
BY

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This hospital is situated in the highest part of Aldershot. It stands on a plateau measuring 7 acres, and is 362 feet above sea-level. A visit from any angle requires a climb; but one’s labour is more than rewarded by the wonderful view of far distant country in all directions. It has well been called “The Aldershot Riviera”, and very closely resembles the outlook from many a hill station in India. The official “Guide” states that the weather in Aldershot is remarkably good, but the temperature recorded is extremely low in winter, this being due to the sandy nature of the sub-soil. It was well chosen for its purpose, and I attribute our very low death-rate to the salubrious atmosphere enjoyed by all patients, in addition to the fact that the patients generally consisted of healthy young soldiers.

At the outbreak of war the bed establishment was 58, but it soon had to be increased to 100, and later to 177, extending in emergency to 253. This, of necessity, has been very elastic for at one time in 1940 we had as many as 365 bedded patients, some of the beds improvised.

The hospital is comprised of three main sections or divisions: (1) The Men’s Division of 38 beds; (2) “The Colony”, consisting of two brick wards and four wooden huts with 112 beds, for male “other ranks”; and (3) The Women’s Division of 47 beds, of which there is a modern brick cubicle block for women and children and one ward of 12 beds earmarked for A.T.S. The other wards in this division are very fluid and have often been in use for male patients.

The O.C.’s house, at the lower end of a delightful copse of birch trees, was misappropriated and furnished as an overflow ward for officers, and at one time was itself full and overflowing.

The Men’s Division comprises a ward of four cubicles for officers. “The Colony” has been reserved for the minor infectious diseases, and convalescent scarlet fever or diphtheria cases transferred from the Men’s Division.

With the increase of beds followed the necessary addition to the nursing staff and their accommodation. We solved this problem by taking over some married quarters adjoining the hospital, and there they have extremely comfortable sleeping accommodation—not only for the R.A.M.C., but also for the 17 A.T.S. who were posted to us, releasing 14 R.A.M.C. for field service. Later 5 V.A.D. auxiliaries were posted to us and we converted the hospital steward’s quarters into a comfortable Mess for them.

The staff of the hospital consists of the O.C., a Detachment R.A.M.C. Officer, a Matron and 12 Q.A.I.M.N.S. Nursing Officers, a Quartermaster, and a Detachment of R.A.M.C. with V.A.D. and A.T.S. totalling 66.

During the war there have been 26 medical officers as colleagues for varying lengths of time, and of these three have been ladies. I have had no less than 16 matrons, 7 quartermasters and 23 serjeant-majors. “C’est la guerre!” It can easily be judged that so many changes in such key positions have not helped from the point of view of administration, but the keenness in assistance and co-operation practised by all has more than counterbalanced this. Here may I pay generous and genuine tribute to one and all of my large family of matrons. Matrons, I salute you!
The matrons and sisters have a very comfortable and well-appointed Mess adjoining the administrative block.

Now, as regards the work done. The grand total of patients admitted during this war is 9,210, of which 8,903 were a "true-bill," that is, they were suffering from an infectious disease. The other 307 cases were suffering from another disease not generally admitted to this hospital, and were accordingly transferred to the correct hospital. I submit a list of the final diagnoses made in these cases. They were:

- Glandular fever
- Influenza
- Diphtheroid infection
- Streptococcal tonsillitis
- Vincent’s angina
- Urticaria
- Cervical adenitis
- Belladonna poisoning
- Empyema
- Rheumatic purpura
- Alveolar abscess
- Purulent parotitis
- Cyst of Stenson’s duct
- Bronchitis
- Seborrhoeic dermatitis
- Pityriasis rosea
- Catarrhal sinusitis
- Enteritis
- Pleurisy and pneumonia
- Bronchopneumonia
- Pulmonary tuberculosis
- Influenzal tracheitis
- Acne
- Shingles
- Glandular fever
- Bronchitis
- Scurvy
- Seborrhoeic dermatitis
- Pityriasis rosea
- Catarrhal sinusitis
- Enteritis
- Pleurisy and pneumonia
- Bronchopneumonia
- Pulmonary tuberculosis
- Influenzal tracheitis
- Acne
- Shingles
- Quinsy
- Peritonsillar abscess
- Rhinitis
- Stomatitis
- Eczeema
- Otitis media
- Submandibular abscess
- M & B rash
- Tinea
- Post-inoculation debility
- Lumbar fibrositis
- Acute rheumatism

