about 12 months, never being longer than three to four weeks without pain. This was often felt in the right hypochondrium, and radiated at times through to the back, but not to the shoulders and was not related to meals. He had no history of jaundice, rigors, or pyrexia associated with the pain. He had not vomited, but the pain nauseated him. He suffered considerably from flatulence, and for the previous 12 months he had tended to suffer from frequent bowel actions with loose stools. There had been no blood or mucus in the stools and there was no history of haemat-

Intravenous cholangiogram 80 minutes after injection showing the biliary passages and no gall-bladder.

emesis or melaena. There were no symptoms of urinary disease. His appetite was poor and he had lost weight recently.

On examination his general condition was good. No abnormal physical signs were found except for some tenderness over the gall-bladder region and over McBurney's point, not nearly so marked as when he was first seen. Cholecystitis with possible subacute appendicitis was provisionally diagnosed.

Operation.—On January 17, 1957, the abdomen was explored through a right subcostal incision, and the gall-bladder was found to be completely absent. There was a narrow, shallow groove on the liver in the position of the gall-bladder fossa. The common bile duct was dissected out and found to be of normal size and not dilated. There was no evidence of a rudimentary cystic duct. A small triangular pad of fat which usually fills the space between the cystic duct and the hilum of the liver contained a small artery which presumably would have been the cystic artery. The caecum was very high in position, lying just beneath the liver and constituting part of the hepatic flexure, so that in fact there was really no ascending colon. The appendix was retrocaecal, pointing upwards and backwards so that its tip was in contact with the liver. It contained a faecalith and was much thickened. The appendix was removed and the abdomen closed.

The histological report stated: "The appendix shows marked fatty infiltration in the submucosa, which is a rather unusual finding. It contains a large faecalith."

On June 24 an intravenous cholangiogram (see Fig.) was carried out and the report stated: "The biliary passages are well visualized in the films taken at 40, 60, and 80 minutes after injection. The right and left hepatic ducts are shown

but no evidence of a cystic duct or gall-bladder. No dilatation of the duct is shown and no calculi are demonstrated."

He had been seen several times as an out-patient: his symptoms had completely disappeared, and there had been no recurrence for over six months.

COMMENT

Gross (1936) reported 38 cases of absence of the gall-bladder with hepatic and common bile ducts normally present and functioning, also 35 other cases of abnormalities of the biliary ducts suggesting atresia, etc. Perusal of the reported cases would suggest that when the gall-bladder is absent the gall-bladder fossa is commonly absent too, but the shallow dimple made by the presence of a rudimentary cystic duct appears to be present in rather less than half the reported cases. The literature suggests that the condition of absent gall-bladder is two or three times as common in the female as in the male.

Smyth (1949) stated that most of the reported cases presented with stones in the common bile duct associated with biliary colic and jaundice. In a number of cases in which stones were not present in the common bile duct the biliary ducts were found not to be dilated as in the present case.

I cannot find any reference in the literature to the carrying out of an intravenous cholangiogram on these patients. It is interesting in that the cholangiogram in the present case showed normal passage of the dye through the bile ducts. I can find only one reference to associated congenital abnormalities in the abdomen with this condition: Rains (1951) described an abnormality of the lesser omentum associated with absence of the gall-bladder.

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D. A. REID, M.B., Ch.B., F.R.C.S.Ed.,
Casualty Surgeon.

St. Margaret's Hospital, Epping.

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Primary Varicella Pneumonia

Primary varicella pneumonia was first described by Waring *et al.* (1942); since then about 60 cases have been reported in the United States of America (Hampton, 1955; Kriss, 1956; Endress and Schnell, 1956; Weinstein and Meade, 1956; Fitz and Meiklejohn, 1956; Southard, 1956; Tan *et al.*, 1956; Moore, 1957; Krugman *et al.*, 1957), and one of a Hawaiian serving in the American Forces in Germany (Cowley *et al.*, 1956).

No report of the condition occurring in this country has been found in the literature, and it is thought that the following case, which presents similar features, would be of interest.

