends the patient's lumbar region and perhaps just the upper part of the sacrum.

A second sling is attached to the second cradle and to the outer adjustable bar to take the weight of the thigh just below the natal fold.

A third sling is fixed to the leg splint near the foot.

The head, shoulders, and opposite leg being suitably

supported, the patient can be raised by means of these slings 6 in. or more above the bed.

Fixation is obtained by means of a padded perineal band strapped to the transverse cradle above and below him.

Extension is obtained in the way usual on a Thomas's leg splint.

Abduction.—By the adjustment of the short outer bar any required abduction can be obtained.

The diagram shows the patient with apparatus in position.

#### Method of Application.

1. Place the transverse cradle in position at about the level of the umbilicus, passing it over the patient's head and shoulders.

2. Push the second cradle into position, passing it between the patient's thighs as shown in diagram, and fix above and below to the transverse cradle by the thumbscrews—but not tightly.

3. Slide the leg splint under the limb and attach the semicircular ring to the second cradle.

4. Fix the short outer bar in position (roughly).

5. Raise the patient by means of the slings, at the same time supporting the head, shoulders, and opposite limb on pillows or half mattresses (biscuits).

6. Fix the perineal band.

7. Apply the necessary extension.

8. Abduct the limb as required by adjusting the short outer bar.

9. Tighten the thumbscrews connecting the two cradles.

## Memoranda:

### MEDICAL, SURGICAL, OBSTETRICAL.

#### RECURRENCE OR REDEPOSIT OF CANCER: WHICH?

In your issue of March 24th Mr. Mansell Moullin relates the case of a lady upon whom he performed gastrectomy for carcinoma of the stomach, and who died "seven and a half years after the original operation, for seven of which she had enjoyed perfect health." He states that "the whole liver was full of small nodules of an unmistakable character." I should like to add very brief notes of two cases of late recurrence or redeposit of laryngeal cancer.

The first was a man who had an epithelioma of the left vocal cord. The diagnosis was confirmed by Sir Felix Semon, and by microscopic examination after operation. I removed the growth by laryngofissure, and the patient enjoyed perfect health for thirteen years. I was then called to see him one evening because of urgent dyspnoea. He was cyanosed, laryngeal stridor was very obvious, and both lungs were congested. It was obvious that while an immediate tracheotomy might prolong life, it was improbable that it would be successful owing to the serious condition of his general symptoms. A tube was inserted, but the patient died a few hours afterwards. Permission was obtained to remove the larynx only. This showed that the scar of the original operation was perfectly healthy, while a fresh cancer had developed in the right, or originally healthy, cord, and that this growth had been the cause of the final laryngeal obstruction. The specimen is in the museum of University College Hospital, and further details of the case may be found in the *Journal of Laryngology* (September, 1903, p. 473).

The second case was originally operated on by Sir Felix Semon for malignant disease of the left vocal cord, and fourteen years later (after Sir Felix had retired from practice) the patient was referred to me for increasing dyspnoea. The larynx was reopened (laryngofissure) and I found such extensive recurrence that in view of the patient's age and general condition only as much of the disease was removed as seemed possible at the time, and the tracheal cannula was allowed to remain. In the course of a few months the growth spread into the trachea, appeared around the tracheotomy opening and assumed such dimensions that a long spiral König's cannula was necessary to reach below the cancerous mass in the windpipe. Eventually he died from pulmonary complications. Here again we have a patient who enjoyed perfect health and immunity from his disease for nearly fourteen years after the primary operation.

I have records of three other cases in which recurrence

of laryngeal cancer took place nine, seven, and seven years respectively after operation.

In reading the statistics of the results of operations for cancer in different parts of the body it has often been assumed that if there is no recurrence within three years the disease has been cured. Such experiences as Mr. Moullin's and my own unfortunately do not warrant such optimism, although at present no method of treatment other than radical intervention in early cases of cancer offers anything like the same prospect of a long immunity. This is particularly the case with laryngeal cancer if the disease is limited to the vocal cords or to their immediate vicinity, because the lymphatic connexion with surrounding regions is fortunately very restricted.

As to the light in which we are to regard such experiences opinions will differ very widely. In my first case a growth appeared on one vocal cord and was removed. The patient lived for thirteen years and then died as a result of a similar disease in the opposite cord. It is improbable that at the primary operation cancer cells were detached and infected the healthy cord, but laid dormant there for thirteen years. Is it possible that the primary growth confers an immunity on the patient, and that the period of this depends on certain constitutional predisposing factors of which we have at present little or no knowledge?

