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does not prevent rotation movements of the leg. With the object of eliminating this defect, the modification, here illustrated, was devised. It will be seen that the spring is obtained in a similar manner by using mild steel; but the lateral extensions of the clip rest firmly on the bars of the splint, and in so doing hold the foot dorsiflexed and comfortably steady, without the addition of a foot piece.

The Millbank Clip is made of one piece of metal, has sufficient spring to permit the jaws opening to grip the sole, and when the extension tape is applied to the lateral arms the bite is secured in proportion to the extending force, and the boot upper remains undamaged.

![Fig. 4.](http://example.com)

It is hardly necessary to insist that all credit for the inception of this type of clip belongs to Dr. Picton.

I am indebted to the Commandant of the Royal Army Medical College for permission to send this note for publication. I also wish to thank Colonel J. M. Weddell, F.R.C.S., K.H.S. (late Consulting Surgeon to the Army), Mr. Reed, and Staff-Sergeant Farrimond of the Surgical Department, for much valuable assistance and advice, and Mr. Leach for the excellent illustrations.

DUODENAL ULCER: A PLEA FOR A MORE RATIONAL SCHEME OF TREATMENT.

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This short article does not describe some new and startling remedy which will banish duodenal ulcer in a night, rather it is a series of observations which Punch might describe as “Glimpses of the Obvious,” yet which appear to require emphasis however obvious they may seem to some. The treatment of duodenal ulcer appears, in some quarters, to be so encumbered with ritual that the rationale of the treatment has become obscured.

Information collected from patients themselves and from their medical
documents, shows that in many cases treatment has been of the following nature: They had been put to bed and placed on a "No. 1 Diet" consisting chiefly of milk, Benger's food, custard and fruit jelly, and in addition, antacid powders. Later they had graduated to a "No. 2 Diet," which had a few minor additions. Finally, after weeks in hospital, they arrived at a diet excellent in many ways for anyone who could stay permanently in hospital but totally different from anything which the soldier-patient could hope to procure in barracks. The treatment had ended with the gift of a long printed list of articles of food which they were to avoid, and then they were discharged to the unsympathetic outer world to fend for themselves. Delighted at their release from hospital, and free from symptoms, most of these patients had quickly lost the printed list of "Don'ts," and had quite forgotten what it was they were supposed to avoid, and many of them sooner or later were back in hospital with the same complaint. One recent case did "remember" quite clearly that he was allowed white meat but not red, but was quite surprised to learn that there was anything wrong in having a hurried breakfast at 7.30 a.m. and lunch at 1.30 p.m. with no food in the interval, a custom of his for many years.

Treatment should, but frequently does not, take into consideration the patient himself, and this is especially important in this condition. If it is agreed that habits, customs and mental state are important factors in the causation, they must be taken into account in the treatment. These patients should be taught to know themselves, and by this self-knowledge assist themselves to recover. And yet how rare it is to meet an ulcer patient who has any insight into his condition. This lack of insight is well known to be present in those suffering from their first attack, but it should not exist once they have come under medical supervision.

The type of man who suffers from this condition is well recognized. His long, thin face, sharp nose, spare features, and absence of spare fat, have often been described. The air of "aggressive alertness" and other features have been well portrayed by Davies and Wilson (1937) in their excellent review of the life history of a peptic ulcer. These authors found that in no less than 84 per cent of their series of patients, disturbing events concerning work (30 per cent), finances (32 per cent), and illness or family misfortunes (22 per cent), had immediately preceded the onset of dyspepsia which had ended in peptic ulcer. McGregor (1938) too, commenting on the fact that peptic ulcer is usually treated as a purely digestive disease with diet, alkalis, rest, etc., states that the emotional factor in the causation of duodenal ulcer receives less attention in the treatment than it deserves.

The same type is found in the Army as in civil life. His job, more often than not, is either that of a busy clerk in a responsible position, working long hours in an office, smoking innumerable cigarettes and getting his meals at long and irregular intervals; or he is an over-conscientious N.C.O.; or he is a driver of a motor lorry, a job entailing prolonged and strained attention and often leading to that underlying feeling of anxiety which is so
often present in these patients. In nearly all of them a tendency to be over-conscientious or a tendency to worry unduly, has been a feature of their personalities.

