that the mental condition was due to shock; and this view appears to have been correct. I saw him three months after he left the hospital, and he appeared then quite well.

THE MANUFACTURE OF ASEPTIC HOSPITAL FURNITURE.

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ALTHOUGH hospital furniture has been improved during the last twenty years, it is still far from perfect from an aseptic point of view. A considerable proportion of it has been made in Germany, and now that this source of supply

Fig. 1.—An operating-room table.

The angles A, A are all rounded and scalloped out. The socket carrying the castor is continuous with the table leg, so that no joint is visible, B. The rabbet holding the upper glass shelf C is scalloped out, though this is not seen in the photograph. The rounded and scalloped inside of the angles is seen at D.

is cut off, there is some difficulty in meeting the present increased demand.

At such a juncture I feel that it may be an advantage if I describe some of the articles which I have invented.

On examining some specimens of hospital furniture it will be seen that the manufacturers have left angles and depressions which act as receptacles for dirt and germs. It is difficult, and in some instances impossible, to clean them. I have endeavoured to guide some of the makers from their erroneous ways into the right direction. Hitherto my efforts have been without result; even when I have submitted models these have sometimes been incorrectly copied.

Fig. 2.—A ward wagon.

This is somewhat similar to the table, Fig. 1, but is of larger size and is provided with a metal rail, which has rounded angles at A, A. The feet are so constructed that they fit into the wagon, leaving a scooped-out edge, as shown in Fig. B.

Manufacturers appear to have adopted a stereotyped method of employing cornices, panels and ornamentation, and to be unable to avoid such adornment. Furthermore, they are not surgeons; they do not fully understand what we require, and they are consequently incapable of attending to the necessary details. It is equally true that surgeons are not furniture makers. If a perfect article is to be produced, combined effort is essential.

I have been fortunate in finding a local cabinet-maker able and willing to work with me and carry out my views. The drawings illustrate furniture he has recently con-

Fig. 3.—An instrument cabinet.

There is an entire absence of ornamentation. The angles are all rounded at A, A, A, and the same applies to all the inside angles. The bottom, C, is made to open flush, without any ledge to catch the dust and dirt, and the corners are all rounded as at D. The catch and striking plates are let in flush, and there is a spring stop in the striking plate to prevent a hole, which would contain dirt. The door is rounded at the corners to avoid angles, as at B, and it is bevelled down to the glass inside and outside. The edge is rounded, and fits into a scalloped rabbet. The glass shelves are supported by rounded metal plugs, which can easily be removed and inserted.

structed under my supervision. These show my methods of construction, which it is difficult to explain clearly in an article.

Briefly, my object is to avoid any depression or angle—to make the furniture in such a way that the most

Fig. 4.—An operating-table.

The angles A, A, A are all rounded and scalloped. Where the cross pieces join, B, B, B, it is also scalloped. There are wheels on the feet of the table at the head, so that it is easy to move it about if the foot end is raised. The rack allows the head to be raised or lowered.

perfunctory dusting cannot fail to clean every portion of it.

To attain this end it is necessary to apply the above principles to the parts hidden at the back and underneath, as well as to those which are in full view. So far as I can judge, it is possible to obtain perfection in this respect—that is, to construct a piece of furniture without any receptacle for dirt.

All this furniture is constructed of wood and is enamelled white.

Some surgeons maintain that all hospital furniture must be constructed of iron. I understand that the argument in favour of this is that iron is non-absorbent. Do the advocates of metal realize that it is covered with a coat of enamel, and that it consequently becomes a question of this material? The enamel burnt on to metal is, perhaps, harder than the enamel on wood, but it possesses the great disadvantage of chipping. These chipped places provide spaces which form as commodious dwelling-places for germs as the caves in the rocks did for our ancestors. I have never seen a piece of enamelled metal furniture which has not chipped in a few weeks, and most of it is bespeckled before a year has passed. Enamel on wooden furniture never chips. There may be some separation of joints or a crack in the wood, but these can easily be filled with hard stopping. The furniture can be rubbed down and re-enamelled at intervals, after which treatment it comes out like new.

Wooden furniture is far lighter for moving about; it is strong enough for its purpose, and the cost is less than half that of the metal. I prefer wood. Those who retain an affection for metal could, no doubt, obtain furniture made after my designs.

The cabinet-maker who has assisted me is unable to manufacture any large quantity. Messrs. Salt, of Birmingham, assure me that they are in a position to do so.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

IONIZATION OF ADHESIONS AFTER WOUNDS.

