THE CONVALESCENT DEPOT OVERSEAS.

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Having spent over two years in Convalescent Depots in this country and nearly as long visiting those in the Middle East, Persia and Iraq, it is interesting to compare the differences in their working. My remarks will be confined to the *modus operandi* of five 2,000-bedded British Depots though there were at one time in the Middle East also Indian, New Zealand, South African and Australian Depots in addition to smaller British units at outposts such as Malta and Cyprus.

The work of overseas Convalescent Depots falls easily into two categories—forward and base.

These latter base units, which will be discussed first, were situated in widely different localities, some in desert surroundings and some, for instance in Palestine, under conditions more comparable with those at home. A few were entirely hutted but the majority had tents dug in on concrete bases with sheds or built-up huts for annexes, kitchens, dining halls, N.A.A.F.I. and often a cinema. Bathing facilities were always available either in the sea or, in one case, in the Suez Canal.

Apart from climatic considerations—as a rule little work was desirable in the heat of the afternoon—they had to cope with two problems not met at home—they had to take cases at an earlier stage of treatment, owing to the absence of Red Cross Homes, and the lack of outside amenities made a greater need for the organization of entertainment and occupation within the unit.

As a result of the absence of B.R.C.S. Homes, a number of cases arrived at the Depots before they were fit for any physical training; many were still in plasters. Most of these latter cases were looked after by a Specialist, or graded Specialist, in Physical Medicine who was held on the Depot Establishment. The procedure was that all cases were seen by the O.C. Medical Division and those—perhaps 200 out of 2,000—that required special care, physiotherapy and remedial exercises were referred to the Physical Medicine Specialist who was responsible for them till they reached the final hardening grade, when they were returned to the O.C. Division for discharge. Repairs and minor alterations to plasters were carried out by the Specialist in Physical Medicine in the Depot while others requiring checking by X-ray were returned to hospital. Arrangements were made for an Orthopædic Specialist from the nearest centre to visit the Depot every week or so to see those cases about which a second opinion was required.

An officer of the Army Catering Corps, a Sergeant of the Educational Corps and a chiropodist were all found to be very useful additions to the staff and more than justified their appointments.

Grading was very similar to that in this country, usually four grades proving sufficient. Grade IV, in which no P.T. or fatigues were carried out, was missed by some of the fitter patients. A man in Grade III did light P.T. and light fatigues, together with remedial exercises and physiotherapy if indicated by his condition. Grade II did heavier P.T. and fatigues and those of lower medical category were discharged from this grade. Grade I was for hardening and the men did some marching and an easy run and obstacle course.

Documentation was simplified as much as possible. Each man arrived only with a discharge form (A.F. ME 32) and no I 1220. Only two other forms were then completed, A.F. ME 17A, on one side of which were the particulars of his age, address, unit, trade, etc., and on the reverse were his medical notes. This form was filed at the Divisional Office. A.F. ME 17B was a small card which the man retained himself and on which were entered his grade, any special treatment or any permission granted for him to have his bed down, be excused agility work, etc.

The establishment of A.P.T.C. staff was raised to 12 and deficiencies were made up by training Assistant P.T. instructors, selected from among the patients and held by the Depot by permission of Second Echelon. The P.T. staff supervised all remedial cases, P.T., games, bathing and the hardening programme. Three principles in this connexion are worth stressing; the lightest P.T. must be very easy—there is the greatest difference between doing nothing and even the easiest exercise; games must be for all, not just for the few athletes; the obstacle course is not an assault course—jumps from high ramps causing frequent sprains are taboo. The Physiotherapy Department varied in activity according to the type of work but often four or five masseurs were fully employed.

Occupational Therapy and Diversional Occupation became an important service. True therapy was mainly used for the hand cases but the value of the workshops in employing the patients both on and off duty cannot be exaggerated. Carpentry, tinsmithing, engineering, leather work and painting and drawing were most popular. The shops assisted greatly both in raising morale and in making useful articles to brighten and improve the Depot.

The feeding was as a rule excellent and a small additional ration was obtainable. The family system of messing did much to reduce the length of time spent in queues and in ensuring that the food reached the men hot.

With regard to entertainments Depot Concerts were a great feature. Once a week an informal talent spotting contest was held in the N.A.A.F.I. when any volunteer performer received cigarettes or a bottle of beer and from these volunteers the "stars" for the weekly concert were selected. The spotting contest was quite informal and took place while the remainder of the room was full of men playing chess, darts, etc. The Depot band was of course an important feature both at the concert and playing in the break or for massed P.T. Its nucleus of four was augmented by convalescents whose selection was assisted by a combined Labour Exchange and Information Centre. Here was kept a register of men's qualifications, trades and hobbies, a register accessible to those arranging entertainments, sport and Depot maintenance. Here there was also a wall newspaper and outside was erected a large notice board giving a list and time of all amenities and sport. Brains Trusts and Spelling Bees were also organized but the most popular of all departments were the library and cinema.