HERBERT TILLEY, F.R.C.S.,

Surgeon, Ear and Throat Department, University  
College Hospital.  
London, W.

## Reports of Societies.

### RE-EDUCATION OF ATTENTIVE CONTROL.

At a meeting of the Association of Registered Medical Women on March 13th, when Dr. HELEN BOYLE was in the chair, Dr. MARY BELL, in a paper on some modern methods of re-education of attentive control used in the treatment of the functional neuroses, said that children and many adults had no power of selective attention and could not concentrate on any one thing for long. In mature age those stimuli had generally been selected which were connected with one or more so-called permanent interests and attention had grown irresponsible to the rest. The level of consciousness varied in different people and in the same person at different times, being lowest in fatigue. Some people were aware of so many sensory stimuli within and without their own bodies that life became a burden to them, and they tended to become increasingly self-centred. Many were unable to concentrate on a simple exercise for more than three-quarters of a minute. A large variety of exercises were used in the treatment; at first two minutes were allowed for an exercise, followed by varied exercises calling forth different faculties for ten to fifteen minutes. Any simple exercise would do, provided it could not be carried out mechanically—thus, a right-handed person might learn to write with his left hand or to do looking-glass writing, etc. Ordinary reading was of no use, but the patient could be made to read upside down. Exercises were given for fixing the attention on co-ordinating muscles and for training the observation. Some patients did better with a subjective type of exercise such as controlled breathing, visualizing words and numbers. Patients tended to be bored at first, and at every pause to talk about themselves, but in a few days they became interested in their progress. The whole day was mapped out, first by the physician, and later by the patients themselves; they walked, gardened, dusted, cleaned motors, played patience, etc. It was good to include some distasteful work in order to develop the power of forgetting themselves. Dr. Bell described some cases of chronic invalids who had been cured by this method and were now doing useful work. Dr. HELEN BOYLE thought patients might be made too conscious of trying to improve themselves by these modern methods. As depression was a very common element, it was important to give encouragement and allow them to do the things they enjoyed rather than those they disliked, by which means a greater concentration on external things was likely to be secured.

## Reviews.

### GRANULOMA VENEREUM.

VENEREAL GRANULOMA is one of the many names given to a chronic ulcerative affection of the skin about the genital organs, occurring in tropical and subtropical countries. An account of some recent investigations of its etiology, occurrence, and treatment, made by Dr. H. C. DE SOUZA ARAUJO, of Rio de Janeiro, was published in the BRITISH MEDICAL JOURNAL of July 29th, 1916 (page 146). A description of a case of the disease, acquired on the Gold Coast, and treated at the Albert Docks Hospital in London by Drs. G. C. Low and H. B. Newham, is given in the BRITISH MEDICAL JOURNAL of September 16th, 1916 (page 387). Quite recently Dr. de Souza Araujo has published at Rio de Janeiro a full account<sup>1</sup> of venereal granuloma, in a book which may be regarded as an extension and completion of his inaugural thesis mentioned above. This new work, which was presented at the first Medical Congress held at S. Paulo in December, 1916, contains eight chapters, and is throughout very fully documented with references to the literature of the subject. The first chapter describes *inter alia* the geographical distribution of the disease, which has been seen in England, Germany, Portugal, various parts of Africa, and North America; it is endemic in Asia, and is comparatively common in Australia, South America, and Oceania. The second chapter deals with the etiology and pathogenesis of venereal granuloma. The author concludes that it is due to a capsulated bacillus discovered by C. Donovan in 1905, and named *Calymmatobacterium granulomatis* by Aragao and Vianna in 1912. It may be added that other microbes of the new genus *Calymmatobacterium* are Friedländer's bacillus, the bacilli of rhinoscleroma and ozaena, the *B. lactis aërogenes*, and other capsulated organisms. The disease rarely attacks children or persons more than 40 years old; the primary infection habitually takes place by direct contact during coitus through cracks or erosions of the skin. The disease is not disseminated by the blood or the lymph channels, but spreads by contiguity of tissues or autoinoculation. A full account of the bacteriology of venereal granuloma is given. The specific microbe is described as capsulated, non-motile, Gram-negative, non-spore-forming, unable to liquefy gelatine or to coagulate milk. The organism was first cultivated in 1912 by Aragao and Vianna, and is polymorphic, occurring as cocci and bacilli, diplococci, diplobacilli, and filaments, all with a mucous capsule, whether in the tissues or in artificial cultures. It retains its virulence for experimental animals, at any rate as far as the hundredth subculture on gelatine; the virulence can be increased by the method of passage through animals up to a certain point. The experimental study of venereal granuloma began in 1896 with the unsuccessful attempts of Conyers and Daniels to inoculate guinea-pigs with infective material from cases of the disease in British Guiana. Aragao has employed rabbits, guinea-pigs, rats, marmosets (*Haple penicillata*), and dogs in his experiments. Death due to *C. granulomatis* septicæmia usually occurs in twenty-four to forty-eight hours after intraperitoneal inoculation and sometimes after subcutaneous inoculation. The account of the pathological histology of venereal granuloma is illustrated with microphotographs and coloured plates; the disease begins in the corium, which becomes extensively infiltrated with plasma cells, particularly in the papillary and Malpighian layers. The plasmomas thus formed presently break down, with ulceration of the skin, which spreads widely but not deeply. Spindle cells and mast cells are not abundantly present; newly formed connective tissue is found in the older cutaneous lesions with numerous capillaries, forming nodular outgrowths and later scar tissue, which contracts. No giant cells are seen. The specific bacterium can be seen in sections stained with Unna's polychrome blue or Giemsa's stain; taking the form of intracellular or extracellular cocci, diplococci,

