

mouth. His palate was lacerated at the time but healed well, and he had never thought any more about it. Unfortunately, infection in the lung spread rapidly, and he died on Nov. 15.

The astonishing thing is that a foreign body of this size could have remained blocking the bronchus for 31 years without giving rise to serious trouble. It is possible that this may be due to the fact that the airway through the centre of the vulcanite had remained patent and that he was therefore able to get enough air backwards and forwards through it to ventilate his lung. Careful examination of the vulcanite showed no corrosion or disintegration at all.

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Recurrent Dislocation of Ankle due to Rupture of External Lateral Ligament

It is still a fact that many cases of recurrent dislocation of the ankle due to a rupture of the external lateral ligament pass undiagnosed and untreated. Such a case usually presents itself with a history of a recent sprain. On examination the ankle is swollen, bruised, and painful. However, on questioning, the patient admits having had previous sprains of varying severity. On the other hand, the case may present itself with a history of recurring slight sprains and a general feeling of weakness in the ankle-joint.

The outstanding fact in the history of a case of ruptured external lateral ligament is an original injury of some severity. Further examination of the ankle does not elicit any more inversion than is found in a normally sprained ankle without a ruptured external ligament. Straight radiographs, both lateral and antero-posterior, show no evidence of the ruptured ligament. For this to be demonstrated the muscle spasm has to be relieved by an injection of novocain on the outer aspect of the joint. The result is as shown in the accompanying radiograph (Fig. 1).

A Suggested Operation

The only treatment for an ankle with a rupture of the external lateral ligament is operation. The following technique was devised by me.

At operation the old rupture is quite apparent. The ligament is repaired by splitting the tendon of the peroneus longus from above downwards. The detached end is then threaded through the external malleolus and through the os calcis (Fig. 2). The value of this method is that it is easy to per-

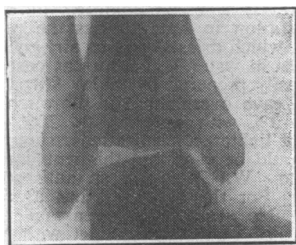


FIG. 1

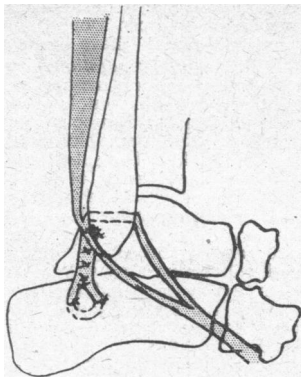


FIG. 2

FIG. 1.—Radiograph showing dislocation of the astragalus.

FIG. 2.—Diagram showing half of the peroneus longus tendon threaded through the external malleolus and the os calcis, and back again on itself.

form and that it reconstitutes the ligament. At the same time no muscle is damaged, as the remaining half of the tendon hypertrophies.

The radiograph shown is that of a patient upon whom I operated. When first seen she was aged 32. On examination she had what appeared to be a severe sprain or a fractured ankle. Her history, however, revealed that this occurred every few months. She also clearly remembered a severe sprain as a child. This undoubtedly was the time that the ligament was ruptured. Operation revealed the old tear of the ligament. The patient has had no further trouble since the operation.

I should like to thank Mr. A. T. Fripp, F.R.C.S., as it was while assisting him at one of his cases that I devised this operation.

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Reviews

SOCIAL WORK FOR THE TUBERCULOUS

Social Work for the Tuberculous—A Practical Guide. By Harley Williams, M.D., and Irene Harbert. (Pp. 153. 5s.) London: National Association for the Prevention of Tuberculosis.

The presentation of information on social work, in any of its many forms, in a concise and readable manner, is a difficult task, and that side of it devoted to tuberculosis is no exception to the rule. The authors of this book are therefore to be congratulated on having produced a valuable guide containing a storehouse of useful knowledge in so small a compass as 153 pages. The title of the book is a little ambiguous, but the subject-matter is for the most part a clear and well-constructed summary of the management of the tuberculous patient in his home and gives an excellent account of the assistance which is available under Memorandum 266T and the help provided by care committees. It is agreed that "if its principles and ideals are grasped the care worker will be more confident in her own judgment."

In detail, however, there are some points which need correcting and revision. Where the book touches on clinical matter there is a certain degree of confusion, and in some places it gives rather misleading information. For instance, a positive skin test does not always mean there has been contact with an open case of pulmonary tuberculosis: it may result from drinking infected milk. It would have been useful to have more information on the subject of pensions and the help given by the British Legion in this direction. There is a tendency to draw a too optimistic picture of the assistance which the tuberculous patient will receive under the Ministry of Labour and National Service rehabilitation scheme, and there is little guide as to the employment of the "open case" except in the village settlements. Certain paragraphs will no doubt be redrafted in future editions, for this book will be helpful to social workers for many years to come.

