POSTURE DURING CYSTOSCOPIC EXAMINATIONS.
DESCRIPTION OF A NEW PATTERN OF LEG SUPPORT

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In the performance of cystoscopy the position of the patient on the operating table and especially the placing of his legs are important factors in facilitating the technique. These factors are even more important when the examination is made under local anaesthesia. I prefer the lithotomy posture as I can then sit in comfort opposite the perineum and can perform manipulations with greater steadiness and less fatigue than when straining neck and back over a patient in full recumbency. I admit, however, that it is easier to pass rigid instruments up the male urethra when the patient’s legs are in the horizontal plane.

In the semi-lithotomy position I use, the legs are raised to an angle of 45 degrees and fully abducted. This, to the conscious patient, is perfectly comfortable so that he is able fully to relax. By general muscular relaxation he is better able to relax the perineal muscles and so make easier the manipulations of the cystoscope; a spasm is less likely to be set up, and the local anaesthetic is thereby assisted.

Tables designed for urological work provide this position, but with most general surgical tables, if the orthodox vertical posts and ankle slings are used, the hips will be hyperflexed and a position is provided which is bad for three reasons: it is uncomfortable, the normal curves of the urethra are exaggerated and the ureteric orifices are less easily seen and manipulated.

In 1932 (British Medical Journal, 1932, November, 973) I designed a fitting adaptable to any standard operating table, which has now been adopted by the Army. The accompanying illustration is self-explanatory.
The device consists of a metal support and a calf-hammock for each leg. The supports have vertical and curved sections surmounted by hooks to hold the rings of the hammocks. The vertical sections (hexagonal) are received in the slots with which every table is equipped and are gripped by tightening the screws on to a flat surface in such a position that the curved sections are thrown out at right angles to the long axis of the table. The hammocks, fitted neatly to the calves, extend up to just below the bend of the knees; they must be smoothed out flat. The height of the supports will depend on the length of the patient's legs. The buttocks usually do not reach lower than 4 inches from the bottom of the table. The "bowed" metal leg supports can be used equally well in combination with the double loop foot sling, for maintaining the patient in the lithotomy position.

If there is difficulty in passing the cystoscope when the legs are in this position, they are dropped to the horizontal by releasing the screws and allowing the supports to descend. When the cystoscope is in place the legs are easily raised by the reverse process.

CEREBRAL INFLUENZA SIMULATING EARLY CEREBROSPINAL MENINGITIS.

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The following is an account of twenty consecutive cases of a type of influenza which has arisen recently in two nearby but entirely separate military units. In military camps or billets where there is a large number of young men, many recently having environmental and occupational changes, associated with that degree of overcrowding sometimes incidental to military life and in addition having that extra burden of vigilance and fatigue due to the greatly increased activity of the war. These are all factors which lower resistance to infection. In particular cerebrospinal meningitis is one of the infections to which these factors apply.

The twenty cases of influenza were remarkable in the similarity of their signs and symptoms and also with those of cerebrospinal meningitis in its earlier stages. In general these were pyrexia, headache of varying degrees of severity, in some cases most intense, and marked malaise. Some cases in addition showed photophobia and a scarlatiniform rash. The influenza was in all cases confined to the cerebral type; none of the other involvements of the throat, nose or chest was observed. A detailed list of the men is given.

In the detailed analysis it will be noticed that the temperature within twenty-four hours of onset was high; in 60 per cent all of the men had fever of 101°F. and over. The initial rise was sudden and subsided slowly. The pulse-rate as a rule was high also and although it is usual to regard a slow