<sup>1</sup> *Granuloma Venéreo. Trabalho do Instituto Oswaldo Cruz. Prefaciado pelo Dr. Fernando Terra, apresentado ao primeiro Congresso Médico-Paulista. By Dr. H. C. de Souza Araujo. Rio de Janeiro: Companhia Lithographica Ferreira Pinto. 1917. (Imp. 8vo, pp. 246, with 7 coloured plates and 40 figures in the text. Price, 10 dols.)*

## The Services.

### EXCHANGES.

CAPTAIN in field ambulance in France desires to exchange with an officer in training centre or hospital at home.—Address No. 1050, BRITISH MEDICAL JOURNAL Office, 429, Strand, W.C.

Recommending Medical Officer, Birmingham, desires an immediate exchange with one holding similar appointment in London area.—GALLETT, Captain R.A.M.C., Curzon Hall, Birmingham.

M.O., Divisional Train, would like to transfer to some unit in a Scottish Division, preferably 15.—Address, No. 1049, BRITISH MEDICAL JOURNAL Office, 429, Strand, W.C.

## Universities and Colleges.

### UNIVERSITY OF ABERDEEN.

At the graduation ceremony on March 23rd the following degrees were conferred:

M.D.—J. C. Bell, \*G. Riddoch.

M.B., Ch.B.—†A. G. Lumsden, †G. R. McRobert, W. F. W. Betenson, J. S. B. Forbes, †R. R. Garden, †A. C. Irvine, W. C. MacKinnon, †C. G. S. Milne, Maggie J. Moir, J. M. Morrison, W. W. Nicol, F. M. Rorie, C. Shearer, A. P. Spark, †R. Thom, T. D. Watt, Jean Yule, V. T. B. Yule.

\* Honours for Theses.

† With second class honours.

‡ Passed fourth professional examination with much distinction.

§ Passed fourth professional examination with distinction.

### UNIVERSITY OF MANCHESTER.

THE following gentlemen have obtained the Diploma in Public Health: T. C. Mackenzie, S. N. Mitra.

## Medical News.

MAJOR H. MACCORMAC, R.A.M.C., will read a paper on April 19th, at 5 p.m., before the Dermatological Section of the Royal Society of Medicine, 1, Wimpole Street, W., on skin diseases under war conditions in France. A discussion will follow.

A BILL allocating £50,000 for the establishment of a national home for lepers passed the United States House of Representatives on May 4th, 1916, and the Senate on January 25th, 1917. It provides a national institution for the care and treatment of lepers, and thus, it is hoped, will prevent the spread of leprosy in the United States.

THE arrangements of lectures at the Royal Institution after Easter include two by Professor C. S. Sherrington, on tetanus: its prevention, symptoms and treatment; and on rhythmic action in muscle and in nerve. Professor D'Arcy W. Thompson will give two lectures on laws of growth and form; and Professor William Bateson two on heredity. Among the Friday discourses (5.30 p.m.) will be one on the organs of hearing in relation to war by Dr. Dundas Grant, another on the complexity of the chemical elements by Professor Soddy, and one on breathlessness by Mr. J. Barcroft.

THE meeting of the Poetry Society on March 23rd, to hear the poems of Sir Ronald Ross, was well attended. Sir Herbert Warren, who was in the chair, paid a tribute to the poetry as instinct with "the passion of the head," and as affording a rare example of high scientific combined with high poetical achievement. The poems, read by the poet assisted by Miss Miriam Lewis and Mr. William Stack of the St. James's Theatre, were representative of the graver side of his work. It was announced that Sir Ronald Ross will shortly succeed Sir Herbert Warren as president of the society.