It is suggested that the valuable time which the patient spends in hospital should be used to introduce him to new ways of thinking and to train him to those new habits which, it must be emphasized to him over and over again, must serve him for the rest of his life; a time in which he can contemplate the error of his previous ways. He should be told that the treatment in hospital is merely in the nature of a preliminary training, hospital and post-hospital treatment being continuous. A simple explanation of the nature of his condition and the treatment, emphasizing the necessity of neutralizing the acid in his stomach with alternatively food and powder every two hours, the part which worry and smoking plays, is of more practical use than all the printed lists in existence. Assuming he will have four main meals a day after he has left hospital, it is necessary for him to take extra food, say biscuits or chocolate, only three times, and powder, preferably neutral in reaction, only three times a day for the acid in the stomach to have something to act upon every two hours over a fourteen-hour period.

It may be argued that the average soldier does not get the opportunity to like such extra food and powders, but this argument does not hold as these patients are not average. Their jobs, more often than not, are of the type already mentioned and essentially do allow them this opportunity. It is perfectly possible to carry three small packets of powder in a pocket, yet even this simple device has sometimes to be explained as some patients plaintively ask how they can "carry bottles of powder about."

The importance of the two-hourly régime is obvious to anyone who has seen the crop of recurrences which is apt to occur in a big command, such as Aldershot, after annual manoeuvres when meals may become most irregular and mental strain more intense.

In regard to diet, are we not apt to be too fussy with our five ounces of this and seven ounces of that? Is not the diet that is given apt to be too pappy, to contain too many "slops"? It came as a shock to be told by Meulengracht (1935) that he treated his cases of hæmatemesis and melena, not with the traditional starvation, but with food of which the patients could have "as much as they want." The food which he allowed them to have included such things as "sliced meats, cheese, meat balls, broiled chops, omelette and fishballs." Revolutionary though this treatment may have appeared, he was, nevertheless, able to produce statistics to show that in a large series of patients the mortality was only about 1 per cent, a figure far lower than that published by any other authority. Further, when the patient is discharged from hospital, it does not seem to be of much practical use to give the soldier-patient (or any other patient for that matter) a long list of forbidden foods. He is quite sure to lose the list or forget which articles of food are forbidden, and in any case he is unlikely to obey any instructions if they are too complicated. It is better to explain that
he should "go short" on meats, meat soups and meat extractives, as these especially stimulate the secretion of acid in the stomach; and forgo the doubtful satisfaction in being correct in mentioning every conceivable article of food or drink which might possibly have a deleterious effect on his gut.

It is worth exaggerating, if this is possible, the evil effects of smoking, if thereby he can be permanently impressed with the necessity of reducing his smoking to the bare minimum.

It is a probable waste of time to tell a patient "not to worry so much," but at least he can be told the connexion between his worrying (conscientious) habits and his symptoms, and warned that periods of mental stress and worry should for him be regarded as the danger times when he must be particularly careful to carry out the scheme of treatment most conscientiously.

**SUMMARY.**

(1) It is suggested that the treatment of duodenal ulcer is often too mechanical and ritualistic, and appears often to end when the patient is discharged from hospital.

(2) A plea is made for a closer personal interest in the patient, abolition of the printed list of forbidden foods, simple explanation to the patient regarding his condition, and above all ensurance of continuation of treatment after he has left hospital by instituting a régime sufficiently simple to be understandable and practical.

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**REFERENCES.**


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**Echoes of the Past.**

**TWENTY YEARS AFTER.**

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*(Continued from page 323.)*

**CASE 43.—Laceration of Brain.**

*Clinical History.*—Nature of wound: Gunshot wound, head. (Bullet.)

Signs and symptoms: Brought in unconscious with a bullet wound of the head in the posterior portion of the parietal region to left of middle line; having frequent convulsions, apparently starting with flexion of fingers of the right hand, followed by flexion of the elbow, gradually extending