The dermatologists on the staff of the old Connaught Hospital—that is before it was taken over by the Canadians as a General Hospital—were of unfailing help with their expert knowledge in diagnosing cases which we could say nothing more than that they were not infectious. The very common diagnosis was seborrhoeic dermatitis or pityriasis rosea. Most of these were sent in as scarlet fever, measles or rubella.

As a general routine, throat swabs were taken of all cases on admission, and three clearance swabs before discharge. This was eventually given up, with the exception of diphtheria cases, as not being of any practical value to the medical officer, the patient or the outside public.

The following table shows the annual incidence of each disease:

<table>
<thead>
<tr>
<th>Disease</th>
<th>1939</th>
<th>1940</th>
<th>1941</th>
<th>1942</th>
<th>1943</th>
<th>1944</th>
<th>1945</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubella</td>
<td>40</td>
<td>2,745</td>
<td>528</td>
<td>229</td>
<td>222</td>
<td>242</td>
<td>190</td>
<td>4,196</td>
</tr>
<tr>
<td>Measles</td>
<td>26</td>
<td>105</td>
<td>179</td>
<td>131</td>
<td>291</td>
<td>163</td>
<td>221</td>
<td>1,116</td>
</tr>
<tr>
<td>Mumps</td>
<td>8</td>
<td>59</td>
<td>338</td>
<td>285</td>
<td>147</td>
<td>94</td>
<td>163</td>
<td>1,094</td>
</tr>
<tr>
<td>Chicken-pox</td>
<td>2</td>
<td>29</td>
<td>59</td>
<td>69</td>
<td>67</td>
<td>89</td>
<td>31</td>
<td>346</td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>4</td>
<td>116</td>
<td>127</td>
<td>131</td>
<td>181</td>
<td>159</td>
<td>139</td>
<td>857</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>1</td>
<td>21</td>
<td>41</td>
<td>65</td>
<td>187</td>
<td>86</td>
<td>24</td>
<td>425</td>
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<tr>
<td>Diphtheria carriers</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>47</td>
<td>27</td>
<td></td>
<td>75</td>
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<tr>
<td>C.S.F.</td>
<td></td>
<td>121</td>
<td>59</td>
<td>27</td>
<td>26</td>
<td>16</td>
<td>10</td>
<td>263</td>
</tr>
<tr>
<td>Meningococcal septicaemia</td>
<td>-</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
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<td></td>
<td>12</td>
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<tr>
<td>Meningococcal carrier</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Whooping-cough</td>
<td>-</td>
<td>1</td>
<td>8</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>29</td>
</tr>
<tr>
<td>Erysipelas</td>
<td></td>
<td>6</td>
<td>14</td>
<td>16</td>
<td>26</td>
<td>16</td>
<td>7</td>
<td>85</td>
</tr>
</tbody>
</table>

**Annual total**: 85, 3,206, 1,357, 959, 1,202, 898, 793, 8,500

**Note**: For a time, until cases of scabies were treated in unit lines, we admitted and treated 403 such cases amongst members of the A.T.S., thus bringing the grand total up to 8,903.

