AN EPITOME OF CURRENT MEDICAL LITERATURE.

War Number.

MEDICINE.

74. War Psychiatry.

AT a meeting of the Royal Medical Academy of Genoa ARTURO MORSELLI, consulting neurologist to the First Army of Italy, presented a communication on war psychiatry which he called a new chapter in mental pathology. He excluded from his purview all the common forms of psychosis which the circumstances of warfare had forced from a condition of latency into active development, and those such as alcoholism, epilepsy, and dementia praecox, which had already existed when the patients were mobilized. Dealing only with mental aberrations due directly to the war, he said these mostly occurred in an acute form; they were brought on by the emotional excitement of battle, and, in his experience, had a basis of asthenia. He divided them into seven groups: (1) Acute nervous asthenia, mostly in the form of neurasthenia and psychasthenia; 2) hysteria, of which there were many varieties manifesting themselves in dumbness, stammering, tremor, paralysis, convulsions, catalepsy, or somnambulism; (3) depression, showing itself sometimes as simple sadness, at others as delirium with ideas of suicide; (4) stupor, sometimes simple, sometimes accompanied by catatonic phenomena recalling those of dementia praecox; (5) hallucinations, coming on in a transient form after emotion; (6) confusional states, having the characters of amentia; (7) in rare cases, maniacal excitement. All forms of war psychosis in the strict sense are, in Morselli's experience, curable within a short period if treated early; it is important, therefore, that the diagnosis should be made at once within the war zone. It is better that a soldier whose mind has been deranged by the conditions of military service should not be sent to a lunatic asylum unless the case proves refractory to early treatment. The author points out the difficulties presented by more or less conscious simulation. It is in dealing with such cases that the experience of the psychiatrist is most useful, as, without special knowledge, mistakes are easily made. Once the doctor has made up his mind that the soldier is shamming, the best plan is to send him back to the fighting line. The results of treatment in the psychiatric stations within the war zone are very satisfactory. In some forms of psychosis the proportion of cures within the first ten days is 60 per cent.

CHAVIGNY (*Paris méd.*, January 1st, 1916) says that soldiers on active service are peculiarly liable, under the strain of the number and variety of the duties imposed upon them, to show mental breakdown by "reactions" which expose them, if their nature is not recognized, to be punished for breaches of discipline. Temporary loss of memory may make a man forget that he is a soldier and leave the trenches, with the result that he is court-martialled; the same thing may happen in cases of deaf-mutism from shock. The reactions of real insanity are shown by desertion, abandonment of post, refusal to obey, breaking of arms and destruction of equipment, burning of buildings, mutiny, and acts of violence. These offences include almost all those which under military law are visited with increased penalties in time of war. Chavigny relates several illustrative cases in which an expert examination saved men from death, and obtained for them a recognition of unfitness for military service. Chavigny insists that simulation is relatively rare, and he strongly urges the doctor, even when a case looks most suspicious, not to allow himself to be carried away by a first impression. He should carefully observe the man, not letting him, or any one about him, know that he is under suspicion. The expert must remember that a mistaken diagnosis of simulation justly exposes him to the severest criticism. But having made up his mind that the case is one of malingering, he should act without hesitation. The author relates a curious case of what he calls super-simulation. A censor of correspondence from the front intercepted a letter from a soldier to his wife, in which he told her not to worry about him when she was informed that he was in hospital, as in order to get away from the firing line, where he ran too much risk, he was shamming deaf-mutism. He instructed her how she was to answer all questions in case of inquiry, so as to give a convincing history of hereditary and personal antecedents. The man at this time had been under Chavigny's care, and was being treated for typical deaf-mutism caused by shell shock. All the classical symptoms were present—local anaesthesias peculiar to such cases, persistent cough, etc., besides loss of speech and hearing. Examination after cure of the deaf-mute condition showed a very marked state of mental instability. But more typical than this, inquiry of the man's family doctor confirmed the absolute reality of the hereditary and personal history which, in his letter to his wife, he had described as invented to suit the requirements of his case. The wife, on close examination, confessed that her husband was the victim of his imagination, as it often happened that he could not distinguish his own inventions from what he had actually seen. He was, in fact, a mythomaniac, who doubtless in order to give himself some importance had invented a disease from which he really suffered. Ravaut, as the result of a series of puncture experiments in cases of mental disturbance caused by the war, had pointed out the frequent presence either of abundant albumin or blood in the cerebro-spinal fluid in men who for the lack of objective symptoms might have been put down as simulators. Chavigny thinks this may be a useful help in diagnosis, but only if the result is positive. He has seen it negative in cases as to the genuineness of which there could be no doubt. Furrowing of the nails, dating from the appearance of nervous or mental disturbance, may be important in cases of late or retrospective examinations.

