which would have resulted in a fracture in one or more of these places as in the other cases.

We desire to thank Squad. Ldr. J. D. Milne, R.A.F., and Major R. B. Davies, I.M.S., for permission to publish this case report, and would like to emphasize the co-operation between all the medical services concerned.

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Unusual Burn of Cornea from Molten Wax

Dr. H. Sewell Sims, of Palmer's Green, asked me to see a female patient whom he had attended the previous day. She complained of loss of sight after flicking out a lighted wax taper with which she had lit a gas stove, when she said some wax flew between the eyelids. There was no reaction to this foreign body, and the appearance of the cornea was quite normal till, on examination through a loupe, a perfectly transparent layer of wax was seen covering two-thirds of the cornea, which looked as if it had a contact lens lying on it. Until this was removed the cornea did not stain with fluorescein; afterwards approximately two-thirds stained, but the erosion was quite superficial. The wax was removed with a blunt instrument under cocaine, when the vision at once improved from one-tenth to one-third of full vision. Atropine and castor oil were instilled and the eye bandaged. The effects of the cocaine passing off, the eye wept profusely and was very painful. With the ophthalmoscope there was seen a fine line on the cornea, which marked the limit of where the wax had

rested. In spite of the extent of the lesion it had no depth, only the epithelium being affected. It is quite feasible that it acted as molten metals often do—forming a cast of the front of the eye, with a fine layer of protective vapour between. Usually, of course, the lids close so quickly that the cornea escapes injury.

Considering the risks that housewives run several times daily, it really is remarkable that injuries of a similar nature from splashes of boiling fat are not more common. Würdemann (1932) mentions boiling soap, fat, or lard as being possible causes of burns. Sir Stewart Duke-Elder (1938) makes no mention of this in his *Textbook of Ophthalmology*, though there is a diagram of a case of Mr. Doggart's which rather resembles this class of burn—a case of keratoconjunctivitis due to mustard gas. Haab (1909) has a plate in his *Hand-Atlas* showing a lime-burn of the cornea, which is more or less the same in appearance. Fuchs (1933) does not mention it.

Figs. 1a and 1b show the appearance after removal of the wax, Fig. 2a the line of demarcation, which, however, had entirely disappeared three days afterwards, when the eye was quiet and the vision normal again. Figs. 2b and 2c show the area stained by fluorescein. On the third day there was no staining, and the lesion had healed.

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REFERENCES

- Duke-Elder, Sir Stewart (1938). *Text-Book of Ophthalmology*, 2, 1713, London.
Fuchs, H. E. (1933). *Diseases of the Eye*, 10th Eng. ed., Philadelphia.
Haab, O. (1909). *Atlas of External Diseases of the Eye*, Philadelphia.
Würdemann, H. V. (1932). *Injuries of the Eyes*, 2nd ed., p. 11, St. Louis.

Reviews

FRACTURES

Pictorial Handbook of Fracture Treatment. By Edward L. Compere, M.D., F.A.C.S., and Sam W. Banks, M.D. (Pp. 351; illustrated. 27s.) Chicago: The Year Book Publishers; London: H. K. Lewis and Co. 1943.

Fractures. By Paul B. Magnuson, M.D., F.A.C.S. Fourth edition, revised. (Pp. 511; illustrated. 30s.) London: J. B. Lippincott Company. 1943.

It is noticeable that the large number of textbooks on fractures which have appeared within recent years coincides with improvement in the results of treatment which has come about following segregation under specially trained staffs. Not all fractures, however, can be dealt with in special units, and it is necessary for both general surgeons and practitioners to be familiar with the most effective methods of reduction, fixation, and after-treatment. The scope for textbooks of fracture treatment is therefore wider than ever. The *Pictorial Handbook of Fracture Treatment* needs no apology such as we find in the preface. It is an excellent little manual and the pictorial part is particularly good—e.g., Fig. 130, p. 265, illustrates the method of production as well as the stages of treatment of "bumper" fractures; while Fig. 151, p. 295, depicts the way in which Colles's fracture and fractures of the os calcis and lumbo-dorsal part of the spine are produced. Fig. 163, p. 313, claims to depict Böhler's method of reducing a flexion compression fracture in the dorsal spine, but the credit for this method of treatment should, we believe, be given to Watson-Jones of Liverpool, and it is not usually desirable to anaesthetize the patient. Fractures of the patella are well done—it is pleasing to notice that the author does not support a recent radical and quite unjustifiable tendency to excise the simple transverse variety. Fractures of the skull may be thought to be rather briefly dealt with, but these fractures usually constitute a minor part of head injuries calling for treatment, and the surgical treatment—as opposed to first-aid treatment—of skull fractures may reasonably be considered to be beyond the ambit of this book. The book can confidently be recommended as a modern and well-illustrated outline of fracture treatment.

Like most new and the recent editions of older textbooks of surgery which have appeared in the last few years the fourth and latest edition of Magnuson's *Fractures* shows the influence of the war, and efforts have been made by the author to render the book more useful to surgeons in the Services. It is not surprising, therefore, that the principal additions deal with transportation and the early treatment of compound fractures. Written clearly in rather dogmatic style and well illustrated by line drawings and x-ray photographs this textbook is a straightforward guide which should be particularly helpful to medical students, practitioners, young surgeons generally, and Service medical officers. The line drawings, of which there is an abundance, appealed to us especially, as they indicate very clearly the steps in treatment of particular fractures—e.g., the method of reducing supracondylar fracture of the humerus (Fig. 5, p. 101)—a series of drawings showing the manipulations necessary and the reason for them. We are glad to find that the term "Pott's fracture" is still used despite a recent tendency noticed in some quarters to discard it. We disagree with the statement (p. 429) that "every patient with a skull injury accompanied by coma should be kept flat in bed at all times for a minimum period of two weeks." Nursing these patients with the head raised lowers intracranial venous congestion and has proved more effective; but in general the sections on skull fractures and their complications and those on fractures of the spine are as well done as the remainder and bulk of the book. Of the recently published books on fractures—of which there has been almost a spate—this is certainly one of the best.

FOOD POISONING

Food Poisoning: Its Nature, History and Causation: Measures for its Prevention and Control. By Elliot B. Dewberry. Foreword by Gerald R. Leighton, M.D. In three parts; with appendices. (Pp. 186; illustrated. 15s.) London: Leonard Hill, Ltd. 1943.

Food poisoning is a complicated and extensive subject, but within 180 pages the author has covered its main features. The book is severely handicapped by being a compilation from other sources and not by an author who has himself investigated