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(4) The essence of the treatment consisted in the adoption of immediate, persistent, and almost extravagant serum therapy.

(5) The result of the treatment was an uncomplicated recovery, with entire absence of secondary lesions.

TRANSMISSION OF MALARIA IN NORTHERN FRANCE.

By Captain J. H. Dible.
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The presence of malaria-infected persons in the area occupied by British troops in Northern France raises the question of the likelihood of transmission of the disease to uninfected subjects living in the same districts. The cases quoted below show that such transmission can and does occur.

Both of these cases were sent from the Front to a base hospital. In neither case had a diagnosis of malaria been arrived at when they were admitted here.

Case 1.—Private O., Black Watch, was taken ill whilst in the trenches with his battalion about a fortnight prior to his admission. He complained of pains in the head, general malaise, and attacks of shivering; also of pain in the left side over the splenic area. The symptoms first commenced at about mid-day, and recurred daily, starting with chilliness and shivering, which was later followed by sweating and amelioration of his condition. He was admitted to this hospital as a case of indeterminate pyrexia; an accompanying temperature chart showed periods of pyrexia occurring at about 2 to 3 p.m. daily; on three occasions rigors had been noted. He complained of pain over the splenic region, but the organ was not palpable. The history was thus that of a typical quotidian fever.

On the day of admission (August 26) he had a rigor at noon, and at 2 p.m. his temperature stood at 104.6° F. Blood-films taken at this time showed the presence of numerous malarial parasites, mostly moderately grown plasmodial forms, with scattered particles of hemozoin pigment, though less mature and young ring forms were also seen. The appearances of the parasite identified it as that of tertian fever. The condition entirely subsided under the administration of quinine.

Prior to the War this patient had never been out of Scotland. He was a pottery worker by trade, and had spent most of his life in the vicinity of Paisley. He came to France on May 10, 1915, and landed at Boulogne, from whence he was moved to the Armentières-Bailleul district, and thence after a short time to Lillers, and on to ———, where he remained until the occurrence of his present illness. When not in the trenches he was billeted in various farms; both in billets and in the trenches he suffered a good deal from mosquito bites.

Case 2.—Gunner G., Royal Garrison Artillery, admitted to base
hospital, August 24, 1915. He had been taken ill at the village of ---, near Lestrem. The illness began in the evening, and was of sudden onset with pains in the head and legs, malaise, and shivering, which were, after a time, succeeded by fever and sweating with relief to his symptoms. The following day the attack recurred, and he "reported sick." He was laid up in his bivouac for three days, and finally evacuated as a case of influenza. In hospital he was found to have a marked intermittent fever, the periods of pyrexia recurring every second day, and the temperature reaching on an average 105° to 106° F. The spleen was not palpable. Blood-films, taken during the cold stage of one of the attacks, were found to contain numerous malarial parasites. These, at this time, were chiefly the fully grown and early sporulating forms; in addition typical sporulating forms were seen. The appearances of the parasite and the number of merozoites to which it gave rise enabled it to be identified as that of tertian fever, the Plasmodium vivax.

This man, also, had never been out of England prior to joining the Expeditionary Force. He had served four years in the Army and had never seen foreign service. Before enlisting he had been a labourer. He came to France on August 17, 1914, landing at Rouen and subsequently being at Mons and through the retreat. After the battle of the Marne he was in the Ypres district from October to April, when he was moved to the vicinity of Lestrem, where he has been quartered ever since. During the summer he has bivouacked under a temporary tarpaulin shelter in the orchard of a farmhouse; this bivouac was within fifty yards of a canalized river and in a low-lying field surrounded by stagnant dykes, such as are a prominent feature of this part of French Flanders. He was much bitten by mosquitoes.

The significance of these two cases lies in the fact that the possibility of their being recrudescences of an old-standing infection does not occur, so that, in both cases, the infection has taken place in French Flanders, where, so far as I am aware, there is no endemic malaria.

Both these men, then, have contracted the disease in the region occupied by the British Army, and it is logical to conclude that malaria-infected mosquitoes are now present in this area.

The country in which these cases occurred is eminently suited to the mosquito, being flat and well watered. It is largely intersected with deep dykes which, even in the height of summer, have some feet of stagnant water in them and form an excellent breeding-ground. Moreover, the farms of this region are of a very insanitary description and an abundance of decaying organic material is inevitably to be found in their vicinity. Anyone who has lived in this part of France during the summer months can testify to the abundance of mosquitoes, and these are an especial nuisance to the men who commonly bivouac in small tarpaulin shelters of their own construction. In these low shelters mosquitoes and flies of all kinds are extremely abundant and very troublesome.
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The country is, then, infested with mosquitoes. Prior to the War there were presumably no malarious inhabitants in this region, but, with the coming of the British Army a certain number of individuals have been introduced with the parasite in their blood and all the factors for the transmission of the disease are thus present. It is a significant fact that the patient in the second of the above-cited cases had, for the whole of the summer, been living in a part of the country which has long been occupied by a division of the Indian troops and where recrudescent cases of malaria are consequently comparatively common.

The occurrence of cases such as those above quoted raises the larger question of the possibility of the disease remaining endemic, and suggests the necessity for the adoption of strictest anti-mosquito measures.

RECEPTION OF WOUNDED WHEN ON ACTIVE SERVICE.

By Major G. Baillie.

Royal Army Medical Corps.

Although it may seem somewhat belated to send notes on the subject of reception of wounded, and as each unit has a method of its own which has been found to work well, my excuse for doing so is because the system which has been adopted at this 22nd General Hospital has now been tried for more than three months, and found to work quite smoothly, and in consequence may prove useful to other general hospitals as yet in formation.

There are some important preliminaries to be noted before coming to the actual reception of the wounded in a general hospital.

This general hospital has its wards divided into three sections, viz.: Section "A" (all medical), consisting of eight wards. Section "B" wards 1, 2, 3, 4, surgical; No. 5, dental; No. 6, eye, ear and throat; Nos. 7, 8, 9, medical. Section "C" (all surgical consisting of eleven wards), No. 11 genito-urinary.

The chart on p. 581 is used for the daily return of vacant beds in wards which the medical officers in charge of the medical and surgical sections render daily to the registrar as the wards which they desire to have utilized in the event of a convoy arriving, and for noting the numbers admitted to each ward when the convoy arrives.

The column for "Vacant Beds" is filled in every morning as soon as the wardmasters hand in their lists of beds available in each ward, and later as soon as a convoy is notified each wardmaster places the kits (according to the numbers of vacant beds in each ward) for the patients in the wards which will be assigned to them. This should be done so that the nursing orderlies will not have to do so when the patients arrive, also it may be noted that two extra orderlies are placed on duty at the bath tent to act as conductors for the patients on returning to their