75. Simulated Disease in Soldiers.

EDGARD BLUM and GASTON DIMIER (*Gaz. hebdom. des sciences méd.*, May 21st, 1916) discuss the etiology and treatment of simulation. The determining causes are first, the wish to avoid exposure to new dangers, and secondly, to get a pension. The predisposing causes are often an illness or a wound, or it may be the nervous overstrain after a wound. Occasional causes are found in the organization of the medical staff and in the therapeutic measures employed. Full advantage had not been taken of the services of the neurologists and medical psychologists called to active service; such specialists played an important part in discovering and checking at the beginning any exaggeration by the wounded of their condition. Again, the organization of hospitals left much to be desired. If in the important military centres there were sanitary formations having at their disposal all modern therapeutic agents and a specially skilled staff, in the smaller centres there was often only one civilian doctor and the most rudimentary therapeutic equipment. Simulators had a wholesome dread of the army doctor, but in these centres his visits were made at too long intervals. Infirmarians and lady volunteers were also responsible for much exaggeration by the wounded. Their very devotion tended to encourage morbid sentimentality in the men. Other causes of simulation were excess in medical treatment and the supply of useless prosthetic apparatus. The authors quote the case of a soldier who complained of having received a contusion in the lumbar region which made him unable to stand straight. He had been given a splendid corset worth several hundreds of francs, and professed to be unable to do without it. He was a man of herculean build, and the authors were convinced that he was shamming. They took away his apparatus in spite of his protest, and a week later he walked straight and asked for his discharge. The wearing of the corset had fixed in his mind the idea of incapacity. A number of wounded were led to exaggerate their disability by the very care bestowed upon them, such as wearing a dressing too long or immobilization in plaster-of-Paris. In addition to the interference of the circulation and the stiffness of joints thus caused, the idea of disability became crystallized in the brain of the wounded man. Electricity applied with small batteries, often by persons unskilled in their use, might be another cause of simulation by giving the wounded man the notion that the failure in treatment was due to the gravity of the hurt. The authors agree with Dejerine and Bergonié that if the functional activity

was sooner brought into play; if doctors were less liberal in ordering walking-sticks and crutches; if, in short, there was less treatment of a kind tending to fix the attention of the wounded man on his hurt, there would be less exaggeration. "Firing" they think particularly harmful, as the marks left gave a sort of stamp of authenticity to the hurt which helped simulation. Discussion in the presence of the patient of the symptoms and diagnosis, and criticism of what had been done encouraged exaggeration. The authors have often heard men on the strength of these criticisms attribute the aggravation of their state to wrong treatment. They have often known wounded men refuse to submit to examination on the ground that a doctor under whose care they had been had recommended them to avoid any kind of movement under penalty of formidable complications. Medical boards were also responsible for a good deal of simulation. Overworked, and not always taking into account the reports furnished them, they often granted too long leave without sufficient reason. That was an encouragement to the simulator, especially in view of the fact that the truly brave and deserving were rewarded only with the regulation seven days. There were, according to the authors, two classes of simulators. One invented diseases; detection was generally easy. The exaggeration of their disability and the *fioriture* with which they described their suffering at once enlightened the experienced physician. Others perpetuated the affection from which they suffered, and instead of getting well in the ordinary time exploited their troubles. This kind of simulation might be conscious or unconscious. Among the unconscious were certain patients with exaggerated emotivity. Some were neurasthenics and naturally exaggerated their hurt. As Duprez says, there are persons who pass rapidly from suggestion to simulation. "The psychopathic process generally follows a course which may be summed up in the following words: Commotion, emotional suggestion, exaggeration, simulation and claim for compensation." A similar evolution is seen in workmen who suffer from accidents. These cases were the easiest to cure. Then there are conscious malingerers who set their wits against the doctor's; with them it was necessary to use coercive measures.