A useful index to agencies for personal aid is given at the end of the book as well as a general index. The well-defined and clear font of type makes the text easy and pleasant to read without fatigue.

INDUSTRIAL OPHTHALMOLOGY

Industrial Ophthalmology. By Hedwig S. Kuhn, M.D. (Pp. 294; illustrated. 32s. 6d.) London: Henry Kimpton. 1944.

Industrial ophthalmology is not synonymous with a study of industrial eye injuries any more than ophthalmology in general is merely the study of the causes of blindness. Different occupations require different degrees of visual acuity, stereopsis, muscle balance, adequate illumination, and capacity for quick visual judgments. Furthermore, different industries involve varying degrees of ocular fatigue, and danger of damage from mechanical or toxic factors. The conditions under which some industrial processes have to be carried out may be so trying that special measures are needed to enable the worker to see clearly and comfortably for prolonged periods. Studies on these and kindred aspects have appeared in the periodical press and in monographs, but there is no systematic survey of industrial ophthalmology as a whole. It is perhaps also no exaggeration to say that there is as yet no comprehensive formulation of the problems.

The appearance of Dr. Hedwig Kuhn's *Industrial Ophthalmology* is therefore a welcome portent, for here at last is an attempt to survey the field as a whole. The numerous photographs of factories, workrooms, and machines, and of workers concentrated on particular tasks are in themselves a substantial contribution to the formulation of the problems of industrial ophthalmology. Incidentally they also show how much has been done in isolated factories, here and there, to meet some of the problems. The chapter devoted to eye protection shows forcibly enough that this is not merely a matter of goggles; like all general remedies goggles tend to conceal more dangers than they have overcome. The introductory chapter, with its stress on the need for tests to eliminate those who are visually unfit for particular tasks, is particularly illuminating; to most ophthalmologists the whole concept and

its application will prove distinctly new. The chapter on visual skills is an excellent essay on the adaptation of workers to their jobs. Even at this stage in the development of industrial ophthalmology it is clear that, as distinct from an encyclopaedic knowledge of the details of various industrial processes, there are certain general principles that are applicable throughout industry and readily adapted. To have shown this is a substantial achievement for a pioneer effort in the writing of a textbook on a new subject. Dr. Kuhn's book in addition contains a mass of detailed information, and there are particularly useful sections on toxic hazards and on danger from radiant energy. It is regrettable that the high achievement of this book is marred by the inclusion of a considerable amount of irrelevant and ill-balanced information, and by a style that lapses alternately into purple passages and sheer slang.

THE SICK AFRICAN NATIVE

The Sick African. A Clinical Study. By M. Gelfand, M.B., Ch.B., M.R.C.P., D.M.R. (Pp. 372; illustrated. 25s.) Capetown: The Post-Graduate Press in association with the Stewart Printing Co., Ltd. 1944.

Most textbooks on tropical medicine in describing diseases in the Tropics consider these mainly from the point of view of the European who is merely a visitor in a foreign land. Only those diseases which are not found in his own country—the so-called tropical diseases—are dealt with, while those which are common to both tropical and temperate countries receive little consideration. In *The Sick African* the author deals almost entirely with the native, and considers the European only in so far as his susceptibility and response to certain diseases differ from those of the African.

The native is a very different person from the European. He has little or no education, is under the influence of the witch doctor, and is always afraid of offending the spirits of his ancestors. He is fatalistic, and is often reluctant to consult a white man about his symptoms. When he does so it is with difficulty that he is persuaded to carry out a long course of treatment, for immediately his symptoms abate, though cure has not been effected, he will leave hospital and not return for further advice or observation. On this account treatment must be as rapid as possible, even though it is understood that this is not entirely satisfactory. The solution of many of these difficulties, in the author's opinion, is the African-trained native doctor, who understands the native mentality and speaks his language as no European can ever hope to do. All these and many other aspects of medical practice among Africans are discussed in the two introductory chapters of the book. There follow others on malaria, bilharziasis, hookworm disease, leprosy, yaws, and the many other conditions to which the native is liable. It is noted that he far more commonly suffers from those diseases which occur in temperate climates than he does from those that are purely tropical. Dr. Gelfand has had a wide experience of native practice, and the advice he gives as to the methods of handling and treating the native will be invaluable to all who find themselves in the position of having to carry on this kind of work.

As Col. A. P. Martin says in his foreword, this is a book which in an outstanding manner meets the needs of all workers in the African field of tropical medicine.

LIP-READING AND DEAF AIDS

Lip-reading and Hearing Aids. By Irene R. Ewing, M.Sc. Second edition. (Pp. 73. 4s. 6d.) Manchester: The University Press. 1944.

