globinuria almost disappeared, and the kidneys were normal to the naked eye and on section.

The entry point of the infection is discussed.

Further investigation of myanesin in the treatment of tetanus seems to be warranted.

We wish to acknowledge the courtesy and promptitude with which a large consignment of myanesin was dispatched to us by British Drug Houses, Ltd., in response to the urgent action of Mr. Foggan, the chief pharmacist.

BIBLIOGRAPHY

- Belfrage, D. H. (1947). *Lancet*, 2, 889.
 Berger, F. M., and Bradley, W. (1946). *Brit. J. Pharmacol.*, 1, 4; 265.
 Cowen, J. (1948). *Lancet*, 1, 965.
 Davison, M. H. A. (1948). *British Medical Journal*, 1, 544.
 Hewer, T. F., and Woolmer, R. F. (1947). *Lancet*, 2, 909.
 Hunter, A. R., and Waterfall, J. M. (1948). *Ibid.*, 1, 366.
 Mallinson, F. B. (1948). *Ibid.*, 1, 41.
 Ogilvie, T. A., et al. (1948). *Ibid.*, 1, 947.
 Pugh, J. I., and Enderby, G. E. H. (1947). *Ibid.*, 2, 387.

A "MINOR" INJURY OF THE TERMINAL PHALANX

BY

F. I. POWELL, B.Sc., M.B., B.Ch.

Late House-surgeon, Fracture and Orthopaedic Department,
Royal Infirmary, Cardiff

Terminal phalangeal injuries are often regarded with a great deal of indifference and, indeed, sometimes scorn. They are the Cinderella of hand injuries, and yet these injuries are amongst the commonest in casualty departments, causing as they do a varying amount of pain, discomfort, and unemployment to the patients.

The particular injury under review here is a common one, a crush injury to the terminal phalangeal area, usually caused by a heavy weight—e.g., an oxygen cylinder or metal bar falling on to the finger. The finger is caught by the object and crushed against the floor or a wall, the lesion produced being somewhat characteristic. There is always a degree of "dislocation" of the nail; the proximal end may be dislocated wholly or partially from the nail-bed, the cuticle usually being damaged with this uplift as well. The soft tissue is split, the amount of laceration varying a great deal; there is some oozing of blood; and the radiograph may show a fissure or an appreciable fracture of the terminal phalanx.

I would like to advocate here a procedure that has yielded good results even with the most badly crushed fingers, the essential feature being the removal and replacement of the nail.

Method

The hand is cleansed of any grit and oily material by a good soak and "scrub" in C.T.A.B. Procaine 2% is then injected by a fine needle lengthwise along the margins of the nail (Fig. 1). When the finger is anaesthetized the nail is lifted or cut clean off and placed in C.T.A.B. and then manicured and trimmed with scissors.

On examination of the nail-bed area the amount of laceration and dirt is often surprising. There is always free oozing of blood, and a fracture of the terminal phalanx may be clearly visible. If bleeding is severe the usual attempts to stop it—haemostats or topical thrombin—are made. After cleaning the area with C.T.A.B., suturing of soft tissue is carried out and the nail-bed is sprinkled with sulphanilamide or penicillin powder. The clean nail is then placed in its correct anatomical position and sutures of either horse-hair or silkworm-gut are passed through the

nail at about four points to anchor it to the finger (Fig. 2). The whole is then covered in "tulle gras," a firm dressing is put on, and a plaster shell is finally applied.

FIG. 1.—A schematic drawing of an injured phalanx. Sites of procaine injection (P). The nail is avulsed proximally, showing the nail-bed.

FIG. 2.—Nail replaced in correct position by four sutures.

An injection of A.T.S., A.G.G.S., and 250,000 units of penicillin is given. The dressing is removed a week later, when it will be found that the sutures can be removed without difficulty: the nail does not drop off, as might be expected, but stays on for a variable but appreciable time. There is usually a small haematoma under the nail, but the whole finger is pleasingly free from pain and infection. A powder dressing, with or without another plaster shell, is applied for another week. At the end of about three weeks the patient's finger is quite satisfactory and the cosmetic result good. A new nail will eventually form.

On the other hand, in cases in which the nail has been left dislocated proximally excessive granulation tissue constitutes a troublesome complication at the break, and often pus forms under the nail. Where the nail is avulsed and not replaced there is often oozing of blood for a few days, for which repeated dressings of the area may be necessary, and even after two weeks the finger may be very tender.

Recently a man received this type of injury when working in a dockyard. The finger had not been cleaned, but was placed straightway in a plaster cap with just a gauze dressing. When we saw him a month later, he having moved from the town where he sustained the injury, his finger was still in plaster, and on its removal the terminal phalanx was one mass of foul-smelling slough. It took many weeks to get anything like a satisfactory result for him.

The method outlined in detail for these injuries is a satisfactory one; it is simple to perform and can be carried out with a slight amount of material. It is well within the range of minor surgery work of general practice, and it can be performed with complete confidence on the practitioner's part.

A memorandum issued by the Department of Health for Scotland states that under the National Health Service hospital almoners should be released as far as possible from office duties and allowed to concentrate fully on the medical social work for which they have been specially trained. The duties of the almoner should properly include investigation and interviews to provide understanding of the social and personal background of the patient, and in particular to give the doctor information of this kind which is relevant to diagnosis and treatment; social action to minimize personal anxieties; helping the patient in his adjustment to home life, to resume employment, or to a continuing disability; and advising on the planning of facilities for patients. At present the supply of trained almoners is well below demand, and it is therefore particularly important that their services should be confined to these tasks for which they have special qualifications. The salary of an almoner holding the certificate of the Institute of Almoners is on a scale of £340—£390 per annum. Head almoners earn up to a maximum of £660.