FIG. A.—Swelling round temporal artery.

persisting a week after admission. The pupils of the eyes were constricted, but when they were dilated with homatropine the optic fundi and vessels were normal. There were no other abnormal signs in the central nervous system.

The only other abnormal physical findings were a persistent tachycardia, a white furred tongue, and a liver palpable two fingerbreadths below the right costal margin. The blood pressure was 128/68 mm. Hg.

Lumbar puncture was performed soon after admission and clear colourless fluid under a pressure of 160 mm. was obtained. This showed a raised protein content and excess of globulin. Unfortunately no cell count was carried out.

Investigations.—On August 11 a blood count showed: Hb, 85%; red cells, 4,130,000; M.C.H., 30 $\gamma\gamma$; white cells, 9,700 (polymorphs 75%, lymphocytes 24%, monocytes 1%). A blood culture was negative. The cerebrospinal fluid was colourless and contained 76 mg. of protein and 690 mg. of chloride per 100 ml. Pandy's test was positive. The Wassermann and Kahn tests were negative. On September 1 a catheter specimen of urine contained a light amorphous precipitate, an occasional leucocyte and epithelial cell, and less than 10 mg. of protein per 100 ml.; it was sterile on culture. Cold agglutinins were not detected. On September 15 lumbar puncture revealed a colourless fluid, 87 mg. of protein and 690 mg. of chloride per 100 ml., and 4 leucocytes per c.mm. The erythrocyte sedimentation rate on August 15 was 52 mm. in the first hour and 90 mm. in the second; on August 22, 118 and 136 mm.; on August 29, 78 and 122 mm.; on September 5, 90 and 125 mm.; and on September 19, 100 and 125 mm.

The results of investigations showed no abnormality save a mild hypochromic anaemia and a persistently raised E.S.R.

On August 13 tissues around the temporal arteries from the angles of the jaw to the hairline were infiltrated with 2% procaine. Complete abolition of local pain and tenderness was achieved, but the headache, though less in intensity, persisted for a few more days. The arteries became less swollen and all signs of inflammation disappeared from the overlying skin. Three days later the left temporal artery again became swollen and tender. Local infiltration was repeated, with permanent results.

Biopsy was performed on August 31, and a segment of a branch of the occipital artery was excised. On microscopical investigation this showed typical histological features. The report states: "There is severe fibrosis of the media with giant cells of the Langhans type in the outer part of the media. The internal elastic lamina is fragmented and the lumen almost occluded by fibroblastic increase in the intima. The adventitia shows a lymphocytic infiltration."

The photograph (Fig. A) shows the patient's temporal area with swelling round the temporal arteries.

Photomicrographs show respectively a high-power view of the media, including many Langhans giant cells (Plate, Fig. 1) and a low-power view of the whole cross-section of the artery (Fig. 2).

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Reduction of Tibial Fractures

In the absence of specially designed distraction apparatus, unstable, oblique, or comminuted tibial fractures can be reduced without difficulty as follows.

METHOD

The anaesthetized patient is laid on a folded sheet on an adjustable operating table. A Steinmann's pin is introduced through the os calcis or the distal end of the tibia and fixed to a stirrup. Strong cord is made fast to the stirrup and to a hook or beam about 8 ft. (2.44 m.) above the floor and close to the end of the table so as to exert traction on the leg. The hinged footpiece of the table is lowered and the table tilted head downwards to about 40 degrees below the horizontal. The body weight of the patient thus provides strong traction, and to increase traction the table can be tilted further or lowered. Rubber-covered cushions or rubber sheeting under the patient prevent the sliding which develops traction, and therefore must not be used.

When reduction is satisfactory plaster is immediately applied from toes to thigh without moving the limb. A padded sling behind the knee can be used to give 10 degrees of flexion and thereby prevent rotation of the upper fragment. Lateral or antero-posterior compression can be applied while the plaster is setting.

COMMENT

This method does not require any special apparatus. It is easy to take radiographs after reduction and before applying the plaster. Since the knee is straight instead of being flexed to a right-angle as in some other methods, the whole plaster can be put on without moving the limb.

When no orthopaedic table was available fractures of the neck of the femur have been reduced by a similar method, and the reduction has been maintained during the prolonged insertion of Smith-Petersen nails.

So simple a manoeuvre can hardly be new, but it is not described in the standard works on fractures, and its very simplicity makes it worth recording.

Miss Rosemary Grimble kindly drew the diagram.

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Dr. T. M. Montford, of Castle Donington, near Derby, has been unanimously re-elected vice-chairman of the Leicestershire and Rutland Executive Council for 1950-1. He also represents the West Midland Division on the Management Committee of the Association of Executive Councils (England).