by the time he was examined in hospital it had fallen to 102.8°. The
tongue was furred, there was a palpable spleen, and some cough. Other­
wise, no signs or symptoms were made out. Enteric fever was thought
of, though the history of a sudden onset was against it, and preparations
were made to obtain a culture from the blood in the evening. By 6 p.m.
the temperature had fallen to 99°. A culture was, however, made, 5 c.c.
of blood being introduced into a large quantity of broth.

The following morning, the 12th, the temperature had again risen to
102.6°, and the patient was in a rigor when seen. A blood-film was
taken which showed benign tertian parasites in all stages, from the ring
form up to the fully formed rosette. He was given calomel, and later in
the day quinine. The sulphate was given by the mouth in doses of
10 grains thrice daily. By the following morning the temperature had
fallen to normal, and it has remained so since. The blood culture showed
no growth.

His residential history is as follows: Born in Hammersmith, he left
that place as quite a small child and went to Acton, where he has lived
ever since, until 9 weeks ago, when he came to Woolwich on enlistment.
He has not left Woolwich since, except for one day when he went to
Acton. He has never been out of England and has never previously
suffered from the disease.

It seems pretty obvious that the infection was acquired in Woolwich,
though he says he has visited the docks in the neighbourhood once or
twice, on each occasion returning to barracks by 9.30 in the evening, he
does not remember having been bitten by mosquitoes.

The interest of the case lies in the possibility of the disease again
spreading widely in England. It is well known that malaria used to be
common, it is well established that anopheline mosquitoes breed in
England, there is a susceptible population, and many human carriers of
the parasite are landed in the country every year. In addition, in these
days of rapid transit, mosquitoes infected, say, in India, may be carried to
England in time to enable them to infect fresh individuals here.

I am indebted to Lieutenant-Colonel R. J. S. Simpson, C.M.G., officer
in charge of the Medical Division, Royal Herbert Hospital, for permission
to publish the case.

THE ASEPTIC TREATMENT OF BURNS AND SCALDS.

By MAJOR F. J. W. PORTER, D.S.O.
Royal Army Medical Corps.

The treatment of these injuries by the ordinary methods of oily appli­
cations is most unsatisfactory. That by the use of picric acid may be less
so, but I have no experience of it. I do know, however, that extensive
scalds or superficial burns, owing to their always being infected when they
come under treatment, usually suppurate. This leads to further destruc­
tion of tissue, and scarring is very apt to ensue. At any rate, these injuries when treated in the usual manner with oily applications, remain a very long time in hospital and convalescence is slow. Having lately seen an instance in which after a large scald (by boiling water) healing took no less than seventeen weeks, in spite of grafting, I determined to treat the next case I saw by strictly aseptic methods from the very commencement.

On May 1, Gunner D. was admitted to the Alexandra Hospital at Gosham, having slipped into a copper of hot water. The right leg was scalded as high as the popliteal space, but the fore part of the foot and anterior surface of the leg had escaped. He had been dressed with carron oil and lint before arrival. I injected 1 grain of morphia and had him anesthetized at once.

After removing the dressing, the whole of the limb was thoroughly washed with plenty of methylated spirit poured from a bottle and scrubbed by sterile swabs. The scalded surface was freely rubbed by the swabs, and all the denuded epithelium removed. At least ten minutes were occupied in this manner. The limb was then washed with iodine water, one drachm of tincture to the pint. After this, plain white sterile gauze was placed in contact with the raw surface and absorbent wool and a bandage over all.

Next morning the temperature was normal and the patient quite free from pain. There had been such considerable exudation that the dressing was saturated. I thought it advisable to remove the wool and apply fresh, but the gauze was not touched. This was done again next day, and the leg was then kept outside the bedclothes to promote evaporation, and to try and get the wound to scab. The leg was slung next day from a cradle and this materially assisted matters.

On the morning of the tenth day the cotton wool was removed and the gauze was found perfectly dry over the whole area, with the exception of a place over the inner ankle and centre of the calf; the gauze at these places was soaked with pus, but no organisms were present. Over the rest of the leg the abraded surface had healed beneath the gauze. After soaking it off, the limb was slung from a cradle exposed to the air for four hours and a sterile gauze dressing reapplied.

The gauze again became soaked with pus over the unhealed areas, and so all dressings were again removed and the abraded surfaces dusted with boric powder and the limb kept slung. Final healing took place about the thirtieth day.

The ultimate result of this method of treatment was, I think, considerably better than one would have got if the injury had been dealt with by oily or greasy applications, but I think it is quite possible that one might improve on it. The great obstacle to immediate scabbing is, of course, the tremendous exudation of serum which follows the injury, and this is much accentuated by the scrubbing which one makes use of in order to
Clinical and other Notes

sterilize the affected area. It was suggested to me that it would be a good plan to have slung the limb from a cradle covered with gauze for a couple of days, but in addition to the risk of infection the exposure of a large raw surface to the air would cause intolerable pain.

Captain Adye-Curran's suggestion, viz., to employ continuous immersion until the bulk of the exudation had ceased, and then to apply a sterile dressing might be worth considering, but there would again be the risk of infection. Another plan would be to smear the part with sterilized vaseline before applying the gauze.

Extensive injuries of this kind do not occur very frequently, and I am therefore recording my results in this case in the hope that others may be induced to try some other line of treatment than the old-fashioned carron oil application.

I think if one had applied ointment to the small raw surfaces which were evident when the gauze was removed on the tenth day, instead of trying to get scabbing under boric acid, much more rapid healing would have resulted.

CLINICAL NOTES ON A CASE OF NEURITIS OF THE FIFTH NERVE EXTENDING TO THE GASSERIAN GANGLION.

By Captain W. S. Crosthwait,
Royal Army Medical Corps.

Previous History.—Some years ago the patient had severe neuralgic headaches for about six weeks after influenza. He has also suffered a good deal from malaria in Burma, but not recently. His father died of gout, and he has had a typical attack of podagra. When on the way home from India he had retention of urine; and the ship's surgeon was unable to pass a catheter, and found it necessary to tap him above the pubes. The retention of urine was evidently due to urates. There is no history of gonorrhoea or syphilis. He caught cold in his face whilst out motoring yesterday, and neuralgia came on soon afterwards, but was not severe at first.

April 2, 1911. Present Condition.—I was called to see Major S. this morning, and found him suffering from acute pain radiating from the front of the ear along the upper and lower jaw as far as the middle line. The pain was limited to the right side of the face. There was some twitching of the muscles of the lower part of face on this side. There was no infra-orbital or supra-orbital pain. There was no pain over the mastoid process or in the ear, and there was no aural discharge. Temperature normal, pulse 60, tension very high, arteries appeared somewhat atheromatous. Specific gravity of urine 1032, reaction very acid, and there was a very large deposit of urates. No sugar or albumen.
The Aseptic Treatment of Burns and Scalds

F. J. W. Porter

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