**Rubella**.—As the figures above show, in 1940 and the first half of 1941 we had an outbreak of rubella amongst the troops, mostly of the 51st Highland Division, who had come straight from the heather, and had built up no immunity to a hitherto unknown virus. The 1st Canadian Division also suffered very heavily. It was a problem how to deal with such numbers. Efforts were made to arrange for unit isolation, but it can be seen how impossible that was in view of each division making up for immediate embarkation overseas. We finally misappropriated a whole block of married quarters in the cavalry barracks. This gave us a possibility of 175 beds. We fitted up an auxiliary hospital, complete with orderly-room, kitchen, and entirely self-contained, with a male staff of 1 visiting medical officer, 2 N.C.O.s, 3 cooks, 1 sanitary assistant, 3 nursing orderlies and 11 general duty orderlies.
The type of infection was mild during this outbreak. The difficulty was the numbers that incessantly flowed in; and at that stage of the war, convalescent auxiliary hospitals and convalescent depots were either unborn or in their infancy. We commenced by keeping the cases in hospital the full eight days, this being soon reduced to six, and eventually to four, when the temperature fell and the rash faded. They were then discharged and sent to their homes on four days' sick leave.

Later on a more virulent type of rubella appeared, with a high temperature and more general disturbance, with even pneumonitis and meningeal signs and a much heavier and coarser rash—hardly distinguishable from measles. As a matter of fact, I am sure that some cases were admitted into the measles ward, and possibly vice versa, and with it all we unfortunately failed to observe any cross infection. There were cases that developed a "secondary rash," and one even a "tertiary rash." May he be forgiven! As the troops disappeared, so did rubella.

Measles.—This has remained fairly constant throughout the whole war. There was one point that impressed us, and that was that measles is definitely a severe infection. A man who has rubella may not know it. That cannot be said of measles. A look at the patient shows you that he is ill, and he knows it, too. Koplik spots were far from constant, or probably not often seen, because by the time that the patient arrived at the hospital the rash was out fully developed. There was usually a high temperature, which remained until the rash faded, perhaps not for six or more days. Serum was never used, as it is of no value after the onset of the fever. The virus is highly noxious, and pneumonitis was a very common part of the illness. Some were so toxic that they had encephalitis with convulsions. One case had a marked spasticity of upper and lower limbs, and became quite irrational and mental, with speech affected as in a tubercular meningitis. This case was lumbar-punctured and given sulfa-lysine intravenously and eventually recovered. The severe cases with pneumonitis reacted very well to sulphanilamide.

Mumps.—1941 and 1942 were our peak years. As a general rule it was the straightforward type of epidemic infective parotitis, often starting on one side and within forty-eight hours becoming bilateral. The females seem to take the infection more severely than the males, and with them the amount of swelling was much more marked. A number of cases did not support the primary diagnosis, and some were dental in origin; one had a cyst of Stenson's duct; one proved to be a purulent parotitis, and one remained undiagnosed beyond the asserted statement that she was not a case of mumps. This last case did not follow the course of mumps, and I believe was eventually diagnosed as hysteria, and sent to a neurological hospital. Ten cases were found to be a mixed infection, with bull-neck diphtheria, and were treated as such. There were two cases of "reversed mumps," i.e. the complication (orchitis) appeared before the parotitis.

The pouting of the orifice of Stenson's duct is a very common sign. In four cases, abscess formation developed and operative treatment ensued. Some had signs of encephalitis with a very high temperature. This can be a very serious illness.

Chicken-pox.—Very little variation in annual incidence. Nothing unusual or atypical in the cases seen here, excepting that there were many cases with much discomfort to the patient with the presence of the vesicles in the mouth, on the soft palate and fauces and gums. One can appreciate the real malaise and constitutional disturbance often seen, and lasting for several days, when one realizes the big area of toxin absorption, especially when there is a superadded staphylococcal infection. One case developed a staphylococcal septicæmia with multiple abscesses, which had to be opened and drained.

There is one tale to be told. There was admitted in the early days a severe case of "septic chicken-pox." He gradually became worse and the skin picture more mixed and disconcerting to the onlooker. He had urticaria with raised weals, vesicles, and papules with a shotty feeling and a superadded very septic impetigo. After four days in hospital he was unfortunately diagnosed as smallpox. I never knew a 'phone could ring so inces-
santly! Two specialists were called in, but just at this time a wire arrived as from the clouds from the patient's own doctor, and quite inadvertently. It merely said "not small-pox, but erythema multiforme." The lad had had a similar attack before the war, and had likewise been diagnosed as smallpox, until a West End specialist had given the correct diagnosis. We never mention the word smallpox now!