DR. GIUSEPPI, in his interesting note in the *BRITISH MEDICAL JOURNAL* for October 16th, mentions the inconvenience and disability caused by the adhesion of scars to muscles and tendons. In such cases he would find that Leduc's method of ionization with chlorine ions gives good results, and obviates the necessity for operative treatment. In the case of stiff joints due to adhesions this method also answers well, and, I think, should always be given a fair trial before such a drastic proceeding as forcibly breaking down the adhesions is resorted to. If, as so often happens, there is a more or less constant aching pain in the wounded limb, ionization with a 1 per cent. or 2 per cent. solution of sodium salicylate is very effectual in relieving this symptom. After three or four applications the pain disappears and the patient is able to sleep better, and the adhesions can then be dealt with by ionization with sodium chloride solution. Should a bullet or any pieces of shell be left in the wound I think ionization is not desirable, as in one of my cases much pain and irritation was caused in the neighbourhood of a piece of shell embedded in the arm by an interrupted galvanic current with which I was treating some paralysed muscles. The sinusoidal current has no such disastrous effect.

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MAY RATHBONE.

REDUCTION BY MANIPULATION OF OLD-STANDING BILATERAL DISLOCATION OF JAW.

THOMSON AND MILES state that dislocation of the jaw of over three months' standing is rarely reducible by manipulation, but that it has been accomplished as long as ten months after the accident.

A. M. was sent to the Livingstonia Mission Hospital, Bandawe, by a Government medical officer, on January 23rd. He was found to be suffering from bilateral dislocation of the jaw, and stated that it had occurred the previous October in the course of conversation. The patient was thin, owing to inability to take food properly, and he had suffered from a large ulcer over the left anterior pillar of the fauces due to the pressure of the condyle, but this had healed. Native medicine had been applied externally without effect.

It was found that the condyles had slipped up beyond the zygomatic processes on both sides, and were lying in the temporal fossae; there they were firmly fixed, little movement being possible.

On January 25th and 27th unsuccessful attempts were made to reduce by manipulation, both with fingers in the mouth and with corks between the teeth, the most vigorous traction only resulting in slight loosening of the adhesions. Preparations were accordingly made for the open method, but when the patient was under chloroform a third attempt to reduce without cutting was made, and succeeded by the following manoeuvre: Instead of trying to reduce both condyles simultaneously, the right condyle was used as a fulcrum to lever the left condyle out of the temporal fossa; the patient lying on his back, traction was made by the fingers of the right hand on the left lower molars, while both thumbs pressed on the chin, and the jaw being thus grasped between both hands the left condyle was levered downwards around the right condyle as fulcrum in the temporal fossa, and so delivered below the left malar arch. The right condyle was then easily delivered from the right malar arch, and the dislocation reduced.

The condyles, however, did not slip into the glenoid cavities, as these were filled up with organized extravasation, and the process of grinding them into place was not thoroughly enough done, as the patient on recovering from the anaesthetic redislocated his jaw in spite of a tight bandage. A few days later chloroform was administered for a fourth time, the dislocation was easily reduced by the method above described, the condyles were ground thoroughly home, and a tight bandage applied. This time the result was permanent, as the patient went home quite pleased after a day or too, and has since been seen at his village.

1. In the only two skulls to which I have access the space between the condyles is wider than that between the malar arches, so it is obvious that the condyles could only slip up one at a time, and must also be reduced one at a time.

2. By reducing one side at a time much greater leverage can be obtained; the whole length of the jaw acts as lever instead of half. The physics of this might be difficult to demonstrate because of the shape of the bone, but in practice there is no doubt of the fact.

Nyasaland.

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Reports of Societies.

DISCUSSION ON GUNSHOT WOUNDS OF PERIPHERAL NERVES.

At a meeting of the Medical Society of London on October 25th, the President, Dr. W. PASTEUR, being in the chair, Dr. WILFRED HARRIS in opening, from the medical aspect, a discussion on gunshot wounds of the peripheral nerves, considered the subject under two main headings—the one, diagnosis and accurate localization; the other, the degree and kind of injury, its prognosis, and the decision as to whether operation were advisable. Hysterical phenomena of anaesthesia and motor paralysis were common complications of nerve injuries, and the true symptoms must be carefully sifted from the false. Again, multiple nerve injuries might occur, and the resulting paralysis must be correctly apportioned. Careful charts of the sensory loss were usually a better guide to an estimation of the severity of a nerve lesion than the degree of muscular paralysis, even with reaction of degeneration. Charts were shown illustrating commencing recovery of sensation in sutured nerves as early as seven and thirteen days after operation. Recovery in nerves compressed by scar tissue was even more rapid after successful operation. He illustrated by means of the epidiascope the defects in sensation which he had met with in various gunshot injuries of nerves, and the improvement which followed operative procedure.

Mr. WILFRED TROTTER (temporary Captain R.A.M.C.) opened the discussion from the surgical aspect. He said that the problem of the restoration to the normal of an injured nerve presented certain peculiarities which distinguished it from all other similar tasks of plastic surgery. for (1) the interruption of a nerve left a permanent defect in the physiological equipment of the body, which could not be overcome or compensated for by any other mechanism; (2) the restoration of a nerve to its normal anatomical continuity, although an essential preliminary