

eosinophile infiltration was a marked feature. Sections of the subcutaneous nodules showed the same characters.

Since polyarteritis nodosa was first recognized in the middle of last century as "a peculiar disease of the arteries which is accompanied by Bright's disease and progressive general paralysis of muscles," about 200 cases have been reported and in only a few of these has the diagnosis been made before death. Pathologically, whitish grey nodules are seen along the small and medium arteries of the kidneys, heart, liver, alimentary tract, mesentery, muscles, pancreas, peripheral nerves, skin and brain, in this order of frequency. These nodules may be of varying sizes and are really aneurysmal dilations which are apt to rupture, while in some thrombosis may occur leading to the formation of multiple infarcts. It is believed that the earliest change is in the adventitia with subsequent necrosis of the media and final proliferation of the intima of the arteries involved. The cause is unknown, but in a certain proportion of cases it has followed some kind of infection; the cause has been ascribed to the action of a virus and alternatively, owing to its resemblance to acute rheumatism, it has been regarded as an allergic effect in a streptococcal infection. The symptoms are the result of the combined effects of the presence of these arterial dilations, infarcts and hæmorrhages resulting in an alteration of blood supply in the regions affected. Briefly, these effects are fever, increasing general weakness, anæmia, tachycardia, muscular pains in body and limbs, with tender muscles, signs of a peripheral neuritis affecting any or all limbs with loss of reflexes and perhaps some sensory loss, albuminuria with casts and red blood cells, the presence of nodules about the size of a pea which seem to be fixed to the skin but movable over subcutaneous structures. Changes in the retinal arteries are unusual but albuminuric retinitis has been reported. There is usually a leucocytosis with a relative increase in polymorphonuclears. Diagnosis is usually made by examination of a subcutaneous cyst when the arterial nature of the latter is revealed.

REFERENCES.

- BARBER, H. *Brit. Med. Journ.*, 1938, i, 433.
LEISHMAN, A. W. D. *Lancet*, 1937, i, 803.

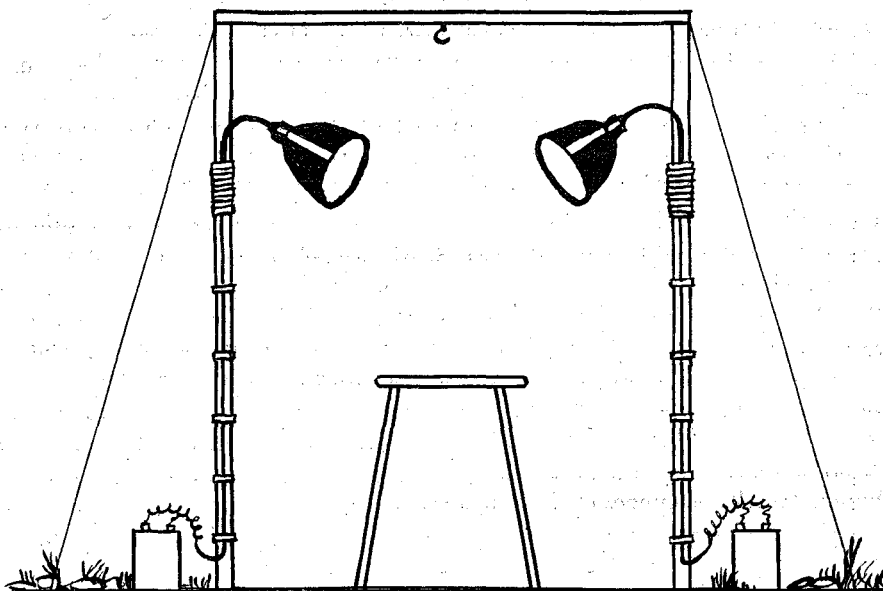
AN IMPROVED LIGHTING SYSTEM FOR A FIELD AMBULANCE OPERATING TENT.

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It is generally admitted that the type of acetylene light which is provided for operating tents of field ambulance units is inadequate, and, no doubt, a more suitable lighting system will, in due course, be approved and eventually form part of the permanent equipment of a main dressing station.

In the meanwhile, however, now that these units are mechanized, a simple but efficient lighting system can be improvised with the materials which already form part of the unit's equipment. The following materials are required :—

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| 2 headlight reflectors | } Such as are in use |
| 2 12-volt lamps (36 watt) | |
| 2 sets of 2 six-volt batteries | } Leader lorry. |
| 25-30 feet of insulated electric wire. | |
| 3 feet of stiff wire. | |
| 1 roll of insulating tape. | |



All these materials can be provided by the M.T. section of the field ambulance and the whole system erected in less than ten minutes.

The batteries are kept outside the tent, the electric wires passing under the tarpaulin to the foot of the tent poles. The reflectors are fitted to pieces of stout wire, which are attached to the uprights with insulation tape ; the wire must be sufficiently pliable to enable the surgeon to manipulate the lamps easily and direct their rays where he requires them. The electric wires are fixed to the uprights with insulating tape, to prevent them impeding the work in the operating tent.

