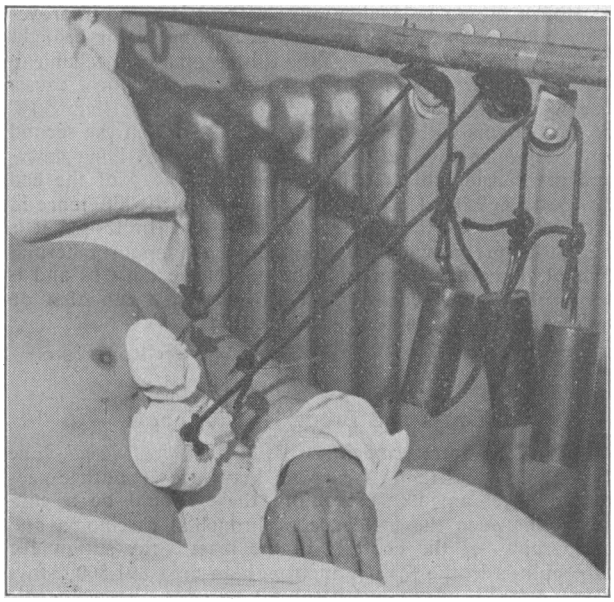
Stove-in Chest Injury

SIR,—Mr. L. Henry (*Journal*, August 10, p. 339) treats a stove-in chest by plating the sternum. Mr. J. A. Rhind (*Journal*, August 24, p. 470) accuses him of tempting providence and advises tracheotomy in all cases. It is gratifying to note the interest in the treatment of this hitherto neglected injury, but it is to be hoped that rival schools of "stabilizers" and "tracheotomists" will not arise. Clearly there is a place for both approaches to the treatment of this grave disorder. The two lines of treatment are complementary; stabilization provides specific treatment and tracheotomy symptomatic treatment.

If the instability of the chest wall is diagnosed early, then stabilization of the flapping segment will save the patient from wet lung and the necessity for tracheotomy. It must be emphasized, however, that the method of stabilization should be simple. Rigid fixation is unnecessary. Fixing the sternal fracture with a plate is unnecessarily complicated, because adequate stabilization can be obtained by



screw traction. I have designed a guarded sternal screw (manufactured by Zimmer Orthopaedic Ltd., Bridgend) which can be inserted blindly under local anaesthesia. Wiring of multiple rib fractures by open operation is also unnecessary. A few strong nylon sutures inserted blindly around the ribs at the centre of the flapping segment will provide effective stabilization (see Fig.). The sternal screw or rib sutures should be attached to a weight passing over a pulley rather than springs, because this enables the patient to move freely without altering the degree of traction.

Where the patient has already a wet lung, or where stabilization is not possible, then tracheotomy is a life-saving procedure. But it is surely irrational to apply this as a first line of treatment. Tracheotomy with repeated suction is not without its discomforts and dangers, as emphasized recently by F. Plumb and M. F. Dunning.[1] A reasonable approach to the stove-in chest can be summarized by advising stabilization if possible and tracheotomy if necessary.—I am, etc.,

Bridgend, Glam. A. W. FOWLER.

REFERENCE

[1] Plumb, F., and Dunning, M. F., *New Engl. J. Med.*, 1956, **254**, 193.

SIR,—In his criticism of the effective operation performed by Mr. L. Henry (*Journal*, August 10, p. 339), Mr. J. A. Rhind (*Journal*, August 24, p. 470) asserts that the performance of a tracheotomy is the only measure needed in the management of these injuries. I, too, have had occasion to note the effectiveness of tracheotomy as an adjunct to treatment in stove-in chest. But it is most important that treatment should primarily be directed towards the restoration of normal cardio-respiratory function. The elimination of paradox, which Mr. Henry achieved, is of prime importance; in his case it rendered tracheotomy unnecessary.

When I read the article by Dr. Hulman[1] to which Mr. Rhind refers, I was surprised to note that the presence of a large haemo-pneumothorax was not considered of sufficient moment to warrant its immediate and active removal. It is only by effective correction of all of the factors which combine to produce anoxia resulting from a stove-in chest that the distressingly high mortality will be reduced.—I am, etc.,

London, E.2. J. E. JACQUES.

REFERENCE

[1] Hulman, S., *Lancet*, 1957, **1**, 454.

Centipede Bites

SIR,—Occasionally mention is made about centipede bites (*Journal*, December 31, 1955, p. 1619; April 28, 1956, p. 986). However, the occurrence of bites by the giant tropical centipedes is widespread, and many a practitioner in hot countries is well aware of the painful bites and after-effects inflicted by these vicious arthropods. All authors confirm unanimously the immediate and excruciating pain at the site of the bite and the subsequent infection and lymphangitis. Even paralysis and contractures of the extremities and heart irregularities are described. After two or three days the symptoms generally subside.

As far as I could trace in the literature on the subject, a recurrence of symptoms has never been mentioned. Only from the far east came a legend of recurrent oedema at the site of the bite when the moon was full.[1] In a series of twelve cases of centipede bites in Dutch New Guinea, however, I noted recurrence of pain and swelling in seven separate cases.[2] After a week's interval the local inflammation returned for a short period of one to three days. In one case there was a swelling of the interdigital joints of the bitten finger. Similar after-effects due to animal bites were observed in the case of a spider bite[3] and probably also after rat bites. The local symptoms of rat-bite fever caused by *Spirillum minus* infections are supposed to be a cyclic allergic reaction of the skin to the bacterial antigen. In my opinion the recurrence of the symptoms after centipede bites is also due to an allergic reaction of the superficial layers of the skin, for it seems probable that the centipede does not inject only venom with its poison-fangs but also bacteria. If this hypothesis of a combination of immediate tissue destruction by venom and a later sensitization by inoculated bacteria should be correct, the cortisone treatment as advocated by Ariff (*Journal*, July 16, 1955, p. 204; April 28, 1956, p. 986) seems to be the most excellent therapy. Other readers may be able to confirm my observations regarding the rather frequent recurrence of symptoms after centipede bites.—I am, etc.,

G. T. HANEVELD.

REFERENCES

[1] Cornwall, J. W., *Indian J. med. Res.*, 1915, **3**, 551.
[2] Haneveld, G. T., *Ned. T. Geneesk.*, 1956, **100**, 2906.
[3] *J. Amer. med. Ass.*, 1937, **109**, 380.

Corrections.—The name of Professor W. W. Mushin was omitted from the list of members of the Medical Research Council's Committee on Non-explosive Anaesthetic Agents given in our issue of August 31 (p. 479). One of the co-authors of the report on "Some Pharmacological Actions of Fluothane" was Dr. G. A. Feigen. We regret that his name was wrongly spelt on p. 479.

The figure "400 g. and over" qualifying the column heading "Perinatal Mortality" in the table in Professor F. J. Browne's letter, "Stillbirth Rates in 'Non-White' Women" (*Journal*, August 17, p. 412), should have been placed so that it related only to the third percentage perinatal mortality rate listed in the column, that for "Hospital Z" (2.7%). Professor Browne was using the table, which compared "the results of interference and non-interference in cases of so-called post-maturity," to answer points raised in a letter by Drs. D. N. Menzies and J. S. Scott (*Journal*, July 6, p. 46) which followed an earlier letter by Professor Browne on foetal post-maturity (*Journal*, June 22, p. 1472).