the foot with petrol or ether to remove the grease. Apply the sock dry, and paint its outside with the following preparation:—

\[ B \text{ Canada balsam in xylol} \\
\text{Venice turpentine} \\
\text{Ether} \]

When dry, place a layer of cotton-wool between the perforated zinc and foot, and fix the two together with a band of adhesive plaster round the dorsum. Adjust the cord from the arc L until the bars H I are parallel to the bones of the leg. Embed the latter in a plaster case extending down as far as convenient (about 6 or 7 inches) from the tuberosity of the tibia. Support the uncovered portion of leg with suspensions of elastic webbing or bandage. The foot is now fixed at right angles to the leg. Figs. 2 and 3 show the splint applied to a patient and slung by four cords, snap hooks, sandbags, and eight pulleys to a modified horizontal bar. This gives the patient free movement in bed, and the attendants free access to the wounds.

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**A CASE OF CEREBROSPINAL MENINGITIS, WITH PARATYPHOID “A” FEVER, COMPPLICATED BY HERNIA OF THE SMALL INTESTINE THROUGH THE MESENTERY; OPERATION, RECOVERY.**

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The following case is worthy of record on account of its complication and eventual recovery:

W. W., aged 21, was admitted to the isolation hospital, on September 24, 1915, with the provisional diagnosis of cerebrospinal meningitis. Four days previous to admission he commenced to suffer from general malaise, nausea with vomiting, drowsiness, sore throat with glandular enlargement. He continued at his duty, but on September 23 lost power in both lower limbs which, he said, were "too stiff" to move, and he reported sick on that date.

On admission, September 24: Pulse 100, respiration 24, and temperature 101.2° F. His mental condition was good, except that he was very lachrymose, crying repeatedly on the slightest provocation. Head retraction was marked and he complained of intense headache, more especially in the occipital region and back of the neck, which was increased on movement. The pupils were dilated but reacted to light and accommodation. There was slight photophobia, and he complained of pain at the back of the eyes. Kernig's and Brudzinski's signs were marked. He moved his lower limbs with difficulty and they were markedly rigid. His knee-jerks were increased, but there was no ankle
There was no hyperæsthesia and tachecerebrale was not obtained. His mouth was very dirty and throat injected. Clinically, he was a typical case of cerebrospinal meningitis, so a lumbar puncture was performed and fifteen cubic centimetres of clear fluid were withdrawn under pressure. As the fluid appeared clear no serum was introduced.

Lieutenant A. Banks Raffle, R.A.M.C., examined the fluid and found meningococci microscopically. Subsequently he obtained a pure culture of this micro-organism from the specimen.

On September 25 a lumbar puncture was again performed, fifteen cubic centimetres of fluid being removed, and fifty cubic centimetres of Mulford's antimeningococcic serum introduced without difficulty by the gravity method. I have found no danger in these cases from the introduction of a larger amount of serum than fluid withdrawn, if the gravity method is adopted. Meningococci were found in this specimen.

The following mixture was also prescribed:

- Hexamine 15 gr.
- Sodi salis 10 "
- Pot. iod. 5 "
- Aq. menth. pip. 1 oz.

One ounce every four hours in water.

This mixture was given as a routine in all my cases of cerebrospinal meningitis. It was continued in all until the slightest trace of blood was found in the urine, when it was discontinued for one day, repeated for two days, omitted on the third day, and so on, the urine being meanwhile carefully examined for albumin and blood.

The nose and throat were syringed four-hourly with liq. cresol co. 1 in 100, and calomel 3 grains, followed by mist. alba, was given as required for constipation, which is usually a marked feature in these cases.

Three hours later there was marked serum reaction, with temperature 104·2°F., pulse 116, respirations 24. He complained of intense headache and was excited and restless. There was great pallor and considerable collapse. He improved under stimulants, and twenty-four hours later was much better.

On September 28, 18 cubic centimetres of cerebrospinal fluid were withdrawn and 15 cubic centimetres of serum introduced; no reaction followed. Micro-organisms were not found in this specimen.

On September 29 hematuria was present, so hexamine mixture was omitted.

On September 30 his condition was as follows: Kernig's and Brudzinski's signs and head-retraction slightly present; headache much better. He could move his legs freely, though knee-jerks were still slightly exaggerated. On this date symptoms suspicious of enteric group fever were apparent. His temperature was of the enteric type, his abdomen tumid, with a suspicious roseolar rash, and the spleen was just palpable.
Clinical and other Notes

On examination of the blood the paratyphoid A bacillus was isolated. The patient's serum agglutinated the typhoid bacillus when in a dilution of 1 in 100, but did not clump the paratyphoid A bacillus.

Subsequent examination of the patient's serum made at intervals of four days showed that its agglutinating power for Bacillus typhosus remained constant, whilst that for the paratyphoid A bacillus rose, being 1 in 50, 1 in 100, and 1 in 400 on the second, third and fourth examinations respectively, as is frequently found in Bacillus A infections. Probably the agglutination of B. typhosus was the result of previous inoculation (February, 1915.) Paratyphoid B bacillus was not agglutinated.

For the following three weeks he ran the uneventful course of paratyphoid A fever, of more than usual severity, and his temperature had
been practically normal for eight days, when at 12 noon on October 22 he cried out owing to a sudden onset of intense pain in the epigastrium.

His condition on examination was as follows: Temperature 99.8° F., pulse 124, respirations 36, and abdomen rigid with no respiratory movement. There was diffuse tenderness on palpation which was more marked in the epigastric region. He was seen one hour later in consultation with Major H. C. Donald, R.A.M.C.(T.F.), and Major G. Baillie, R.A.M.C., when the rigidity had passed off and he complained of practically no pain on palpation. There was no distension of his abdomen. His condition continued the same except that his pulse-rate rose steadily to 144, and there was a gradual increase in the rigidity of the abdomen, but he complained of no pain and repeatedly said that he felt all right. There was no sign or symptom of a recurrence of the cerebrospinal condition and a thorough examination failed to account
Clinical and other Notes

for the rising pulse-rate apart from the abdominal condition. Perforation was suspected and laparatomy decided on. His general condition was very bad, and one and a half pints of saline were given intravenously during the operation, with marked benefit to the patient.

The operation was performed by Major H. C. Donald, and it was found that a coil of small intestine had passed through a breach in the mesentery and was twisted on its axis. On untwisting the gut, it was easily withdrawn through the aperture in the mesentery. The intestine did not appear greatly damaged. The subsequent progress of the patient was without event; the laparatomy wound healing by first intention, and the patient was sent to England convalescent, on November 11, 1915.

The case was one of twelve suffering from cerebrospinal meningitis which were treated at the isolation hospital. The method of treatment described above for the cerebrospinal condition was adopted throughout and appears to have been particularly successful, as there were only two deaths in the series. All the cases were diagnosed bacteriologically, the meningococcus being found in the cerebrospinal fluid by Lieutenant-Colonel L. W. Harrison, D.S.O., R.A.M.C., and Lieutenant A. Banks Raffle, R.A.M.C.

TRESTLE FOR SUPPORTING FIELD STRETCHER.

MIGHT I venture to refer to the interesting description in the Journal of the trestle for supporting field stretchers, invented by Captain McFayden, R.A.M.C. This trestle was very kindly first shown to me by Major Symons, D.S.O., R.A.M.C., and from a pattern he gave me, I had many made for the use of No. 4 Stationary Hospital. I have tried them constantly in a building and in camp since December, 1914. Major Symons pointed out to me the nails used in fixing the upper horizontal battens at each end as the weak point. This I am now able to confirm after