The forward Convalescent Depots had to improvise, be ready to expand and to turn their hands to any type of work that the situation might require. Two near Tripoli expanded to take 6,000 cases at one time during the Tunisian Campaign and repeated the expansion during the assault on Sicily.

One Depot was in a large Italian workshop, the sheds lending themselves well to improvisation of kitchens, barracks, workshops and gymnasia. The other was entirely tented. This brought out the fact that the tentage allowed is quite inadequate unless, as is usually the case, some buildings can also be utilized. The difficulty here was solved by borrowing from a neighbouring hospital that was housed in buildings.

In the Tunisian Campaign at one time 60 per cent of the cases in these Depots were minor battle casualties who had only been in hospital a day or so and who required daily minor dressings. Some medical staff had to be loaned to assist in coping with the situation. Among the remaining 40 per cent was a number of battle weary, who had temporarily cracked under the strain. They had had five days of rest and "dope" in hospital and then had two or three weeks at the Depot, during which time they were kept fully occupied with moderate physical work. A very large percentage of both these minor injuries and borderline psychiatric casualties returned to the front line in less than a month. Even if evacuation to the base in the Delta had been possible they would have been lost to their units for 3–6 months instead of one.

Again in the Sicily Campaign these Depots expanded to 150 per cent capacity to take malaria cases. They received these cases as soon as their fever was controlled by quinine and both the mepacrin and plasmoquine treatments were carried out while in the Depots.

The only type of case not catered for at an overseas Convalescent Depot is the "gastric" as dietetic facilities cannot be provided. All other needs can be met, most Depots running

a Camp Reception Station of twenty to sixty beds as part of the team. To cope with all the demands made, however, taxes the ingenuity of the staff owing to the small War Establishment, which leaves them particularly short of storemen and clerks, a Warrant Officer for the Orderly Room and transport. The British Red Cross helped greatly in the latter respect by providing a bus for recreational purposes.

Latterly no sick leave was granted to officers in the Middle East and Convalescent Sections for 120 officers were attached to certain 2,000-bedded Depots. They had their own Establishment which included another medical officer. The experiment worked well and, much to our surprise, they became quite popular. Officers fed with the staff and every effort was made to Mess them as well as was physically possible. They were occupied in the camp till lunch time with P.T., bathing, riding, games and craft work, but they could go where they liked during the latter part of the day. They usually paid a few visits to the nearest town, but many spent the bulk of their time interesting themselves in Depot activities.

A Convalescent Depot is a very difficult unit to run happily and efficiently yet, when so run, it is of all medical units the most important from the point of view of manpower. Conversely, a poor Depot is not only a squanderer of manpower but is a menace to morale.

MENINGOCOCCAL SEPTICÆMIA ASSOCIATED WITH JAUNDICE.

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Since the rarity of association of these two conditions is likely to lead to the question being raised of their being entirely due to the meningococcus or of the septicæmia occurring as a separate entity in a patient with an infective hepatitis already developing on its own, brief notes of another example of this nature are submitted for comparison with those already published in the *B.M.J.* of 4.3.44 [1].

A. P. A. became ill on 23.4.44 with headache, malaise, nausea and vomiting; there was no cough, bowels were regular, stools of normal colour and urine was slightly dark. There was no fever and apart from the features mentioned clinical examination was negative until 28.4.44 when icterus of skin and conjunctivæ was observed and he was admitted to hospital on 29.4.44. On admission he proved, for the first time, to have a temperature of 102° and a pulse of 90 per minute; he had moderate jaundice and the only other feature was a petechial eruption chiefly seen on his legs but also on his chest and fore-arms. He still had headache and anorexia but did not look very ill. Apart from these physical signs and symptoms, together with the presence of albumin, bile salts and bile pigment in his urine, examination yielded nothing.

His blood count was Hb. 104 per cent (Haldane), R.B.C. 5,150,000, W.B.C. 13,800. Polymorphs 73 per cent, lymphocytes 20 per cent, monocytes 7 per cent.

His temperature fell to normal that night and on 30.4.44 rose to 101; there was no change in his condition. Blood culture was undertaken. On 1.5.44 a scanty growth of Gram-negative diplococci was observed and at 14.00 hours sulphathiazole treatment was commenced, 2 grams followed by 1 gram four-hourly. His temperature had fallen to normal again by then and remained normal subsequently.

His condition, never regarded as serious, rapidly improved, the petechiæ fading and shortly afterwards the jaundice. One or two of the petechiæ on the legs developed small vesicles in their centres but culture of the contained fluid (before therapy had been instituted) was sterile. On 5.5.44, Major Riddell, Pathologist, reported that meningococcus was confirmed on culture and biochemical reaction; confirmed also by agglutination test—Griffiths type II. A total of 20 grams of sulphathiazole was given over a period of four and a half days. He is now (15.5.44) convalescent and up and about but rather washed out; his hæmoglobin fell to 80 per cent during his illness. At no stage was there any evidence of meningeal reaction.