The treatment of chicken-pox was nothing more than symptomatic.

**Scarlet Fever.**—Again no variation in annual incidence, and no deaths. Total 857 cases.

We know that of recent years the virulence and mortality of this streptococcal infection has been on the decline, and when we review the cases seen twenty years ago, with their grave and sometimes fatal complications, such as bronchopneumonia, empyema, nephritis, arthritis, endocarditis and pericarditis, meningitis, mastoiditis, and others; and form a comparison with the cases seen in this hospital, one fully corroborates this view. However, it is the exception that proves the rule, and I have seen in this hospital what I had never seen anywhere before: two cases of hämorrhagic scarlet fever. They were bleeding at every point, and both recovered after repeated injections of hämoplastin. Sulphonamides did not touch the case at all. Also, we had many cases of the septic or toxic type, in which the toxemia was marked and accompanied by definite signs of cerebral irritation. I use the word "irritation" because the patient became very resistive and had to be kept down with morphia. He suffered with intense headache, with a livid colour, and nuchal rigidity. In fact one actually doubted the diagnosis, and made preparations for a lumbar puncture. There was certainly some meningitis present. Here, sulphanimide in big doses effected the cure. We also have used the concentrated antistreptococcal (häemolytic) serum very freely; in fact, in all cases with a temperature of 100 or over, and those with a well-marked rash. The cases in which one expects and meets complications are those with signs of old enlarged tonsils and adenoids. In view of the excellent work that has been done by the State for the children with T. & A. clinics throughout the country, it is surprising still to meet so many adult patients suffering with scarlet fever, and with the other conditions present, that is, with deep-rooted tonsils and signs of old granular meningitis. There were periodic admissions of surgical scarlet fever, following a varied assortment of operations, such as hernia, appendicectomy, compound fracture of the leg, tonsillectomy, and several following burns of the second degree. We admitted and treated as scarlet fever, and correctly so, some cases of streptococcal tonsillitis which displayed no sign of any rash. All such cases should be isolated.

**Diphtheria.**—There was a definite increase in the number of cases admitted during 1943; but the same applied to other diseases during that year, and the reason was nothing more than an increase in military personnel preparatory to "D-Day." They were mostly faucial in type, there being only two cases requiring tracheotomy. These were, of course, soldiers' children, and both did well. More and still more has one seen the extreme importance of early diagnosis and treatment. The only cases we lost were those which had, for one reason or another, been "sat on." One exception to this last statement, a fatal case, had an additional lesion, in the form of chronic nephritis. The two lesions were too much for him, and us.

Relapses were rare, although they did occur in a few cases that had had between 150,000 and 200,000 units of anti-diphtheritic serum. These were called "relapses" when new growing membrane appeared, and they had to be treated as new cases as far as the administration of antitoxin was concerned. With others, if the relapse was spotted and treated at the onset, it was found that a twice daily injection of antitoxin, 40,000 units in the morning followed by 24,000 units in the afternoon, very soon brought about a complete and final cure. The teaching is that 100,000 units is an adequate total dosage, and that the membrane will ultimately completely separate, but actual practice disproved this, for in some cases that had had as many as 200,000 units of serum and more, either new membrane appeared, or a small speck of membrane kept under daily observation for final disappearance.
actually started regrowth. These cases of relapse did not show any marked signs of renewed toxemia. In severe and developed cases, the initial doses of serum were given intravenously and massive doses of vitamin C were given as part of the treatment.

Very few cases developed complications, and the mortality figure is very low—1.4 per cent. This chiefly owing to the improvement in the manufacture of the anti-diphtheria serum, enabling one to administer really tremendous doses without the fear of any foreign protein reaction. The cases of cardiac collapse, either primary or delayed, were very few.

