forthwith at the time the treatment was commenced. Since then the patient had been on the strictest oral antisepsis. For years the mouth and tongue had been swabbed out twice a day with carbolic lotion. When a tooth became bad it was removed, and no risks were run in that respect. Oral sepsis was the cause of a non-haemolytic anaemia, which he called "Septic Anaemia," and that anaemia was frequently present, sometimes in an intense degree as a severe complication of Addisonian Infective Anaemia. He made it the first object of treatment to remove this septic anaemia. He did not allow any sepsis to come into contact with the glossitic or gastric lesions which were likely to recur. The word "pernicious" anaemia did not sufficiently connote Addison's "idiopathic" anaemia; he had therefore abandoned it and given the disease the title of "Addisonian Anaemia." The present case was the most favourable which he had had for fifteen years.

Stokes-Adams Symptoms in a Lad aged 18.

By James Galloway, M.D., and W. J. Fenton, M.D.

The patient is a fairly well developed lad, aged 18; there is no history of any serious illness till the month of May, 1910. He was then employed in an office in the City, and had passed through a hard winter's work. During the month of May he commenced to suffer from repeated partial fainting attacks, and for this reason medical advice was sought. When he came under observation the pulse frequency at the wrist varied from 32 to 40 per minute. Occasionally marked irregularity occurred, but the irregularity appeared to be always of the same type—two or three beats with long intervals, followed by a succession of beats with short intervals. The fainting attacks occurred with no warning—a slight exertion was often sufficient to bring them on. Occasionally he has lost consciousness for a very short time in these attacks, but usually they are transient and consciousness is not completely lost. On several occasions climbing to the top of an omnibus made him inclined to be faint. Rarely several fainting attacks have occurred in rapid succession.

There is no evidence of valvular lesion nor of cardiac enlargement or hypertrophy. No other visceral disease is present. Since the commencement of his attack the patient has rested, but the conditions described persist. Fainting attacks are less numerous. The sphygmographic and string galvanometer tracings¹ of the heart's action are shown, and give evidence of very distinct "heart-block."

¹ These observations have been kindly made by Dr. Thomas Lewis.
**Note by Dr. Thomas Lewis.**—The case is one of partial heart-block. The ratio of the auricular and ventricular rhythm is, as a rule, as $2:1$; occasionally as $1:1$. Some abortive ventricular contractions, the nature of which is not clear, are also present at times (fig. 1). During

![Fig. 1.](image1)

**Fig. 1.**

Apex and radial curves, showing that no beats are dropped in transmission from heart to pulse.

![Fig. 2.](image2)

**Fig. 2.**

Venous and radial curves. Over the early period of the curve each ventricular contraction, $c$, is preceded by an auricular systole, $a$. At the end of the curve every second auricular impulse fails to reach the ventricle; $a$ waves are twice as frequent as $c$ waves. $2:1$ heart-block is present.

![Fig. 3.](image3)

**Fig. 3.**

Electrocardiogram (from right arm and left leg). During a $2:1$ heart-block phase. $P$, auricle; $R$, $S$, $T$, ventricle.

the $2:1$ heart-block stage the auricular contraction following each ventricular beat is premature; this is a phenomenon not uncommonly encountered, but the meaning of it is as yet not fully understood. It will be observed that the early auricular variation (fig. 3) is of the same
form as that which succeeds it. They both arise in the same place—viz., the normal pace-maker of the heart.

Dr. Galloway added that when he saw the case with Dr. Barington Baker, the difficulty in diagnosis was in determining that the case was not one of epilepsy (petit mal). The attacks of swooning and the short periods of semi-consciousness resembled in many respects what might be expected in a case of petit mal, and it was only after careful consideration of the circumstances that epilepsy was excluded during the earlier clinical investigation of the case. The heart-block was not perfect under all circumstances, and occasionally the pulse-rate, instead of the regular thirty to forty beats per minute, could be counted at the wrist up to sixty or seventy. It was evidently of the utmost importance to make as definite a diagnosis as possible, and the case was investigated further. With the assistance of Dr. Fenton and of Dr. Thomas Lewis, the case was studied by means of cardiographic tracings and by the use of the string-galvanometer. A study of these tracings very definitely confirmed the diagnosis—namely, that the case was not one of minor epilepsy, but the unusual occurrence of "heart block" in a young man, suggesting a definite injury of the heart affecting the sino-ventricular band. There is complete absence of the history of any disease likely to cause injury of the heart. There were no previous illnesses of serious character, and no history of rheumatic fever. The result of the investigation had been that the patient was carefully treated by means of iodide of potassium, and it was an interesting commentary on the effects of this treatment that now the patient's heart was beating more regularly; the fainting attacks were less numerous and his condition was distinctly improved. It is to be noted, in addition, that about a fortnight ago, while under treatment by means of iodide of potassium, the lad had an attack of what appeared to be influenza. It was known that syphilis, in addition to the production of the more ordinary gummatous lesions, might bring about an endocardial syphilide, destroying the surface of the musculature rather than the actual thickness of the muscle substance. From the evidence obtainable no more than a suggestion could be made that the lesion producing the heart block in this patient's case was due to congenital syphilis, but the possibility of this cause had to be borne in mind in treating any such case.
DISCUSSION.

Dr. F. J. POYNTON said he hoped members would have an opportunity of seeing the case again later. He asked whether Dr. Galloway thought the patient would get well, or whether he would remain more or less an invalid. He supposed that a congenital syphilitic affection of the auriculo-ventricular bundle of His at the age of 18 would probably mean a more or less permanent lesion. One could hardly imagine that treatment would completely clear this up, so that from this point of view the prognosis would not be good. On the other hand, it was stated that the patient went through an attack of influenza, and that his heart beat was quicker after that than before—in fact, there had been some improvement. This improvement, in spite of influenza, fostered the hope that the prognosis might be more favourable than that on the hypothesis of congenital syphilis. He was led to hope this latter view might be the correct one, because there were undoubted cases of heart-block without demonstrable lesion of His's bundle. Our knowledge of the behaviour of His's bundle was as yet only elementary. He suggested that if His's bundle were implicated, it was a functional loss of conductivity.

Dr. GALLOWAY, in reply, said he would endeavour to bring the patient again on a future occasion. It was admittedly unusual to find so clear a case of this cardiac affection in so young a patient. The symptoms of heart-block occurred usually in elderly persons in whom distinct evidence of other cardio-vascular degeneration could be obtained. This patient's blood had not yet been examined to ascertain if the Wassermann reaction was present. He hoped, however, to be able to carry out this test. If the result were positive it would afford very considerable reason for carrying out an efficient course of mercurial treatment. On the whole, regarding the improvement in the symptoms and the condition of the patient, he felt inclined to regard the prognosis as a favourable one.

Multiple Cutaneous Telangiectases of Recent Origin.

By James Galloway, M.D.

The patient, a man aged 35, has been in the Army, and has served on the West Coast of Africa, in India, and in Burmah. In 1895 he had gonorrhoea, and no doubt syphilis, but received no regular treatment. The Wassermann reaction in his case is positive. He had repeated attacks of malaria in 1906 while in India, and suffered from enlarged liver and fistula in ano. In 1910 he was invalided out of the service on account of lung disease. There is now extensive consolidation of the right lung with evidences of a cavity at the apex. The temperature