A SIMPLE FORM OF FLY-PROOF LATRINE AS USED IN WEST AFRICA.

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A pit is dug in the ground as shown in fig. 1, in suitable soil, to a minimum depth of 15 feet, the pit is 2 feet 6 inches wide at the top and opens out to about 6 feet in width below, that is in sufficiently dry soil. The length is made according to requirements, allowing 2 feet 6 inches of trench for each seat required.

The bottom of the trench is then covered with a layer of stones or shale.

Small logs or boles of wood are then cut of sufficient strength (about 4 feet long) to span the trench and bear the weight of several people. These are placed across the trench as indicated by the letters A B in fig. 2. In every 2 feet 6 inches of trench length there is a width of 1 foot 6 inches of the cross sticks, followed by an interval or space of 1 foot.

More sticks which may be longer are then placed longitudinally along the trench over the cross sticks as indicated between C D, fig. 2. These cover the whole length of the trench and the whole width with the exception of a 1-foot interval in middle. These may now be secured to the cross sticks by a few turns of rope (tie-tie).
The whole is now covered with a mound of earth (wet) of a clay-like nature, leaving only the square 1-foot hole E, fig. 3, where the sticks are absent. The earth is well trodden down and the inner surface of the holes smoothed round.

![Fig. 3](image)

Small wooden frames as shown in fig. 4 are now constructed from a few broken boxes and hinged lids fitted. The boxes are slightly over 1 foot square, so as to rest on the upper layer of sticks. They are embedded in wet mud in the apertures, forming a fly-proof roof so long as they are kept closed. The wet mud is given a few hours to dry, and the latrine is then ready for use.

**Notes on the Use of this Latrine.**

1. This latrine does not depend upon its fly-proof lids for its immunity from flies, but upon the depth to which it is dug. It is found in practice that the flies do not penetrate much deeper than 10 feet.

2. The great depth and capacity of the trench ensures liquefaction of the faeces, and will make natural drainage feasible for many months if necessary.

3. The soil immediately surrounding the apertures should be given a daily dressing of creosol or preferably izal, and the soil renewed occasionally.

![Fig. 5](image)

4. The sanitary squad should have instructions to keep a constant eye upon the lids, keep them in good repair and constantly shut when not in use.

5. The latrine is smoked out daily by means of the simple apparatus shown in fig 5. This consists of a tin suspended by a piece of wire from a small cross piece of wood which rests on the wooden frame, thus keeping the lid slightly open at the time of burning and giving enough oxygen to ensure combustion. A few
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Embers are placed in the tin and a few pieces of damp wood, and these will smoulder for hours.

(6) Defecation is performed in the manner natural to the native, and a few palm leaf screens placed round will lend a touch of realism which will prove almost as attractive as his native bush.

Note by Major J. A. Balck, RAMC.

The latrine described above has been seen by me in actual use in West Africa, and in freedom from nuisance and general cleanliness is in my opinion superior to any other form of native latrine I am acquainted with. It is at my instance that Captain Anthony has written this description, as I think his method well worthy of wider notice than it has yet received. It can of course be easily modified for the use of officers or Europeans generally by substituting for the mere framework shown in fig. 4 a complete box, thus giving a seat.

The Diagnosis and Estimation of the Degree of Neurasthenia by Means of Perimetric Examination of the Eyes.

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Neurasthenia is in a lesser degree the analogue in this war of enteric in wars of the past; its victims can be numbered by the thousand, both in and out of the army and every day adds considerably to the total. The importance of the disease is being recognized. Hospitals are being established and medical men specially trained to treat the constantly accumulating masses of cases which are so badly hampering our man power and will continue to do so for a period after the war.

Unfortunately the disease (although its general picture is distinct) is more subjective than objective, and in regard to minuter and more tangible details is somewhat vague. Neither is it always easy to estimate the degree to which the disease has progressed nor to differentiate between simulators, of whom there are many and real sufferers. The usual methods of examination are so vague in their results and so lacking in their quantitative estimation that it needs no apology for bringing to notice certain eye symptoms which are capable of being measured, are very unlikely to be simulated and at least one of which in so far as my experience goes is invariably present. Most of the symptoms are known but apparently not widely even to those treating neurasthenia and no attempt as far as I know has been made to introduce systematic eye examination. Unfortunately in this hospital I have not had a very large number of cases. In the course of examination during the past six months of 2,500 ophthalmic out-patients, most of them British Expeditionary Force men, I have come across some undoubted cases of neurasthenia, many border line cases, a certain number of malingerers, and a goodly proportion of hysterias. In addition most admissions to the neurasthenia ward were sent to me for examination; thirty-seven cases of undoubted neurasthenia...