One patient who had been a prisoner of war for four and a half years, and was very emaciated, had been treated for some days after his release for tonsillitis before being evacuated home by air. He was then diagnosed as diphtheria. After having over 200,000 units of serum, he coughed up a huge cast of membrane, 6½ in. long (bifurcated at the lower end) and over 2 in. wide. He developed pneumonia in both lungs, and was treated with penicillin, with intensive doses, but eventually died of pneumonia as shown post-mortem. Another very interesting case was a Guardsman who had extensive faucial diphtheria. Although he had large doses of serum, towards the end of the third week he developed signs of a partial Stokes-Adams syndrome with varying sites of precordial pain. His pulse-rate went down to 36 or 40 for several days, and his respiration rate to 10 and 12 per minute. He was put on intravenous glucose and ephedrine, and later became definitely psycho-pathological with areas of skin anaesthesia around the lips and nose. He was transferred to the Cambridge Hospital for galvanic treatment and massage, and ultimately made a complete recovery. The few cases of posterior palatal and laryngeal paralysis all recovered with strict enforcement of a recumbent posture. There was one case of peripheral neuritis with a speedy recovery. There were a few cases which developed a definite brachycardia, with pulse-rate of 50 and below. At first they were kept in bed; but as they showed no signs of cardiac distress or disability on the advice of Brigadier Evan-Bedford they were allowed up, and very soon their normal cardiac rate re-established itself. One child died of respiratory and diaphragmatic paralysis.

There were no cases of muscular paralysis affecting the limbs. All the staff are Schick tested before being detailed for duty in any diphtheria ward, and, if positive, they were immunized, each receiving three weekly interval doses of 1.0 c.c. of T.A.F. (toxoid antitoxin flocules) and are re-Schicked after three months, but frequently the demands of the war prevent the completion of this immunization.

For over a full year in 1943 and 1944, a military hospital, through a hidden carrier, had a small but persistent outbreak of diphtheria, and diphtheria carriers. During this time 83 cases were admitted to this isolation hospital and, of these, 25 proved to be true cases of diphtheria, 48 were carriers, and 10 were neither but suffering from some other disease.

The suspected cause of this outbreak was a member of the staff who, while serving in another Command had been treated for tonsillitis, though she later developed a peripheral neuritis and ocular paralysis, and was eventually posted to the hospital where the outbreak occurred. She was found to be a carrier and sent to this hospital. Her throat was cleared up, and she was, I believe, later discharged from the Service on compassionate grounds.

There were 54 cases of the hypertoxic bull-neck type, a mixed infection. They are very easily missed for early diagnosis, for frequently no membrane can be seen, and clinically they look like a peritonsillar abscess or true case of mumps, and maybe there is nothing beyond their fetid breath to suggest any K.L.B. infection. In addition, the laboratory report on the throat swabs almost always comes back negative for K.L.B. These are the cases that die, despite enormous doses of antitoxin, unless diagnosed early. I think no truer words were ever written than those given us by Dr. G. E. Breen in his excellent book, "Essentials of Fevers," in which he says: "If swabs were abolished, the mortality from diphtheria would probably be halved" [1].

We have admitted 186 cases of diphtheria since I contributed an article on Bull-neck Diphtheria, published in this Journal in October, 1943, making a total of 425. Six cases died, giving a mortality rate of 1.4 per cent.
Meningococcal Septicaemia and Cerebrospinal Fever.—There was a small epidemic in Aldershot among the troops in the winter of 1939 and spring of 1940, as will be seen by referring to the table above. This shows four cases in 1939, 121 in 1940, and 59 in 1941. The age incidence showed it to be a disease of youth, and it was very clearly proved that the predisposing causes at this time were lack of ventilation through black-out regulations, and crowding together in barrack-rooms at night. Numbers of cases were between 18 and 20 years of age, and many with only two to ten weeks’ service in the Army.

The sudden severe headache was the predominating and most constant symptom, and one that was greatly relieved by a lumbar puncture and the removal of from 30 to 50 c.c. of cerebrospinal fluid, which was always turbid and under considerable pressure.

As a matter of fact, lumbar puncture was only done primarily for diagnosis, and repeated for the relief of symptoms.