FORGUES (*Caducée*, No. 10, 1915; *Il Morgagni*, April 10th, 1916) gives from his own experience some illustrations of simulation by soldiers. Inflamed glands in the groin may be produced by scratching the foot with a needle steeped in faecal matter. The regular outline of the lesion distinguishes it from an excoriation due to footgear. Sores of the leg may be caused by rubbing the field blanket against the skin at points where the bones are superficial (tibia, knee, malleoli, etc.). At the first visit the lesions look trifling. The next day they are reddened and extended, and if faecal matter is applied they take on an alarming phagedaenic appearance. Purulent conjunctivitis may be produced with a little tobacco juice, a particle of lime, or the juice of some euphorbiaceous plant. The absence of the gonococcus and careful watching will reveal the trick. Mucous patches are imitated by cauterization with a lighted cigarette; the size and form of the patches, which are alike in all cases, should beget suspicion. Haematuria is simulated by the ingestion of a very concentrated concoction of carrot which gives the macroscopic appearances of bloody urine. Haemoptysis can be simulated by a small cut on the tonsils or pillars of the fauces; blood is then brought up by coughing. Tonsillitis is produced by gargles of hot alcohol or petrol or a decoction of euphorbiaceous plants; in these cases the diagnosis of simulation is almost impossible. Malaria may be simulated by means of aloes applied by punctures on the flanks, or better by an infusion of laurel water; simulation cannot be proved except by examination of the blood. The author reports in detail an epidemic of dysentery caused by one of his orderlies with enemas of a saturated solution of alum, followed by the introduction into the anus of pledgets of cotton steeped in the same solution. This is retained, and the progressive irritation thus produced caused bloody diarrhoea with tenesmus perfectly simulating dysentery. He has seen fainting fits produced by enemas of a decoction of tobacco in alcoholized water; and dog bites simulated by forks thrust in opposite directions into the hand or arm, the effect being completed by contusion by striking with a stick. A comparison of the lesions with the soldier's fork, and the fact that the wounds produced by a dog's teeth are unequal in depth, whilst those produced with a fork are all equal, will serve to reveal the fraud.

76. War Mutism.

AT a meeting of the medical society of Parma in November, 1915, L. RONCORONI reported four cases of war mutism (*Il Morgagni*, May 10th, 1916). Two of the patients had an evident predisposition to mental disease, one of them having attempted suicide some years before, while the other at the age of 16, after seeing an apparition of a woman clothed in white in his room at night, remained three days without being able to utter a word. The affection also occurs in non-combatants; one of the patients was an orderly, and another a chauffeur employed in collecting wounded. Although the condition is known as war mutism, in the author's cases there were other phenomena—sensory and motor, organic and psychic—besides the loss of speech. One man was the subject of automatic motor symptoms with rhythmical movements of the head—flexion, extension, and from side to side—and twisting of the trunk, which lasted four days consecutively. Two had some muscular hypertonia, especially in the lower limbs; in three there was definite diminution in sensitiveness to pain. In one there was exaggeration of reflexes superficial and deep, and immobility of the eyeballs, so that the man seemed to be always staring at one point. There was an arrest of all the higher psychomotor functions. In the first days the patients were motionless, and incapable of reacting to external stimuli, or manifesting a spontaneous activity except in regard to taking food and emptying the rectum and bladder. In most cases sleep was not disturbed. The power of writing was always recovered before that of speech. In three cases the more important symptoms disappeared after three to ten days, and in a fortnight or three weeks cure was complete, except in the case of the man who had previously attempted suicide. In him the psychic disturbance was prolonged for a couple of months, and he left the hospital before recovery was complete; in his case, however, the condition was not so much a psychomotor arrest caused by the war as a common paraphrenic form of mutism. In all the cases there was some loss of hearing, although examination of the ears gave negative results. This was attributed to a disturbance of perception of sound which ceased with the return to normal psychical conditions. In all the cases there was loss of memory, which lasted some days. Roncoroni holds strongly that war mutism is not hysterical in nature.

