On the morning of November 21 he was unconscious, but not very deeply, since pharyngeal reflexes were still present.

Blood values on November 21 were: Hb, 77%; R.B.C. 4,000,000; W.B.C., 6,900; residual nitrogen, 39 mg. per 100 ml. Unconsciousness continued throughout the day. As the patient soon became more deeply unconscious bemegride and amiphenazole were given in the evening on the same principle as for barbiturate poisoning. Isotonic glucose was given by intravenous drip. At 19.53 hours 50 mg. of bemegride and 15 mg. of amiphenazole were introduced into the intravenous drip. This was repeated at 19.56, 19.59, 20.04, and 20.09 hours. Altogether, therefore, 250 mg. of bemegride and 75 mg. of amiphenazole were given. After the second injection the patient made swallowing movements and sighed deeply. After the third injection he became more alert and turned his head. After the fourth injection his eyelids began to twitch. After the fifth injection, at 20.09 hours, he awoke and could talk a little, but his speech was slurred. Recovery progressed, and at 20.30 hours he was fully awake and aware of having been poisoned by tablets. In the night preceding November 22 he showed motor agitation, sprang out of bed, and had pronounced visual hallucinations. He calmed down after an injection of 50 mg. of chlorpromazine.

In the morning of November 22 he was drowsy, but answered adequately when spoken to. He was, however, a good deal more drowsy than after the bemegride and amiphenazole injections on the previous evening. He required no more stimulants but brightened up later. During the further course pleuropneumonia supervened, which was treated with antibiotics; there were no other complications. The patient was transferred to a mental hospital after staying in this hospital for ten days.

Examination on November 28 showed: W.B.C., 5,600 (polymorphonuclear 54%, "stab" cells 2%, eosinophils 1%, basophils 0%, lymphocytes 37%, monocytes 6%); thrombocytes, 173,000 per c.mm.; prothrombin according to Quick-Lehmann, 96; residual nitrogen, 30 mg. per 100 ml.; Meulengracht, 1:3; Takata-Ara, negative.

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Acute Epidemic Myalgia of the Hip

During the five months August to December, 1955, a series of cases were seen in the neighbourhood of Heatherwood Orthopaedic Hospital all showing a similar clinical picture—that is, severe pain in the hip, with limitation of movement. Most of the cases were pyrexial. Children and adolescents were mainly involved. A characteristic of the illness was early recovery following rest, and it left no after-effects. Eight of the cases were seen by me personally, and the histories and follow-up of six other cases were kindly supplied by Dr. E. V. Lambert.

All these cases were seen during the poliomyelitis epidemic of 1955 (see Chart), and in seven cases poliomyelitis was first diagnosed. Other diagnoses made initially were osteomyelitis in two cases, suppurative arthritis in one case, and some form of trauma in four cases.

The age range of the patients was $3\frac{1}{2}$ to 35 years (average 12.8 years), only one being over 20. The sex distribution was eight males and six females. The right hip was affected in eleven cases and the left in three.

The commonest initial diagnosis was poliomyelitis, and this was suggested by the history of being off-colour for one to seven days, pain in the leg, and in the majority of cases a temperature up to 105° F. (40.6° C.), in some of them associated with coma, vomiting, and frontal headaches. The diagnosis of an infective lesion made in three cases was suggested by a raised sedimentation rate, a raised white-

cell count in two, and severe pain. Those cases thought to be due to injury had given some history of injury prior to admission which it was thought might have accounted for the symptoms. In all cases where x-ray pictures were taken, these were normal. In all cases except

Seasonal occurrence of poliomyelitis and acute myalgia in 1955.

one the symptoms were severe enough to justify admission to hospital. One patient was seen at home, and the symptoms were settling with rest in bed. The average stay in hospital of the other cases was just under 14 days. All patients had made a full recovery in a month, and a follow-up at nine months showed no recurrence of any symptoms.

The outstanding symptoms in these cases were: pain in 14 cases, spasm in 14, pyrexia in 10, and raised E.S.R. in 5. In the majority there was marked spasm in the hip when it was moved. In all cases a few degrees of passive movement could be obtained which was painless.

COMMENT

The clinical picture in these cases suggests that some infection was occurring during the months of August to December, 1955, causing an acute myalgia which seemed to single out the muscles in the region of the hip-joint and mainly affected children and adolescents. It ran a course lasting about two weeks and then subsided completely. In the majority of cases a raised temperature and other general reactions were noted.

From this description one would have to consider a virus infection as being the cause, and the fact that it coincided with a fairly severe epidemic of poliomyelitis during the same season of the year suggests that the virus may have been related—such as a Coxsackie infection (see Chart).

Coxsackie infection was first described by Daldorf and Sickles in 1948. Since then further work has shown that it is the cause of Bornholm disease (epidemic pleurodynia, epidemic myalgia), and herpangina.

It is an acute febrile, self-limiting, infectious disease affecting children and young adults, and in the above conditions the virus has been isolated from the stools or throat.

No specific treatment is available. The disease appears to be widespread and has been reported from most of the countries of the world. It occurs most frequently during the poliomyelitis season and is sometimes found coincidentally in patients suffering from poliomyelitis. It has been shown to be spread by sewage and flies, and is highly infectious—often involving several members of one family. Many may carry the virus without showing any clinical signs of the disease.

I have been unable to find any description in the literature of acute myalgia affecting the hip region, but the present cases were all similar in that they occurred during the poliomyelitis season; the main feature was acute pain; while the condition cleared up completely, leaving no after-effects.

I am grateful to Dr. E. V. Lambert for providing clinical notes of his cases. From the six cases that he had seen he had independently come to the conclusion that these cases were probably due to a Coxsackie-like virus infection.

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