I am inclined to agree with those who affirm that the case itself is not infectious. It has surprised me that Sisters or nursing orderlies whom I have time after time seen struggling with a delirious, almost maniacal, patient, have not contracted the disease themselves. I pay tribute to their grand courage and heroic performance of their duty. We had 12 cases of meningococcal septicaemia which is terrifying in its acuteness and severity. Three of these died within a few hours of admission and just did not react to any treatment, including penicillin.

We had a total admission of 263 cases of septicaemia (12) and meningitis (251) with 9 deaths, giving a mortality rate of 3.4 per cent [3]. The physical signs of the meningitis were very constant: head retraction, varying from a minor degree to marked opisthotonus; nuchal rigidity always; Kernig’s sign frequently positive, but this is not surely diagnostic; Brudzinski’s sign occasionally positive; a facies of extreme anxiety and of one in great pain; the moderate case lay with knees flexed. Sometimes they were in coma; others were restless, and resistive, with signs of cerebral disturbance. Vomiting was common, and difficult to control, continuing for three or four days. The pulse was much more valuable in diagnosis and prognosis than the temperature. Herpes on the lips and other parts of the body was frequently an early sign. The blood picture was one of a leucocytosis with many polymorphs, and the meningococcus was frequently isolated from the blood, even before the meninges had become affected, proving that this infection is really a septicaemia at some stage in its course.

The cerebrospinal fluid was turbid and full of pus cells, with intracellular meningococci. Glucose was reduced or absent. Chlorides were reduced and protein increased. Petechiae of all sizes, extending to large areas of purpura, were present, the latter especially in the acute fulminating septicaemias. We saw none of the mild or ambulatory type described elsewhere.

As regards complications, 95 per cent of the cases escaped—that is up till about a month after their discharge from hospital, which was the last time we saw any of them. I have their home addresses and intend following the cases up in about a year’s time.

On one occasion I received a list of cases which had appeared before the Standing Medical Board and had been discharged from the Service, but none on that list had passed through this hospital. We saw few of the organic nervous sequelae met by others, but these may, and do, develop later. We had one case which developed a panophthalmitis. Another, a complete nerve deafness; another a gangrene of the right lower arm, requiring amputation. A complaint of vague pain in the back was common, but I think the memory of the lumbar puncture had a lot to do with that, for time healed that unpleasant experience.

There were several cases of definite relapse or reinfection after the temperature had been normal for some days. These cases at first created a problem—to differentiate from serum reaction or some complication such as a hypostatic pneumonia. A lumbar puncture and the presence of the other physical signs and symptoms of a meningitis finally settled the question. As regards treatment, we tried all forms and varieties of the sulphonamide group, and after six years’ experience since the introduction of soluseptasine, I strongly
adhere to my former statement, that soluseptasine is the best in curative effect and in the complete freedom from any adverse reactions or results [4]. There is always the fear of something happening locally after injection of one or other of the many varieties of the sulphonamides introduced.

Our routine treatment for all cases is intravenous injection of 20 c.c. of 5 per cent or 5 c.c. of 20 per cent soluseptasine diluted, four-hourly during the day, and similar intramuscular injections during the night, while the medical officer enjoys his well-deserved rest! This is carried out for two or three days and followed by four-hourly doses of 2 grammes sulphathiazole by the mouth. There is no cause for anxiety if the temperature remains high for four to six days. After this time it is bound to fall, and remain down for good, or with a slight evening rise lasting perhaps for another week. The evening will come when it will rise no more!

At the beginning of the war we collected in the cerebrospinal fever wards a disturbing variety of cases, including influenza, chronic bronchitis, emphysema, pneumonia, acute rheumatism, and other diseases listed below, which were admitted without lumbar puncture. This impossible position was relieved by it being arranged for all doubtful cases to be sent to the Cambridge or Connaught Hospital for lumbar puncture and correct hospitalization. This, however, did not appear altogether satisfactory, and it was decided that all cases diagnosed and suspect, should be sent direct here, and a ward was reserved entirely for lumbar puncture and disposal of each case. Our records show that 85 per cent of the cases thus received proved to be suffering from one of the following list of other diseases. They were: Influenza, 25; gastric influenza, 41; bronchitis, 2; pneumonia or bronchopneumonia, 25; pharyngitis, 3; tonsillitis, 2; lumbar fibrosis, 4; hysteria, 2; acute rheumatism, 1; meningitis, not meningococcal, 3; post-vaccinal meningo-encephalitis, 2; otogenous meningitis, 1; benign lymphocytic chooro-meningitis, 3; subarachnoid hemorrhage, 2; head injuries, 2; cerebral glioma, 1; vaccinia, 1; seborrhoeic dermatitis, 1; pittiasis, 1; acute cervical lymphadenitis, 1; belladonna poisoning, 1.

