

an acute infection leading to capillary damage with loss of circulating platelets at the purpuric sites. In other acute infective conditions with purpura, however, the patient is usually gravely ill. Several of the authors quote Dameshek and Grassi's (1946) case, in which there was a dramatic response to splenectomy, and attribute the purpura to hypersplenism. Although this theory may be correct, it should be noted that Dameshek and Grassi's patient had suffered from a haemorrhagic condition for two years before it was aggravated by infectious mononucleosis, and is thus not strictly comparable to the cases under discussion. Whereas the spleen was "considerably enlarged" in Dameshek and Grassi's case, it was not palpable in half the patients in this series, and in the remainder it was only slightly enlarged.

Lymphatic hyperplasia seems to be a factor common to a number of cases of thrombocytopenic purpura in which no other cause for the platelet reduction has been found (Minot, 1936; Cooley, 1938; Lytle and Ward, 1937). In Cooley's patient, for example, greatly enlarged abdominal lymph nodes were found at necropsy. He remarked upon the identical microscopical appearances of the lymph nodes and spleen, and thought that the lymph nodes were taking part with the spleen in platelet destruction. In the case of infectious mononucleosis which we have reported the immediate cause of the thrombocytopenia appeared to be a deficiency of the megakaryocytes in the bone marrow; this finding was also recorded by Wallerstein and Madison (1950).

Conclusion

We would suggest that in patients presenting with purpura, especially children and young adults, infectious mononucleosis should be excluded by means of the Paul-Bunnell reaction. A wrong diagnosis of acute leukaemia or "essential thrombocytopenia" may otherwise be made, and this may lead in the first case to the neglect of life-saving measures and in the second to unnecessary splenectomy. The absence of anaemia at the onset of the purpuric phase is a constant finding in infectious mononucleosis, and will help to exclude acute leukaemia.

We wish to thank Dr. Robert Coope, Dr. W. S. Sutton, and Dr. T. Black for their helpful criticism and for permission to publish this case.

REFERENCES

- Angle, R. M., and Alt, H. L. (1950). *Blood*, 5, 449.
 Bernstein, A. (1940). *Medicine*, 19, 85.
 Bethell, F. H., et al. (1946). *Arch. intern. Med.*, 77, 80.
 Cooley, L. E. (1938). *Arch. Path.*, 26, 390.
 Dameshek, W., and Grassi, M. A. (1946). *Blood*, 1, 339.
 Downey, H., and McKinlay, C. A. (1923). *Arch. intern. Med.*, 32, 82.
 Finlayson, R. (1951). *British Medical Journal*, 2, 1563.
 Goldbloom, A., and Denton, R. (1948). *Canad. med. Ass. J.*, 58, 189.
 Halcrow, J. P. A., Owen, L. M., and Rodger, N. O. (1943). *British Medical Journal*, 2, 443.
 Kutzer, M., and Allen, E. G. (1950). *N.Y. St. J. med.*, 50, 1131.
 Lloyd, P. C. (1946). *Amer. J. med. Sci.*, 207, 620.
 Lytle, C. C., and Ward, D. F. (1937). *J. Iowa St. med. Soc.*, 27, 296.
 Magner, W., and Brooks, E. F. (1942). *Canad. med. Ass. J.*, 47, 35.
 Minot, G. R. (1936). *Amer. J. med. Sci.*, 192, 445.
 Read, J. T., and Helwig, F. C. (1945). *Arch. intern. Med.*, 75, 376.
 Rosenthal, N. (1939). *J. Amer. med. Ass.*, 112, 101.
 Smith, E. B., and Custer, R. P. (1946). *Blood*, 1, 317.
 Thompson, C. A. (1950). *J. Ark. med. Soc.*, 47, 114.
 Tidy, H. L. (1934). *Lancet*, 2, 180, 236.
 — and Morley, E. B. (1921). *British Medical Journal*, 1, 452.
 Wallerstein, R. S., and Madison, L. (1950). *Amer. Practit.*, Philad., 1, 624.
 Wechsler, H. F., Rosenblum, A. H., and Sills, C. T. (1946). *Ann. intern. Med.*, 25, 113, 236.

In a recent address on "Diagnosis in General Practice" the retiring president of the Royal Society of Medicine's Section of General Practice, Dr. J. D. Simpson, divided patients into four classes, depending on their doctors' knowledge of the patient himself, the pathological process, and the patient's environment. His classification was as follows: (1) the old patient with the old disease, where all three were known; (2) the old patient with the new disease, where a pathological process had to be assessed afresh; (3) the new patient with the old disease, where history or previous doctor's notes might help; and (4) the new patient with the new disease.

Medical Memorandum

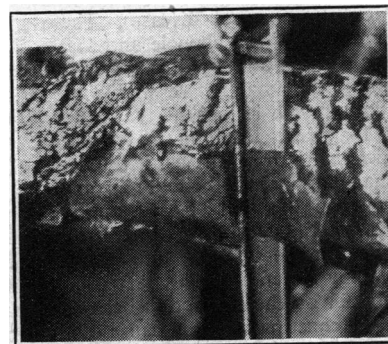
Use of the Humby Knife in the Excision of Burns

The importance of early excision of the extensive deep burn has become recognized in recent years. The surgical removal of these large full-thickness sloughs may offer the only chance of survival in those once-hopeless cases which, thanks to improved methods of controlled intravenous-fluid therapy, are now being brought through the shock phase in increasing numbers. It is a tedious and time-consuming operation, however, and is often accompanied by considerable blood loss, although this factor may be minimized by the use of methonium drugs in carefully selected cases.

A recent improvement in technique has been found so helpful in this unit that it appeared to warrant publication of this short note.

CASE 1

A female patient aged 38 had suffered severe deep burns involving 60% of her body surface. She was treated by the exposure method,



and on the eleventh day after burning was taken to the theatre for excision and grafting, partly with homografts and partly with her own available skin. In an endeavour to reduce operating time a Humby knife was applied to an extensive slough on the upper part of the back. This was removed with such ease and rapidity that the remaining areas were dealt with in the same manner (see illustration).

CASE 2

A few days later the technique was employed in the case of a female epileptic aged 29 who had sustained a deep "roasting" burn of the trunk and other areas, totalling 32% of the body surface. Excision was performed on the seventh day after burning, autografts being applied and the procedure completed in three-quarters of an hour. In this case a considerable depth of fat was found to be non-viable, and in certain areas it was necessary to remove it in two layers.

COMMENT

The Humby knife used in this procedure is the familiar graft-cutting instrument consisting of a long blade the cutting edge of which is guarded by a roller adjustable according to the depth of skin required. The knife is set to cut more deeply than for ordinary use, and preliminary scalpel punctures of the slough may assist in giving some idea of the required depth. It is difficult to describe the ease and selectivity with which these adherent sloughs are removed at the correct level and the manner in which it is possible to follow difficult contours without damage to neighbouring intact skin. Blood loss is minimal, and an even surface is left which is ready for immediate skin-cover. This technique is now being employed in most cases of severe deep burns, and, together with the use of the electric dermatome, is making excision and grafting at an earlier stage a much more practical proposition.

I wish to thank Sir Harold Gillies for permission to publish this short memorandum.

A. J. EVANS, M.B., F.R.C.S.,
 Senior Surgical Registrar,
 Plastic and Jaw Unit, Basingstoke.