77. War and Skin Disease.

MILIAN, chief of the dermato-syphiligraphic service of the French armies (*Paris méd.*, May 6th, 1916), says that skin diseases among soldiers on active service present a number of variations from the ordinary types seen in time of peace. Before the war the most common affections in the Paris skin clinics were eczema, itch, psoriasis, and tuberculosis, lupoid or warty. To-day eczema and tuberculides are relatively rare, but itch, which was also rare, has lately shown an increase corresponding to that of syphilis; this is explained by the fact that it is generally contracted by sexual intercourse. On the other hand, phthiriasis, ecthyma, and trichophytosis are common, but present some special features. Impetigo of the face and non-parasitic sycosis, particularly of the subnasal variety, are often met with. Milian attributes the infrequency of tuberculosis to the vigilance of recruiting officers in looking for the morbid condition, and to the open-air life and good feeding of the men at the front. Alopecia areata, generally common among French soldiers, has so far been little in evidence since the beginning of the war, possibly because men suffering from the affection have not been sent to hospital. The few cases seen by Milian seemed to have no connexion with emotional shock. Phthiriasis occurs in a very acute form, the whole body being invaded; the skin is covered with small oedematous papules of the size of a pin's head. The excoriated papules with small brown crusts of ordinary pediculosis and the dark discoloration characteristic of the chronic form are exceptional. This is due to prompt treatment of the condition. Milian points out that the oedematous papules have a seat of predilection not mentioned in textbooks: that is the region just below the posterior border of the axilla where the sleeve of the vest touches it. Itch lesions, on the other hand, are seen on the front of the axilla. The phthiriasis of war is almost always complicated by ecthyma of the lower limbs caused by scratching. Sometimes the lesions are in the form of straight lines as broad as the finger and several centimetres in length; they are seen in groups of two, three, or more on the front of the thigh and the outer part of the leg. They are bright red in colour, and are absolutely identical in appearance with the wounds left after the removal of strips of skin for grafting by Thiersch's method. So closely do they resemble artificial lesions that Milian at first sight was inclined to believe that they were voluntary mutilations. But their arrangement in parallel lines, their situation within reach of the hands, their direction and breadth, convinced him

that they were infected scratches. These lesions usually get well quickly under wet antiseptic dressings. A more severe form complicating phthiriasis in worn-out and dirty men is characterized by large and deep ulcers left by the separation of black eschars, which heal very slowly. The treatment is careful cleansing of the limb, painting with tincture of iodine and pure oxygenated water, and dressing with picric acid, 1 per cent. Milian says that picric acid is an excellent remedy for pyodermitis, but unfortunately its use is forbidden in military hospitals, as by taking it internally soldiers have been able to simulate jaundice. Artificial dermatitis has been rare. Milian has seen only three cases, in all of which the lesion was a pustular eruption produced by thapsia juice. Trichophytosis has been unusually frequent; Milian attributes this to the great herds of cattle collected for the feeding of the troops. In the winter of 1914–15 the animals near Verdun were packed close together in stables and barns. This was the cause of an epidemic, in which two animals out of three were attacked and the disease was communicated to the men in charge of them. Last winter it spread among the troops, who caught it from their horses, among whom the disease was very rife.

GAUCHER and Mlle. RENEE KLEIN (Ibid.) say that the influence of emotion and shock in the production of psoriasis is well known. They have been struck by the increase of the disease since the outbreak of the war, and they have especially noted the frequency of its occurrence as a sequel of wounds. Often it developed on the scar. They do not think that this is to be explained by irritation, but rather that the wound is a place of least resistance to attack. An objection to this view is the late development of the disease on scars.

SURGERY.

78. Syphilis in War Time.

AT a meeting of the Paris Académie de Médecine on March 28th (*Paris méd.*, April 8th, and *Journ. de méd. et de chir. prat.*, May 10th, 1916) GAUCHER, chief physician to a number of hospitals of the regional camp of Paris, read a paper on syphilis in war time. His observations had convinced him that in France and in the other belligerent countries syphilis was much more prevalent than before the war. In a total number of 2,295 patients treated in his service at the Saint Louis Hospital from January 1st to July 31st, 1914—that is to say, in the seven months immediately preceding the outbreak of hostilities—there were 276 cases of recent syphilis, or in round numbers 300 in 3,000. From August 14th, 1914, to December 31st, 1915, he admitted to the same service 4,912 patients, civilians and soldiers, of whom 793 were cases of recent syphilis, or in round numbers 800 in 5,000. The prevalence of the disease had therefore increased by nearly one-half since mobilization. The proportion of cases among soldiers and civilians was about equal, and the increase in numbers about the same in both classes. Many more chancres were seen in quite young people and in elderly men, and it would seem that those unfit for military service had, in regard to the contraction of syphilis, taken the place of men on active service. According to Vaillard, general inspector of the sanitary service, the 1935, 1936, and 1937 classes were threatened with contamination from birth. Gaucher, feeling that much of the evil was due to ignorance, organized courses of popular lectures on syphilis and its prevention. His communication led to the appointment of a committee consisting of Landouzy, Gaucher, Balzer, Pierre Marie, Pinard, and Vaillard, to study the best means of dealing with the situation.