It has long been known that deaf children acquire the art of lip-reading with comparative facility and require relatively little teaching, while for adults the process is more difficult, and it has been said sometimes to be impossible. The services of Mrs. Irene Ewing to the deaf are well known, and one of them is the compilation of this little book, which describes the nature and scope of lip-reading and the correct approach to the problems of both teaching it and learning it. The difficulties are seen from the sides of both teacher and pupil. The importance of combining lip-reading with the use of a proper hearing aid, so that the use of one sense organ reinforces the activity of the other, is established, and Mrs. Ewing shows that by following her methods the assumption that adults cannot learn lip-reading is ill founded. Those who are becoming deaf

or have suddenly become deaf and are determined to make a serious effort to overcome the disability will find not only that this little book is of great assistance but also that it brings a message of needed encouragement and hope. The methods described are not intended for children.

Notes on Books

Messrs. E. and S. Livingstone of Teviot Place, Edinburgh, have published a third edition of Miss Lois OAKES'S *Illustrations of Bandaging and First Aid*, which received praise in these columns on its first and second appearances. It is a very useful introduction to the art of bandaging and is likely to fill for long to come a niche in first-aid literature. The material has been revised for the new edition and several new features added—for example, a section on how to "blanket" a stretcher, how to lift and lower a patient, and how to remove an unconscious person from a smoke-filled room. An addition is four pages of coloured pictures entitled "Typical War Wounds," taken from Mr. Hamilton Bailey's book *Surgery of Modern Warfare*. The volume is very freely and clearly illustrated throughout. Its price remains at 6s., postage in this country 6d. extra.

Preparations and Appliances

A CHEAP AND EFFECTIVE SUBSTITUTE FOR UNNA'S PASTE

Lieut. J. J. WILD, R.A.M.C., writes:

In 1943, faced with the shortage of elastic bandages and a large number of chronic ulcers of the leg, mainly varicose requiring out-patient treatment, I decided that a substitute for Unna's paste must be found. With the kind co-operation of Mr. Soulsby, the pharmacist at North Middlesex County Hospital, a preparation was evolved which not only fulfilled this purpose, but has proved superior to Unna's paste in two ways at least, namely: (1) No heating is required before application. (2) Low cost and easy availability.

The Preparation.—The basis of the preparation is methyl cellulose, a water-soluble tragacanth substitute. This goes under various trade names. The product used by me was "W.F.Z.," supplied by Imperial Chemical Industries, Ltd. (South-Eastern Division, Dyestuffs Section), Belmont, The Ridgeway, Mill Hill, N.W.1. This is a commercial grade of methyl cellulose, and contains traces of heavy metals so that it is unsuitable for internal administration or topical application to open wounds. Nevertheless, bearing these points in mind constantly, I have found that it is harmless to the intact skin.

Details of Preparation.—"Cellofane W.F.Z.," described as a technical grade of methyl cellulose, is a cream-coloured fibrous cellulosic material. In low concentration in water it has the property of forming a viscous solution, which dries slowly in air, giving a celluloid-like film which redissolves in water. The current cost is 2s. 10½d. a lb. The substitute is easily prepared by taking 95 parts of water and 5 parts of W.F.Z. Leave overnight, stir thoroughly, and then adjust the proportion to 3% with water. Add 20% of zinc oxide and stir well. No doubt lighter concentrations, such as 5% W.F.Z. and 30% zinc oxide, could be used, but this would not pour and would give a stiffer paste. W.F.Z. is not an antiseptic, and will support growth of fungi. For this reason it has always been freshly prepared for my use. No attempt has been made to sterilize the preparation as it does not come into contact with the open lesions. But should this be thought necessary, autoclaving should not affect it.

Method of Use.—The preparation is applied cold on to a wet bandage with a brush, and layers of wet bandage are impregnated with it as for Unna's paste. The final bandage is a dry one and serves to protect the patient's clothing. Drying occurs in a few hours, and the patient is instructed to moisten the dressing if it gets too hard. This procedure is rarely necessary. About four layers of bandage are usually enough.

Clinical Applications.—(1) Varicose ulcers: All ulcerated areas and vulnerable skin are covered with lint after applying the required dressing; then the supportive dressing is applied. (2) Thrombophlebitis: Used as a supportive bandage. (3) For lower limbs after plaster-cast immobilization: I used the preparation for this purpose, in preference to adhesive elastic supportive bandages, for eight months at the Miller General Hospital, Greenwich; no skin reactions were observed. (4) As an occlusive dressing in suspected dermatitis artefacta.

The preparation has been in constant use at the North Middlesex County Hospital for two years, without trouble. The paste is entirely satisfactory, and, bearing in mind the high cost of Unna's paste and the need for economy in glycerin and gelatin at this time, it is gratifying how efficient a substitute this preparation has proved. It might even be deemed to have superseded Unna's paste.

My thanks are due to Mr. Soulsby, the pharmacist, to Sister Peers, and her nursing staff at the hospital for their willing co-operation in evolving this preparation.

Br Med J: first published as 10.1136/bmj.1.4394.413-b on 24 March 1945. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.