As regards penicillin therapy, it was not used actually for the meningococcal infection itself, if a case of meningitis. One man with cerebrospinal fever developed a left lobar pneumonia, and the prognosis became very unfavourable, but after forty-eight hours four-hourly intramuscular injections of penicillin, all physical signs of pneumonia had vanished, and he made a complete recovery.

Whooping-cough.—There were only 29 admissions, of whom 19 were children, and 10 adults. In children the antipertussis vaccine in daily increasing injections of 0·25 c.c., 0·75 c.c., 1·0 c.c. and repeat the 1·0 c.c. in four days' time, and the last 1·0 c.c. dose in another seven days, gave good results. This was tried in adults, but without any apparent success. M & B 693 and its derivatives were of no avail. Ephedrine with tinct. belladonnae were the most trustworthy stand-by.

Erysipelas.—The number of cases admitted (85) appears high amongst young soldiers who are generally in the pink of condition. The site of infection was either face or leg, and in some cases the amount of toxaemia was severe. Two cases, admitted as erysipelas with much cellulitis around the nose and over the antra, extending to the eyelids, and with grievous signs of a very acute fulminating process, died in a few hours. One gave signs of a pure blood culture of a staphylococcus and the other was identical in physical signs. One case, clinically identical with erysipelas, was suffering from respirator dermatitis.

The noteworthy remark about the cases admitted is that not one received any local treatment, although there was much dermatitis with blistering and encrustations. Sulphanilamide, in preference to sulphathiazole, or sulphadiazine, was the unfailling remedy in doses starting at 2 or 3 grammes followed by 1 gramme four-hourly for forty-eight to seventy-two hours.

Cross-infection.—In spite of incessant difficulties in the complete isolation or even barrier-treatment of these cases, we suffered very little from this crossing of infection, which is considered a crime in any civil hospital for infectious diseases.
How are you to keep convalescent soldier patients apart, when through the exigencies of the war they were bedded at times almost in contact with each other, and when they are playing croquet, clock golf, and deck quoits together? But I did receive a great shock when, on visiting a cubicle ward, where a man admitted with mumps developed chicken-pox and another rash which I was called to see. I could not face it, and called it "urticaria," but kept him in hospital a further eight days. I nearly passed out on this visit, when I found all the patients having tea together in the end cubicle.

In spite of such and similar vicissitudes, inevitable in wartime, we have proved ourselves, throughout the whole war, a very happy team.

On the religious side, the nature of the type of cases admitted to this hospital prohibits any general Sunday Service, but the Padres of all denominations have shown particular individual interest in the patients, and for the Staff, the R.A.M.C. recreation room is used as a Chapel for Sunday Morning Service, and the proceeds from the collection have allowed of an annual contribution of £5 5s. to the R.A.M.C. (Comforts) Prisoners of War Fund, and others to such charitable associations as the British Red Cross (Prisoners of War), British Legion Poppy (Earl Haig's), and St. Dunstan's, Royal National Life Boat Institution, and other Funds.

Again, the entertainments of the patients were restricted to outside games as mentioned in another part, but, as regards the staff (R.A.M.C., V.A.D. and A.T.S.), an unused ward was converted into and provided a first-class Concert Hall and Ballroom, where E.N.S.A. concerts and cinema entertainments were given. There is a very good hard tennis court, two table-tennis tables and other games; and at times we have been able to produce really creditable teams on the cricket and football grounds.

REFERENCES.