79. War Injuries.

C. A. MCWILLIAMS, of New York (*Journ. Amer. Med. Assoc.*, April 8th, 1916) reports a case that is of interest on account of the number of wounds received, the way in which they were treated, and the recovery after numerous plastic operations. The man received the first attention ten hours after the infliction of the wound, and was admitted to hospital after four days. The injuries comprised: (1) Wound at the level of the eleventh rib in the midscapular line. (2) Wound in the face involving the right half of the lower mandible, where there was a defect of at least an inch in the bone which had been blown away, the whole lower part of the cheek and right half of the mouth, which involved both upper and lower lips, and the tip of the nose and the right ala. This wound was infected with maggots, and was indescribably foul. (3) Shell wounds on the buttocks which were superficial and suppurating. (4) Shell wound just below right clavicle, with partial paralysis of right arm. Pulse was present on that side. (5) Wound of right great toe. (6) Simple Pott's fracture of both bones of the right leg, apparently involving the ankle-joint, probably caused by falling. The fractured leg was put up in a Cabot splint. The mouth wound was cleaned, and a number of plastic operations performed, some of which are illustrated. The four wounds of the nose, cheek, and chest were all made by a single missile, and were in direct line. The course of the bullet was from the nose to the cheek to the lower jaw, where it had its exit; it entered again just below the clavicle, and penetrated through the axilla, where it injured the brachial plexus, finally making its exit beneath the middle of the scapula behind, or its course may have been in the reverse direction. The injury of the brachial plexus was not a complete division of any of its branches, as the movements of the arm could be carried on, though greatly weakened. The jaw was repaired with grafts from the tibia.

80. Radiography in Gunshot Wounds of the Skull.

VILVANDRÉ (*Arch. radiol. et élec.*, February, 1916) says that to trephine a skull for a depressed fracture, the clinical signs of which are obvious or even urgent, without first ascertaining the presence or absence of a missile by *x* rays, is irrational. The relief of decompression may be obtained within a few hours, but if the patient still has a bullet or piece of shrapnel in his brain the prognosis is not really improved. At the same time, while recognizing the importance of radiography previous to operation in skull cases, there are cases in which *x* rays apparently fail. Even a good radiogram may be negative when the clinical symptoms point to the presence of a depressed fracture, and the failure is still more obvious in the case of a small linear crack or fissure. Damage to the skull, furthermore, is, as a rule, more extensive than can be shown in the radiograph, probably owing to the incidence of the rays on a round body. The author has noticed, in operating theatre and wards, that skulls with long comminuted fractures—even skulls in which the depression is great—do well provided no foreign body is present. The connexion between extensive fracture and good recovery has impressed the author, and he suggests that long fractures may be more efficient in relieving pressure than localized small trephining of one inch or so in diameter. A widespread decompression of a moderate degree may perhaps be better than decompression of a greater degree in a smaller area. In the cases of which he is thinking the bone remains in place, being only lifted up through intracranial pressure. The natural juxtaposition of the bone to the dura, and of the latter to the grey matter, persists to a great extent in such cases, and tends to prevent hernia cerebri and its sequelae of brain destruction and sepsis. The author wonders whether the lifting up of a large area of bone and replacing it after the necessary cleaning of clot and removal of loose bodies is not to be preferred to the trephining and removal of bone by the ordinary method. Future callus may entail further compression, but many fractured skulls, untouched by the surgeon, do well, and the sufferers go through life without further symptoms, except some slight headache.