CASE REPORT

A 26-year-old naval rating became ill with malaise and fever. Twenty-four hours later he developed a typical

chicken-pox eruption. His 10-months-old daughter had had chicken-pox three weeks previously. Three days later, while in bed at home, he suddenly became dyspnoeic in the evening and developed a cough with blood-stained sputum. Early next morning he was seen by his doctor, who gave him intramuscular penicillin (1 million units) at once, with oral penicillin V (500 mg.) in the afternoon.

He was admitted to the Royal Naval Hospital, Chatham, the same evening (August 25, 1958). He was moderately ill, with a temperature of 100° F. (37.8° C.), pulse 84, and respirations 24. The rash was severe, almost confluent on the head and trunk, and present also on the buccal mucous membrane. Rales and rhonchi could be heard over both lungs.

Sputum taken next morning was gelatinous and blood-streaked, and grew only normal flora on culture. A portable chest x-ray film (he was not well enough to go to the x-ray department) showed a diffuse nodular shadowing throughout both lung fields (see Fig.). Intramuscular

X-ray film showing diffuse nodular shadowing throughout both lungs.

penicillin (1 million units b.d.) was continued. The following day the W.B.C. was 11,400 (polymorphs 46%, lymphocytes 45%, monocytes 7%, eosinophils 2%). Chlorotetracycline, 1 g. daily, was given in addition.

His temperature settled within 36 hours of admission, and he continued to improve. An x-ray film taken on the third day showed the nodular pattern to be still present. Five days after admission there were no abnormal physical signs in the chest, and 10 days later the scabs had cleared completely and the x-ray picture of his chest was normal. The results of virus serology are shown in the Table.

Results of Virus Serology

	Influenza			A.P.C. Group	Q Fever	Psitta- cosis L.G.V.	Agg. Strep. M.G.	Sendai
	A	B	C					
1st specimen, taken 29.8.58	N.T.	N.T.	1/8	1/16	N.T.	1/16	N.T.	N.T.
2nd specimen, taken 8.9.58	1/8	<1/8	<1/8	1/32	<1/8	1/16	<1/16	<1/8

COMMENT

Krugman *et al.* (1957) reported cases of their own and reviewed the literature. They had found the condition in 10 out of 30 adults admitted with chicken-pox over a period of six months.

They describe the disease, which is occasionally fatal, as occurring in adults, with the onset of moderate to severe respiratory distress, two to five days after the skin eruption of chicken-pox. There may be cough, chest pain, dyspnoea, tachypnoea, and frequently cyanosis and haemoptysis. Physical examination reveals signs suggestive of patchy consolidation in both lungs. Chest x-ray films reveal a bilateral diffuse nodular infiltration which clears in one to six weeks. There is a normal or slightly raised white-cell count, and no pathogens are found in the nasopharyngeal secretions or sputum. One of their cases came to necropsy, and showed "an extensive haemorrhagic predominantly mononuclear cell pneumonitis, with histological evidence of type A intranuclear inclusion bodies in the pulmonary exudate."

On admission it was thought that our patient was suffering from chicken-pox, complicated by a bacterial bronchopneumonia, but the chest x-ray film, sputum, and white-cell count did not suggest this.

The nodular pattern on x-ray examination may be found in a large variety of conditions, but had it been a bacterial infection some supporting evidence might have been found in the sputum which contained no pathogens.

The rapid clearing of the radiological abnormality seems to exclude the possibility of this being an incidental finding, and there was no evidence or history of tuberculosis, reticulosis, or cardiovascular disease.

The virus serology showed evidence of a possible recent or past infection with adenovirus. There was a history of an infection of the upper respiratory tract four months previously.

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O. MCCARTHY, M.B., B.Ch.,
Surgeon Lieutenant, R.N.,
Royal Naval Hospital, Chatham.

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Arrangements to co-ordinate tape-recording services for the sick and the blind are now being made at the offices of the British Recording Club, 145, Fleet Street, London, E.C.4. The organizations, which will now work in co-ordination with the British Recording Club, whose journal, the *Amateur Tape Recording Magazine*, now has a circulation of over 50,000 copies, are the Hospital Broadcasting Services, the Tape Reading Circle for the Blind, and the British Recording Club Braille Services.