the foot in a comfortable dorsiflexed position: this also is necessary to minimize the transverse creases which are the cause of discomfort to the wearer. The bandage is applied with a moderate amount of tension, special care being taken that it is free from creases, twists, and folds. It takes several minutes to apply, but when it is recalled that the correct application will heal the ulcer and will stay on for months, it is worth the trouble. Each turn of the bandage overlaps its predecessor by two-thirds, so that the final Unna's paste casing is three thicknesses plus the three thicknesses of longitudinal strips. These dressings are always well tolerated; it is the exception to find a patient whom they do not suit. Finally, the wet bandage is dried off by the application of an ordinary cotton bandage beginning at the knee and passing downwards; the bandage will be found to lie better when so applied. Plaster-of-Paris is useless for encouraging epithelization, and, moreover, is unnecessarily inconvenient.

Patients with ulcers must wear stout shoes from early morning to last thing at night; ladies should be advised to procure a boy's shoes, which are made in wider fittings and are robuster than ladies' shoes. The local cobbler will raise and smarten up the heels.

Recurrent Polyneuritis

Q.—*A woman of 72 has had three attacks of severe polyneuritis in the past 10 years. Each attack lasted 2 to 3 months, with symptoms, except for slight numbness, subsiding completely between the attacks. She has had a myocarditis and complete achlorhydria for some 15 years. What are the aetiology, treatment, prevention, and prognosis? Should vitamin B be taken regularly either by mouth or by injection, and if so, in what dosage?*

A.—Recurrent polyneuritis is a rare disorder, the cause of which is not known. There is evidence that in some cases avitaminosis may be one factor in its aetiology, and in the case reported the complete achlorhydria is perhaps more consistent with a metabolic than an infective cause. If the laboratory facilities are available, something might be learned by measuring the patient's urinary excretion of vitamin B_1. For prophylaxis the patient should take all the vitamins of the B group. Tablets providing 1 mg. each of vitamins B_1 and B_2 and 15 mg. of nicotinic acid amide are on the market, and one of these three times a day would give an adequate dosage, assuming absorption from the alimentary canal to be normal. It would also be wise to give an intramuscular injection of liver extract in doses of 2 to 4 c.cm. once a month. If another attack of polyneuritis occurs the same treatment should be continued with the addition of a daily injection of 10 mg. of vitamin B_1, and the physical treatment appropriate to polyneuritis. The prognosis is uncertain and further attacks may occur.

Nose-picking and Nail-biting

Q.—*A boy of 7 years (adopted at 6 weeks old, and brought up knowing this fact) has been biting his nails and picking his nose for about a year. He is getting worse. What should be done?*

A.—Judging from the facts given, this case appears to be one of mixed aetiology. The constitutional factors should first be investigated, especially the calcium metabolism; for parathyroid deficiency often gives rise to such tics. Psychologically, the Freudians regard nail-biting and nose-picking as sexual manifestations related to masturbation, and this view is often borne out by the facts. But, taken in itself, nail-biting reveals a state of tension, and is evidence of repressed assertiveness or aggression. (Children suffering from pent-up energy, say before an examination, often bite their nails.) The thwarting may be caused by undue external discipline, but it may also be the result of conditions in the child's own mind; these latter require special investigation by a child psychiatrist. The thwarting may, in fact, be due to the feeling of inadequacy caused by the physiological deficiency already referred to. As a first-aid measure, the child should be encouraged to do things with his hands, both in order to employ his hands and also to give outlet to his assertiveness and to give him confidence. But he must not be pressed to achieve things, as this would increase the tension.

Caesarean Section after Vaginal Fistula

Q.—*A primipara with small pelvic measurements took some 24 hours to reach full dilatation, and finally, after manual rotation of a persistent occipito-posterior head, had a forceps delivery of a live child. Three days later, despite passing urine normally, she developed a cysto-vaginal fistula. This was successfully repaired five weeks later. She is now pregnant again, three years after the first child. The scar of the repair is sound and of a hard unyielding consistency. In view of the past history and the tough anterior vaginal wall, is the correct treatment to perform Caesarean section at or near term?*

A.—The usual procedure is to advise Caesarean section for cases of this kind. The contracted pelvis may be responsible for another difficult delivery, with a tight fit between the head and the pelvis, so that the old operation scar may be damaged and the fistula recur. The majority of obstetricians would unhesitatingly perform Caesarean section at term in such a case.