81. Night Blindness in Soldiers.

IN a communication to the Paris Académie de Médecine, Dr. WECKER, lecturer at the University of Liége (*Journ. de méd. et de chir. prat.*, May 10th, 1916), called attention to the occurrence of hemeralopia in soldiers, a fact which he said did not appear to have been noted in former wars. Men who see quite well in daylight lose their vision at night, so that they fall into ditches, and into craters often full of water, and require to be helped on their way by their comrades. Often these men, though very brave, dread being put on duty as sentries at advance posts, feeling themselves unequal to the responsibility thus thrown upon them. If they are drivers of vehicles they are unable to do the work at night. Of 3,977 patients in an ophthalmological service at the front, 409, or about 10 per cent., presented very distinct symptoms of hemeralopia. In all the fundus was normal. The principal causes of night blindness—nervous exhaustion, overstrain, want of sleep—are found in abundance among soldiers. A well known form of the disease is that which occurs in endemic form in penitentiaries and orphanages, and in ships, owing to insufficient or improper nourishment. During the seven weeks just before Easter, in Russia, hemeralopia is very common. But among Wecker's patients there was no question of underfeeding. The treatment which he found successful was care of the general health and rest; decided improvement followed the wearing of smoked glasses. If any myopia, presbyopia, or astigmatism were present, those conditions were dealt with by appropriate glasses.

82. Extraction of Intracranial Projectiles under Fluorescent Screen.

ROUVILLOIS (*Arch. d'électr. méd.*, No. 401, 1916) practises the extraction of intracerebral foreign bodies directly under the control of the fluorescent screen. He first takes two radiographs (a front and a profile view), and decides from this information upon a datum point as precise as possible. The patient is then taken to the operating theatre, and trephining is practised according to the ordinary technique, care being taken afterwards to dilate the entrance of the tract in the general direction indicated by the preliminary radiography. This little manœuvre frequently permits of the evacuation of clot and débris, and prepares the way for the forceps. The patient is then returned to the radiographic couch, and, a screen inspection showing that the projectile is still in the same position, extraction is practised there and then. For this purpose the author uses forceps bent at the junction of the blades at an angle of about 45 degrees, similar to that used for foreign bodies in the external ear passage. Holding the fluoroscope in the left hand, he introduces the forceps with the right, working under the control of the screen image, and knowing already the general direction of the foreign body from the previous *x*-ray examination. After extraction, he introduces immediately into the intracerebral passage a drainage tube of sufficient calibre, but penetrating not more than 1 or 2 cm. By means of this drain he injects, under pressure, with a syringe, an antiseptic liquid. He claims that this technique permits one, with a little practice, to extract even small and deeply situated intracerebral projectiles with the minimum of operative damage, and in a time varying from thirty seconds to one and a half minutes.

83. Treatment of Wounds by Hyperaemia.

E. SEHRT (*Muench. med. Woch.*, March 7th and 14th, 1916), says that the treatment of wounds of limbs by Bier's method of hyperaemia has given eminently satisfactory results. He found that, provided the treatment was begun within the first twenty-four to sixty hours of the infliction of the wound, both the local and general reaction to infection was reduced to a minimum, infection being in many cases completely aborted. Since he had begun, in May, 1915, to use this method in severe wounds of the limbs he had never seen a case of gas gangrene originating in such an injury. Severe shell wounds of the trunk he still treated with free incisions. By avoiding the use of the knife in severe wounds of the limbs, and relying mainly on treatment by hyperaemia, he had prevented the occurrence of troublesome post-operative scars. After giving details of many cases, he concludes by insisting on the importance of the treatment being instituted at the earliest possible date.

LINBERGER (Ibid., February 29th, 1916) gives details of several cases treated by continuous hyperaemia, which was found to be applicable even in the field. Indeed, after the first days, this treatment required no more time than any other treatment of severe wounds. The method was particularly useful in projectile wounds of the knee-joint, practically all of which were infected, and it was mainly due to this treatment that suppuration of this joint was seldom seen by him. Even when it did occur, it was kept in check by the hyperaemia which rendered extensive operations superfluous. The fever, which was invariably present at the commencement of the treatment, soon abated; and the pain, which was often severe, decreased under the treatment, and usually ceased after twenty-four to thirty-six hours. The ultimate results were also satisfactory.

