THE BARREL BANDAGE FOR FRACTURES OF THE JAW

BY

W. KELSEY FRY, M.C., M.R.C.S., L.D.S.

The treatment for fractures of the jaw is very little referred to in modern surgical textbooks and always appears to be in the "no man's land" of surgery. Simple fractures of the jaw are generally adequately treated by the dental surgeon, but those fractures resulting from gunshot wounds and from injuries caused through air raids will require the very closest co-operation between the plastic and dental surgeons. In order to ensure the successful treatment of these cases the Emergency Medical Service is providing special centres. The emergency treatment, however, will have to be provided at the first-aid posts and casualty clearing hospitals.

The immediate treatment of fractures of the mandible should be directed towards preventing asphyxiation, which is liable to occur through the loss of control of the tongue. The displacement of the tongue may be such that the air passages are obstructed, and in this condition the posture of the patient is important. The stretcher-bearers should be instructed to place the patient on the stretcher with his face downwards and his head hanging over the end of the stretcher. If the patient is able to walk he must be instructed to stoop well forward. The object should always be to keep the tongue well forward.

For the immediate relief of pain and to guard against the backward displacement of the mandibular fragments it is necessary to apply a bandage which will have the maximum pull in an upward and forward direction and must on no account have any tendency to pull backwards. For many years the textbooks have recommended the four-tail bandage, but it became evident in the last war that the backward pull of this type of bandage not only increased the displacement but was in many cases

FIG. 1.

FIG. 2.

extremely dangerous. It has since been discarded by all surgeons familiar with this type of fracture. The bandage which was found most efficient and easy to apply was the "barrel" bandage. As will be seen from the diagram, this has an upward and slightly forward pull.

To apply this about 6 feet of 2 to 2½ inch bandage—preferably unbleached calico—is required. The middle of the bandage is placed under the jaw, well back just in front of the angle; then a simple knot is tied over the

vertex of the skull (Fig. 1). Using both hands, open the knot so that the front loop comes in front of the forehead and the back portion under the occiput (Fig. 2). The two ends are then taken and upward tension is exerted, and by a slight adjustment the two running hitches are made to occupy a position slightly above and in front of the ear. The two ends are then tied in a reef knot on the top of the head (Figs. 3 and 4).

FIG. 3.

FIG. 4.

I am indebted to Sir Harold Gillies for the use of the illustrations.

A HAEMOLYTIC STREPTOCOCCAL EPIDEMIC IN A HOSTEL

BY

NESTA H. WELLS, M.B., Ch.B.

Honorary Physician, Duchess of York Hospital for Babies, Manchester; Woman Police Surgeon, City of Manchester

What has been called the "unitarian" hypothesis with regard to streptococcal epidemiology has often been referred to during the last few years, a particularly interesting account by Bradley appearing in the *Journal* of October 8, 1938 (p. 733), a most opportune moment for me. He stressed the value of typing haemolytic streptococci and showed the varying types found over a number of years in the semi-isolated community of a boarding school. While reading this I was confronted with an epidemic in a somewhat similar community—namely, a university women's hall of residence, numbering with staff and students about 200. The following is an account of it which may be of value to others, for the more we know how to combat streptococcal infections the nearer we are to reducing one of the most crippling as well as most deadly groups of diseases.

Clinical Record

In the summer of 1938 one student, not my patient, was ill, had cervical adenitis and peeled, and was thought to have had an unrecognized scarlet fever. In early June I was asked to see another girl who had a rash like scarlet fever but no rise of temperature, and who later developed enlarged glands. In late June a definite case of scarlet fever occurred, and another in July among the kitchen-maids. On investigation then I found that three others of the domestic staff and two students had been treated by various doctors during the summer term.