A METHOD OF MAINTAINING EXTENSION ON THE THOMAS' SPLINT.

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In the field all first-aid methods of maintaining extension on the Thomas' splint necessitate the use of some form of Spanish windlass. Tension is obtained by twisting the windlass with a stick.

In practice sticks and other objects used for the same purpose have not been found satisfactory since they may slip or break.

To overcome these faults the suggested method advocates the use of an iron bar to produce tension. This bar is made from $\frac{3}{8}$ inch iron rod in the form of a shepherd's crook and has an overall length of 5 inches (see fig. 1). It possesses these advantages:

1. It can be hooked on to the side of the splint and therefore cannot slip (see fig. 2).
2. It cannot break.
3. It is neat and easily applied.
4. R.E.M.E. can make the requisite numbers quickly and at little cost.
The windlass should be made with tape (a tape supplied by the Royal Engineers was found most satisfactory) since flannelette bandage or other materials were found to tear or stretch under strain. The tape should be applied to the boot by the excellent method described by Lieutenant-Colonel F. A. Bevan, R.A.M.C., in the Journal of November, 1943.

The boot is first padded in front, anterior to the ankle joint, and behind over the tendo Achilles.

The tape is placed with its centre over the anterior pad. The two ends are then passed behind the boot, crossed over the posterior pad and brought forwards and downwards to be tied in a firm knot below the boot in the groove between the sole and heel. The ends of the tape are then tied to the end of the splint to form the windlass. Extension is produced in the normal way by twisting the tape with the bar and, when sufficient extension has been obtained, the bar is hooked on to the side of the splint.

This bar and tape method produces and maintains strong extension, which can be instantly readjusted. The windlass is neat and cannot get caught in extraneous objects. There is never any risk of slipping or breaking and the tension produced is constant.

As an R.M.O: I have used this method for two years with complete satisfaction.

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**Current Literature.**


The yeast fungus was first observed by Hook in 1677 and since then yeast infections of all types have been reported from various parts of North and South America and Europe. Susceptibility does not vary with race, colour or age and the infection is not transmissible. Its manifestations vary with the organ involved and there has been, unfortunately, a tendency to consider each manifestation as a separate disease rather than a one type of yeast infection.

Pathology.—The spores of yeast are resistant and withstand cold and drying to a considerable degree. The primary infection is most often in the respiratory tract. The yeast diseases do not seem to attract much bodily defensive reaction in the form of cellular infiltration or fibrosis. Abscess formation may follow yeast infection or may be due to superadded secondary infection. Widespread blood-stream involvement is associated with a high mortality rate and is generally seen in the coccidioidal granuloma, torula infection and more rarely in moniliasis, blastomycosis and other mycotic infections. In the lungs, it is unlikely that the majority of yeast infections ever get beyond the bronchi and a microscopic appearance of a mycotic infection is similar to a tubercular granuloma.

Clinical Symptoms.—The symptoms depend upon the degree, type and virulence of the infection. Mild cases give generalized bronchitic changes; severe cases are associated with malaise, low-grade fever, night sweats, hæmoptysis and a foul nauseating sputum. The peculiar odour of the sputum may be the only clinical pointer to the diagnosis of yeast infection. The physical signs may be indistinguishable from tuberculosis, sarcoidosis, pneumoniconiosis and many other lung infections. The ultimate diagnosis rests with the bacteriologist.

X-ray Findings.—The earliest lesions are those of increased broncho-vascular markings. These commence as unilateral lesions but soon become bilateral. Hilar adenopathy is not marked. Later, patchy areas of the infiltration appear in the parenchyma generally following a bronchial pattern. Pleural effusion is rare. Another type of involvement shows faint fuzzy shadows along the broncho-vascular structure, giving it a ground glass appearance. Later, moderate fibrosis may develop. In the actino-mycotic infection the lesion may break