during the third week of treatment with 1,500 mg. daily, the peripheral blood and bone-marrow being otherwise normal, with a rapid recovery on suspending the drug. Southwell and Randall (1960) recorded the development of agranulocytosis and thrombocytopenia on the twelfth day of treatment with 1,000 mg. of potassium perchlorate daily, unaccompanied by red-cell changes, with recovery within two weeks of suspending treatment. Each of these patients showed concurrent fever and general toxic symptoms. Murray (1959) has described a third case with similar varied toxic reactions, the dose given being 1,200 mg. a day over a period of three weeks, a neutropenia of 800/c.mm. being observed. A further (unpublished) case under the care of Dr. Harold Lambert has been noted by Morgans and Trotter (1960), in which a severe leucopenia developed within two weeks of beginning potassium perchlorate in a dosage of 1,600 mg. daily.

The case here recorded presented with a previously unsuspected severe anaemia and moderate neutropenia after a period of treatment of just over three months. The anaemia rapidly progressed to a red-cell aplasia with thrombocytopenia, and the neutropenia to an agranulocytosis, giving the full picture of aplastic anaemia about one week after admission, though probably between two and four weeks after the onset of the anaemia. The haemorrhagic complications began to appear about two weeks after admission, and were followed by a thrombocytopenia, increasing in severity prior to the terminal infection.

Aplastic anaemia occurs either as a primary or idiopathic disease, or secondarily to exposure to a substance toxic to bone-marrow. In the idiopathic form the aplasia is rarely a total one, some degree of cellularity of the bone-marrow usually remaining, in contrast to the nearly complete absence commonly found in the secondary types and in the case under consideration. Reviewing the possibility in this patient of secondary causative factors of aplastic anaemia other than potassium perchlorate, thyrotoxicosis itself is not so recognized, and we feel that any aetiological relationship to the giving of 25 μ c. of radioactive iodine for diagnosis is too remote for serious consideration, while there was no known history of recent exposure to any other drugs accepted as toxic to the bone-marrow. In this fatal case, therefore, we feel from the evidence presented that the sudden onset of aplastic anaemia during treatment with potassium perchlorate cannot be ignored as having a probable direct causal relationship.

Whether in this patient a fatal issue was inevitable after the full development of marrow aplasia is conjectural; but it is felt that the risks of terminal infection might have been reduced by strict isolation and barrier nursing against outside pathogenic organisms.

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Acute Dilatation of Stomach as a Complication of Muscular Dystrophy

Acute dilatation of the stomach is a rare complication in muscle dystrophy. Bevans (1945) reported the cases of four patients with progressive muscular dystrophy who came to necropsy, and in two of them there was marked dilatation of the stomach, with perforation in one. Sections of the stomach in one of her cases showed the changes in the muscle layer which have been described in progressive muscular dystrophy—namely, great variation in the size and shape of the fibres, vacuolation, and clumping of the sarcoplasm, with proliferation of the nuclei of the sarcolemma. These were not considered specific, although it is suggested that they are comparable in many ways to those seen in the skeletal muscles. It would appear from her post-mortem findings that the changes which occur in the skeletal muscle in progressive muscular dystrophy may also occur in the myocardium, the striated muscle of the tongue, oesophagus, and the gastro-intestinal tract.

The following case is regarded as of sufficient rarity to be placed on record.

CASE REPORT

A boy aged 9, a known case of muscular dystrophy of the Leyden-Moebius type, was being treated at home by mucopolysaccharides. He was admitted to the paediatric ward of the City General Hospital, Stoke-on-Trent, on January 3, 1960, complaining that two days previously he had developed a sore throat, followed by generalized abdominal pain and vomiting. He had had no food, and his bowels had not been opened for the three days prior to admission.

On admission he was dehydrated, his eyes were sunken, and his tongue was coated. His urine contained albumin. He was given an enema with a poor result. At 5 p.m. the same day he began to vomit profusely, and the vomit was coffee-ground in nature. His general condition became worse; he complained of a colicky pain and his pulse increased to 148. His temperature was 99.2° F. (37.3° C.). At 6 p.m. he was started on an intravenous drip of N/5 saline, and gastric suction was instituted. He was thought to have intestinal obstruction, and I was asked to see him at 6.30 p.m.

On examination his abdomen was not distended. There was no increase in peristalsis on auscultation of his abdomen, but large quantities of fluid, which were of the classical "peat-laden stream" appearance, were being aspirated in his gastric suction. A straight x-ray film of his abdomen showed no fluid levels or evidence of obstruction. In view of this the diagnosis of acute dilatation of the stomach was made. He was given a transfusion of 2 pints (1,140 ml.) of blood, and an intravenous saline drip after this. His condition now gradually improved, and within 24 hours the suction and the intravenous therapy could be discontinued.

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The Health Committee of London County Council has approved plans for the council's first hostel for the mentally ill to be built specially for that purpose. It will be at Brockley Rise, Lewisham. The three-story building will house 62 patients and will have two single-story wings enclosing a paved and planted court. The estimated cost of the building and of equipment is £93,305.