84. Sling Atrophy.

ROCHARD and STERN (*Journ. de méd. et de chir. prat.*, May 25th, 1916) call attention to the evil effects of the too prolonged wearing of arm slings, which they say tends to transform wounded men into chronic invalids. In a typical case the whole limb is wasted; the muscles from the deltoid to the interossei are atrophied; the skin of the hand is thinned, damp, violet blue in colour, and so cold that the patient often wears a warm glove. The joints of the shoulder, elbow, wrist, and fingers are stiffened as if by rust, and passive movement causes pain and resistance. If the limb is allowed to hang free, it retains the same position as when carried in the sling; the arm is fixed to the trunk, the forearm flexed, the hand and fingers point downwards. The falling of the fingers towards the ulnar side is the characteristic sign that the sling has been worn too long; it is caused by the weight of the unsupported end of the limb, and in inveterate cases corresponds to a true inward subluxation—slow, progressive, and often irreducible—of the hand and especially of the fingers. Active movements are awkward, jerky, weak, and limited; they are often accompanied by slight quick tremor. The authors insist that *écharpés*, as they call them, are neither true simulators nor really functionally disabled; they have lost the habit of movement, and the condition is one of atrophy and ankylosis produced by too long immobilization. A wounded limb is forthwith put in a sling, and kept thus supported for an indefinite time. The man finds it relieves him while the hurt is painful; afterwards it gives him the agreeable sensation that everyone gets from holding on to the side strap in a railway carriage. Insidiously the limb wastes and stiffens, and the man becomes a confirmed invalid. The first thing to be done is to dispense with the sling, notwithstanding the protests of the patient and sympathetic friends. Then if there be no definite contra-indication, such as false joint or arthritis, passive movement and massage should be employed. The treatment should at first be carried out by the doctor, who by gentleness and persuasion will gain the confidence of the patient and encourage him to put his will power in action. Of course, in cases where there is an anatomical lesion a sling is necessary; it is the abuse of it that is condemned.

THERAPEUTICS.

85. Prophylactic Inoculation against Dysentery.

ACCORDING to G. SEIFFERT and O. NIEDIECK (*Muench. med. Woch.*, February 29th, 1916), most cases of dysentery in Germany among soldiers and prisoners are due to the relatively harmless bacteria associated with the names of Lentz and Kruse. Accordingly, prophylactic inoculation has mainly been undertaken against these bacteria, whereas inoculation against the Shiga-Kruse bacteria has hitherto seldom been required. The outbreak of a small epidemic in the camp to which the authors were attached gave them the opportunity of studying the effect of inoculation in about 2,000 cases. The reactions of the serum to this inoculation were noted in several cases, and the constant development of antibodies was interpreted as evidence of acquired immunity. The cessation of the epidemic coincided with the change in the weather from severe heat to cold and rain; and it was therefore doubtful whether this or the inoculations were responsible. The authors conclude that there is at present insufficient material on which to base a final judgement on the results of inoculation against dysentery. It is also uncertain how long the immunity lasts, but probably it is short-lived, and it may therefore be necessary under certain conditions to repeat the inoculation after a few months.

86. Fibrolysin in Recent Cutaneous Scars.

HENRI TOUSSAINT (*Bull. et mém. de la Soc. de Chir. de Paris*, August 17th, 1915) has made trial of subcutaneous injections of fibrolysin for the loosening of recent scars. A six weeks' course of injections of thiosinamine did no good in a case in which the urethra was occluded from pressure by cicatricial tissue the result of a wound inflicted four months before. Injections of fibrolysin gave encouraging results in two cases in which there was an adherent cutaneous scar prolonged by an indurated cord, in each case caused by a wound from a fragment of shell received about a month before the injections were begun. The wound was situated in one case above the knee close to the internal saphenous nerve, in the other on the latero-external aspect of the neck. Both patients complained of excessive pain, especially at night. In both Wassermann's reaction was negative; 4 c.cm. of fibrolysin were injected every other day, the needle being pushed deeply along the indurated cord. Even in the case of the patient wounded in the neck, who was a very nervous subject, the injections caused no pain, although he had been unable to bear the rubbing of a collar on the site of the wound. Suggestion was used to further the cure, and the patient was assured that pain would cease as soon as the skin was freed from its adhesions. Massage was used with the injections, and the patient was told to massage the scar himself at odd times. At the end of six weeks the scar was free from the subjacent tissues and the hyperaesthesia had disappeared. The author suggests that in cases similar to those described it is advantageous to free the cutaneous and subcutaneous tissues in order to liberate the nerve fibres which give rise to the pain; also where a quite recent cutaneous scar is threatening to imprison a tendon or a sensory or mixed nerve fibrolysin may prove of great benefit. Treatment must, however, be begun early, it being useless to try the method three or four months after the infliction of a wound which has been accompanied by more or less prolonged suppuration.