A BED-PAN SLUICE IN THE FIELD.

By Colonel R. I. Poston,
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Especially with dysenteric cases it is of the greatest importance that bed-pans are properly sluiced under conditions which prevent the possible extension of infection by flies, etc.

A bed-pan sluice in the field must therefore (a) have an adequate supply of running water, (b) this water must disappear quickly, and (c) the trench or pit into which it disappears must be fly proof.

With these points in mind a sluice was evolved and put into actual practice with good results. The construction is briefly as follows:—

1. A pit 2 feet broad by 6 to 10 feet deep is required.
2. This pit should be revetted.
3. Pre-cast concrete tops, conical in shape and with a central hole, are then fitted over the pit. The hole is fitted with a pipe at the bottom of which is a baffle plate, actuated by a lead counter balance (as in sketch opposite).
4. Over each sluice is erected a stand-pipe. A spring tap is preferable as this controls the amount of water used and prevents the pit from becoming full too quickly when there is bad soakage.

I am indebted to Major Stower, R.E., for his help in evolving this structure and to Colonel C. H. K. Smith for permission to forward this article.

TWO CASES OF TIETZE'S DISEASE.

By Captain B. S. S. Acharya,
Royal Army Medical Corps.

It was decided to report these two cases because of their rarity. Since Tietze [1] described the condition in 1921 only 21 cases have been recorded. The following two cases showed the typical syndrome of non-suppurative, non-specific swellings affecting rib cartilages.

Case Reports.

Case 1.—Male, aged 28. Developed sore throat with impetigo of face and six weeks later complained of painful swelling at the second left costo-chondral junction, pain worse on deep breathing. He also had a slight cough. There was no history of injury or loss of weight. No history of T.B. in the family.

On Examination.—Temperature normal. Throat clear. There was no sign of lung infection. There was a visible swelling at the second left costo-chondral junction, firm elastic consistency, oval in shape, tender, upper and lower limits ill-defined and the overlying skin was normal.

Other Systems.—Nothing abnormal found.

Radiographs.—Showed no abnormality.

Investigations.—Blood count, urine examination, B.S.R. and blood Kahn negative. No material could be obtained on needling.

Progress.—The lump is still tender after six weeks and size unaltered.

Case 2.—Male, aged 22. Three weeks before admission, on gripping a wheel, felt pain at the second right costo-chondral junction and noticed a lump. He complained of a slight cough and there was no history of loss of weight. This man did not give any history of injury either.

On Examination.—Tender swelling in every way similar to the case described above except that the lump was situated on the right side at the second costo-chondral junction. This man has signs of bronchopneumonia. As in the above case all investigations were negative.
NOTE - BED PAN SLUICES TO BE PRECAST CONCRETE WITH CI FITTINGS TO BASE AS DETAIL 'A' ALL INTERNAL SURFACES OF SLUICES TO BE CEMENT RENDERED - COVER SLABS TO PIT TO BE PRECAST REINFORCED CONCRETE
COMMENT.

Five cases recorded by Arden Jones and Leo Pollak [2] showed respiratory tract infection associated with the swelling. In the above two cases, the second case had signs of bronchopneumonia but the first case had no signs of respiratory tract infection at the time of admission. The first case had 21 grams of sulphamidamide for his impetigo but it made no difference to the size of the swelling.

Thanks are due to Major R. V. Facey, R.A.M.C., and Major W. M. Forster, R.A.M.C., for pathological and radiological examinations.

REFERENCES.

A CASE OF PYONEPHROSIS IN A PELVIC KIDNEY.

By Captain G. St. J. Hallett,
Royal Army Medical Corps.

The patient, a P.O.W., aged 32, was admitted to—General Hospital from a P.O.W. Hospital on March 9, 1943.

Past History.—August, 1941, developed pains in the left side of the abdomen and burning pain on micturition. This cleared up but recurred in March, 1942, when he was admitted to the Security Hospital. His urine contained: 

- Albumin + + . 
- Pus Cells + + + . 
- Gonococci + + . 
- No T.B. seen. 
Culture—no T.B. grown.

He was treated with permanganate bladder wash-outs, citrates, and sulphonamide but the urine remained the same.

On admission to General Hospital his general condition was fair. T. 98.4°. Tongue furred. Abdomen tender on left side. Kidneys not felt. P.R., N.A.D.


Blood Urea: 44 mgs. per cent.

Chest X-ray: Lungs normal.

Intravenous pyelogram: Right kidney concentrates well; normal form and position. Left kidney no concentration. No calculi seen. Cystoscopy—generalized cystitis, mucosa congested. Right ureteric orifice normal. Right ureter catheterized and clear urine obtained. Thick pus in region of left ureteric orifice. A thread of pus appeared to be issuing from the left ureter but the catheter persistently buckled and could not be introduced more than a few millimetres. A diagnosis of left pyonephrosis was made and, although a retrograde pyelogram had not been possible, it was decided to operate.

Operation.—April 3, 1943, under G. and O. and E.; via a left lumbar incision. A search failed to reveal any signs of a kidney above the level of the pelvic brim. The wound was closed without drainage.

It was assumed that the man had a congenitally non-ascended kidney which was lying infected in the pelvis.

He made a good recovery from the operation but two further attempts at retrograde pyelography met with the same result as the first. The man's condition slowly deteriorated and in July he complained of more pain in the pelvis and bouts of pyrexia were more frequent. A tender mass was palpable on the left side above the pelvic brim. P.R.—N.A.D. It was decided that a further attempt to locate and drain the kidney was necessary.

Operation.—August 10, 1943, under G. and O. and E.; preceded by transfusion of 1 pint of blood. Lower left paramedian incision, peritoneal. Peritoneum reflected to pelvic wall. The peritoneum stripped easily until a tense fluctuant mass the size of an orange was encountered in the left side of the pelvis. The peritoneum was densely adherent to the front of this. The mass was first aspirated and then incised and some 8 ounces of thick muco-pus evacuated.