Clinic Notes and Other
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
the bed-covering when most of us "snuggle down" in bed, especially in cold weather when the bed-clothes are wrapped in closest proximity to the skin. I have demonstrated with a hand lens blanket hairs in an ulcer.

If these facts are accepted, it is logical that septic sores should be protected by bandages— including those cases treated as out-patients—and that cases arriving at a Hospital or C.R.S. for admission should (as is routine for scabies and vermin infestation) bring their blankets for fumigation.

**Therapy.**

Generally speaking it has been our experience that the most difficult cases are those that have been under treatment prior to admission, with ung. hydrarg. ammon.

Mercury dermatitis and devitalized tissues are formidable handicaps and some cases have been transferred immediately to an E.M.S. or Military Hospital as it has been obvious that no quick cure could be anticipated.

Dermatologists agree that ung. hydrarg. ammon, should not be stronger than 2½ per cent when used in the treatment of impetigo. Unless an indent specifies that "dil" is intended, the issue will presumably be that of the B.P. 5 per cent preparation. During the 1914-18 War, a 1 per cent preparation of amm. hydrarg. in zinc was found efficacious. ("Medical History of the War," 1928) [1]. As Regimental M.O.s seldom, if ever, require the stronger preparation, it would be advisable to make the ung. hydrarg. amm. dil. the routine issue. It has been a shock to find that in the O.P. departments of some hospitals, patients with impetigo have been given a box of ointment with the instructions that they should return in a week, i.e. on the visiting dermatologist's "day." We have seen some of the unsightly messes that have resulted from this week's self-treatment, especially "sick-on-leave" cases. Every case of impetigo should be inspected daily by a medical practitioner. There is, we believe, no routine treatment that can be guaranteed to produce good results in every case. Each case should be treated, not only on its own merits but on its own daily merit. It is the careful daily study that enables the most effective timing of the exhibition of the medical officer's "ammunition," whether it be boric starch poulticing, sulphonamide intervention or chemical cauterization in addition to, or instead of, dye and other antiseptics. A prescription that has proved particularly useful in those cases which have not been treated with a mercury preparation is brilliant green and hydrarg. perchlor, each 0.5 per cent in spirit.

**Caustic Therapy.**

In view of the urgency of the time factor, which is one of the chief "headaches" of Reception Station M.O.s, it was inevitable that the potentialities of chemical caustics, as advocated by Downie [2], should be explored. Apart from the more obvious limitations of the use of the silver nitrate stick, there was one disadvantage peculiar perhaps to a Reception Station, namely, retarded healing owing to devitalization of the ulcer area.
It is admitted that this would not be of any great importance were after-treatment can be safeguarded but our experience has shown that in some units it is risky to return cases whose ulcers, although clean, are as yet unhealed. When dealing with cases it is not only necessary to try to assess the mentality and habits of physical cleanliness of the individual soldier but also to note which units provide the higher proportion of "dirty" diseases such as scabies, vermin infestation and impetigo. The rate of recurrences give a useful index.

It occurred to the writer that by using blue stone—the actual crystals instead of silver nitrate, the benefits of the latter without the disadvantage indicated might be attained. The technique at present used is as follows:

After the removal of crusts by oil or boric-starch poultices each ulcer is mopped clear of exudate and surrounded by a ring of ring. brilliant green which is applied thickly as a skin protective and trap for stray bacteria. The ulcer area may now be sprayed with ethyl chloride but, unless the patient is sensitive, this is not necessary. The blue stone is then rubbed lightly over the ulcer. Before covering with a light bandage, some of the heaped ung. brilliant green is spread over the cauterized area. The employment of an emollient and bandage thus reduces the degree of irritation and any scratching is rendered harmless.

This method is at present under trial. The results, so far, are consistently promising but the clinical material is scanty. It seems, therefore, justifiable to place on record these observations in the hope that others better qualified to do so, and who have wider and unrestricted opportunities, may assess the value of the suggestions made.

ILLUSTRATIVE CASES:

While these notes stress the use of blue stone, this caustic has only been used as one of a number of measures and not as a panacea for all stages and all cases.

Case 1.—C.R.S. No. 737. Mixed infection, scattered lesions on face. Three and a half weeks' treatment, mostly at unit before blue stone therapy at C.R.S. Ulcers on chin, which had persisted in spite of routine treatment, immediately dried up and patient was discharged cured on fifth day.

Case 2.—C.R.S. No. 745. Similar to above; also three and a half weeks' other treatment. Discharged fifth day after application of blue stone.

Case 3.—C.R.S. No. 781. Scabby moist eruptions on left auricle and forehead. Had had two weeks' ineffective treatment by Regimental M.O.'s. New crops suggested active streptococcal infection so patient was given 4 grams sulphonamide on day that blue stone was applied to the ulcers. The tablets were continued for four days. On day following application of blue stone ulcers showed great improvement and by the fourth morning only a few dried-up scabs remained. The patient was detained for two more days for observation and was then discharged "well."

Case 4.—C.R.S. No. 823. Admitted with large dirty ulcer on occiput and a few scattered streptococcal-like spots on neck. One week's history of ulcer. Blue stone applied immediately to large ulcer. Gentian violet painted on smaller lesions. Sulphonamide 4 grams daily for four days given
orally. A clean looking thin dry scab formed over the ulcer immediately and as this gradually separated healed skin was revealed. The patient was fit for discharge on tenth day but detained for another forty-eight hours for observation.

Case 5.—C.R.S. No. 849. Admitted after what unit M.O. described as "six weeks' ineffective treatment with sulphonamide powder." When seen at C.R.S. dirty scabby moist ulcers of ear lobes, sides of face and chin. Starch-boric poultices were first applied and blue stone treatment was given on third day. The lesions immediately dried up with the exception of a small patch on one ear and sores at the corners of the mouth. These mouth sores had not been treated with blue stone on account of position. On eighth day all cauterized lesions were clean and healed skin appeared as the scabs separated. The patient was detained until the thirteenth day in order to allow mouth sores to heal.

Case 6.—C.R.S. No. 867. Scabby dirty ulcers on the chin. Three weeks' history. Starch-boric poultice applied on admission and blue stone treatment given next day. Patient appeared to be cured on fourth day but I decided to detain for observation. Removal of part of a scab showed healthy granulations. Scabs then allowed to separate naturally and on the eighth day normal skin had replaced all ulcers, leaving no trace in way of scabs or scars.

**SUMMARY.**

1. The administrative advantages of short-term treatment is discussed.
2. The suggestion is made that all blankets, etc., of impetigo cases should be disinfected as a routine, as is done for scabies and vermin infestation.
3. The harm done by unskilled use of ung. hydrarg. ammon. is stressed.
4. The question of chemical caustics is discussed.
5. A special technique, involving the use of blue stone, is described with illustrative cases.

**REFERENCES.**


**Reviews.**


Interest in War Medicine continues to occupy the minds of physicians and this book meets the need of a compact reference work for medical officers.

As before, a large part of the book is devoted to a detailed consideration of the War Neuroses. Valuable new additions include sections on Typhus Fever, Diphtheria, Infective Hepatitis and the Sulphaguanidine Treatment of Bacillary Dysentery.

In the tropical field there is a useful chapter on Malaria. However, the treatment described for this disease should be brought into line with the standard method. For example, in malignant tertian malaria, quinine