Clinical and other Notes.

APPARATUS FOR MAKING PLASTER OF PARIS SLABS.

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The accompanying illustrations are of an apparatus made for me by Private J. S. Harrison, R.A.M.C., of this C.C.S., for easy and rapid making of plaster slabs. It is very simple and is perhaps in use already at other units. In all the hospitals and Casualty Clearing Stations to which I have been attached or have visited, however, the comparatively clumsy and
slow method of rolling out the plaster bandages on to a flat surface has been in use.

As fig. 1 shows, the requirements are merely a flat board about four by one and a half feet. To this are fixed two uprights, each holding a projecting bar. One of the uprights is fixed by a winged screw in a slot cut into the wooden board so that its position in the slot can be varied at will in order to make the required length slab by winding the wet plaster bandage around the projecting bars (fig. 2). When the slab is thick enough, it is pulled off the bars and smoothed flat on the board.

The time and trouble saved will be appreciated by those who use plaster of Paris extensively and have been preparing their slabs by the old method.

My thanks are due to Private Harrison for making the apparatus for me.

SOME ASPECTS OF THE MILITARY PROBLEM OF IMPETIGO CONTAGIOSA.

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INTRODUCTION.

Impetigo, one of the nuisance diseases, is peculiarly troublesome to an Army, in war time, whether it affects soldiers who are in training or mobilizing or operational. Its contagiousness renders it essential to treat cases in a medical institution but it is not always that beds are available locally unless Camp Reception or Reception Stations are prepared (and permitted) to accept cases. As the regulations regarding Reception Stations do not allow any case to be detained for more than ten days the M.O. in charge must endeavour to intensify treatment to such an extent that cases, if not actually cured on the tenth day, have at least reached such a stage of healing as to be no longer infective and not likely to flare up from reinfection on return to unit.

The writer is not a dermatologist. This intrusion into the field of a speciality is made because experiences gained in treating some scores of cases in Camp Reception Stations during the past months have suggested some promising lines of action which, it is believed, are not generally known or accepted.

SPREAD.

The resistance of some lesions to recognized therapy, such as mercurial applications, the dyes, silver nitrate or sulphonamide (local and/or oral), indicates that there may be a constant replenishment of bacteria which counteracts the efforts of the medical officer. That such a focus is usually exogenous is evident from the fact that lesions protected by bandages are less prone to chronicity. The lobes of the ears, sides of the face and the chin are most frequently found to provide the sites of this type of lesion and it is just these areas of distribution that come into closest contact with