Children's Wards and Cross-infection

Q.—*How should a children's ward be designed to reduce cross-infection?*

A.—Cross-infection in a children's hospital or unit can best be countered by including a large proportion of single rooms (up to 50% of the available beds); by small wards of 4 to 8 beds; by good ventilation and lighting; by a sufficiency of wash-hand basins in the wards, sterilizers in the annexes, and modern labour-saving equipment; and, most important of all, by an adequate and properly trained nursing staff. The sources, modes of spread, and methods of control of "hospital infection" should be taught to all nurses early in their career. There can, of course, be no standard pattern of ward, but a modern and well-designed unit has lately been described by Jacoby (*Arch. Dis. Childh.*, 1944, **19**, 26). This unit of 35 beds consisted of one 6-bedded ward, four 4-bedded wards, two 2-bedded wards, and four single-bedded wards, with the usual annexes, milk-room, and *accommodation for nursing mothers*. But design alone will not accomplish much if the administrative and nursing precautions given in detail in M.R.C. War Memo. No. 11 are not put into effect. Thus examination and distribution of cases on admission must be done by an experienced R.M.O.; children under a year must be nursed in single rooms; great care must be taken with the preparation of infant feeds; masks should be worn by nurses and medical staff as required; visitors should be discouraged; and passive or active immunization of patients should be practised whenever practicable.

LETTERS, NOTES, ETC.

Psychiatry in the Services

A medical psychologist writes: The answer to the question on page 283 of the *Journal* of Feb. 24 regarding psychiatry in the Services can hardly go unchallenged. In the first place psychiatry does not include *all* acts of behaviour; that is the province of the wider science of psychology. Psychiatry, as its name implies, means healing, and therefore deals only with abnormalities. Nor can one let go unchallenged the writer's exclusion of the "lack of moral fibre" from the concern of the psychiatrist, for this may, among other things, be due to constitutional disorders such as are to be found in the asthenic type. In any case the writer contradicts himself, for if psychiatry deals with all acts of behaviour, why does he tell the psychiatrist to "stick to his last" and not deal with lack of moral fibre, but to leave that to the executive authorities? Is not this a form of behaviour?

Coloured Film of Casualties

Mr. W. McADAM ECCLES, M.S., F.R.C.S. (London, W.1) writes: Since damage and casualties are still occurring in Southern and sometimes Northern England, though the day of their cessation is drawing near, it is not inappropriate to remind medical officers and others associated with Civil Defence and A.R.P. that the unique coloured film of "Casualties" is still available for exhibition after having been shown to many thousands of workers. Particulars can be obtained from the manager, Mr. J. Magrill, 17, St. Quintin Avenue, London, W.10.

Treatment for Superficial Eye Infections

Dr. SHEILA MILLAR-DANKS (Dulwich Hospital, S.E.22) writes: I read with interest Dr. Graydon Hume's letter (Jan. 27, p. 129) concerning superficial eye infections. I was aware of the benefit of a stable solution of ephedrine and silver vitellinate for nasal use, having read the correspondence on the subject in the *Journal* in December, 1943, and January, 1944, but its value for eye infections was new to me, and especially the fact that stabilization of the solution eliminated argyrosis. Although post-anaesthetic conjunctivitis is becoming a rarity due to the increase in the use of closed methods of anaesthesia and decrease in the employment of ether as an anaesthetic agent, it still occurs where the open method of administration is used. Possibly the solution suggested by Dr. Graydon Hume would be efficacious in dealing with the condition.

Corrections

An old Guy's man wishes to register a correction of the item of news published on March 10 at page 353 recording a medical dinner at Delhi. The Director-General, I.M.S., Lieut.-Gen. J. B. Hance, is a Cambridge and Guy's man, not an alumnus of Edinburgh.

The number of cases of pneumococcal meningitis which Dr. Eli Davis stated had been seen in a sister hospital to his own was eight, not eighty as given in the report in the *Journal* of March 17 (p. 379).

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