ON February 19th Dr. Stephen Smith, the doyen of American hygienists, celebrated his 94th birthday. He took his degree at the New York College of Physicians and Surgeons in 1850, and devoted himself to the study of sanitary questions. He took a leading part in establishing the Health Department of New York, of which he was the first Commissioner. He was the founder and first president of the American Public Health Association. He still takes an active part in the work of the New York State Board of Charities.

THE report of Dr. Becerra, Director-General of Sanitation of the Republic of Ecuador for 1915-16, states that during that year the mortality from tuberculosis was 1,970, being 11.7 per cent. of the general mortality. Yellow fever caused 682 deaths, dysentery 255, typhoid fever 209, diphtheria 9, typhus 4; there was no death from small-pox. Ankylostomiasis robs agriculture of hundreds of labourers, and syphilis constitutes a difficult social problem. But one of the principal causes of the stagnation of Ecuador is said to be the failure of immigration, due partly to the lack of guarantees to immigrants.

## Letters, Notes, and Answers.

ORIGINAL ARTICLES and LETTERS forwarded for publication are understood to be offered to the BRITISH MEDICAL JOURNAL alone unless the contrary be stated.

AUTHORS desiring reprints of their articles published in the BRITISH MEDICAL JOURNAL are requested to communicate with the Office, 429, Strand, W.C., on receipt of proof.

THE telegraphic addresses of the BRITISH MEDICAL ASSOCIATION and JOURNAL are: (1) EDITOR of the BRITISH MEDICAL JOURNAL, *Antiochy, Westrand, London*; telephone, 2631, Gerrard. (2) FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Articulate, Westrand, London*; telephone, 2630, Gerrard. (3) MEDICAL SECRETARY, *Mediscera, Westrand, London*; telephone, 2634, Gerrard. The address of the Irish Office of the British Medical Association is 16, South Frederick Street, Dublin.

Queries, answers, and communications relating to subjects to which special departments of the BRITISH MEDICAL JOURNAL are devoted will be found under their respective headings.

### QUERIES.

#### INCOME TAX AND THE WAR LOAN.

THRIFT asks for information as to the liability to income tax of interest paid on War Loan secured by a policy taken out under a special scheme with a company.

\*\* It is difficult to answer this question fully without precise details of the scheme, but if we may assume that the War Loan stands in his wife's name, then the interest paid thereon is *prima facie* liable to tax to be assessed on him. In effect, the interest would be paid to her benefit in that it would, *pro tanto*, reduce her accruing indebtedness to the insurance societies. If annual interest be paid to the latter, then income tax may be deducted therefrom on payment. As regards the quarterly premiums, the usual income tax allowance is due provided that the policy is "for securing a certain sum on death." There are of course other conditions, but these are no doubt complied with in this case. We may perhaps add that in connexion with another case of War Loan interest, we understand that the view of the income tax authorities is that, as the basis of assessment is the amount of untaxed interest received in the year preceding the assessment year, the first liability arises in the year 1918-19, and is determined by the amount received in the year 1917-18.

### LETTERS, NOTES, ETC.

#### GENERAL DE GALLIFET'S "SILVER BELLY."

THE late Marquis de Gallifet, one of the finest cavalry leaders France has ever had, and a highly capable Minister of War, had a great part of his abdominal wall torn away by a shell in Mexico. The wound never completely cicatrized, and for the rest of his life he had to wear a protective cuirass. The general was, like many good soldiers, something of a dandy, and there used to be a good deal of curiosity about what irreverent persons called his silver belly. Now we learn from the *Chronique Médicale* that Ernest Guibal, formerly *prérot d'armes* in the French army, who recently died at Berne, used to tell his pupils that he had seen the cuirass a hundred times. The general, when he came for fencing practice, always took it off. Guibal described it as a kind of coat of mail made of very thin silver plates. It was oval, measured nearly 20 cm. in width by 30 cm. in length, and was fixed round the loins by a leather strap. The wound was covered only by a very thin integument, and for this reason the marquis was advised by his doctors to protect the part by an artificial covering. In this connexion we may recall the case of Jean de Mirabeau who was left for dead at the battle of Casano with twenty-seven wounds, one of them made by a bullet which "severed the tendons" in the throat and divided the jugular vein. He lived however to beget the dour old "Ami des Hommes" who in time beget Gabriel Honoré, the Mirabeau of the Revolution. Jean had to support his injured neck with a silver stock and hence was nicknamed *col d'argent*.

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