the stimulus of sodium amytal. In the present survey it seems that a similar state of affairs may exist in so far as heavy drinking for a limited period damages or interferes with the nystagmoid reaction to alcohol, while long-standing alcoholism leads to non-dilatation of the pupil in addition to the absence of the nystagmoid movements. It is of interest to note at this stage that Rombergism and failure to perform the finger-to-nose test was, with the exception of Case 31, always associated with nystagmoid movement. That exception was the young alcoholic mentioned above.

Conclusion

The taking of alcohol commonly produces a lateral nystagmus or nystagmoid jerks. This phenomenon is associated with dilatation of the pupils and in most instances with their absent or sluggish reaction to light, but bears no relation to tachycardia, to depression of the temperature, or to the loss of tendon reflexes.

Further, the taking of alcohol in large quantities over a period of years seems to suppress the production of this nystagmus and, if continued long enough, interferes with the dilatation of the pupil and its defective reaction to light. Finally, Rombergism and errors of projection do not occur independently of nystagmoid movement unless there is reason to suspect that the latter is inhibited by alcoholism.

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TERRAMYCIN IN THE TREATMENT OF PNEUMONIA IN CHILDREN

BY

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Since the isolation of terramycin from *Streptomyces rimosus* in 1950, it has been prepared in a pure crystalline form which when administered orally is of low toxicity and has a wide range of antibacterial activity.

The effectiveness of terramycin in the treatment of bacterial pneumonia in children has already been reported by King *et al.* (1950), Potterfield and Starkweather (1951), and others in the United States, and by Wolman and Holzel (1952) in England. There is, however, little evidence that this drug is any more effective than or preferable to penicillin and/or sulphonamide therapy, which was recommended for the treatment of pneumonia in preference to chloramphenicol and aureomycin (Medical Research Council, 1951). Eadie *et al.* (1951) also confirmed that penicillin in the treatment of pneumonia was as effective as aureomycin. Therefore a clinical trial of terramycin and a "standard treatment" of penicillin and sulphonamide was carried out from February to April, 1952, at the Royal Belfast Hospital for Sick Children.

Method

A consecutive series of 63 children admitted with a diagnosis of pneumonia was divided alternately into two groups, one for treatment with terramycin and the other for the "standard treatment." Subsequently five children who developed pertussis and three found to have a primary tuberculous infection were rejected: in three others the

diagnosis was considered to be bronchitis, and these were excluded from the series, as were two infants so severely ill that the trial was discontinued in favour of additional antibiotics.

In the remaining 50 the diagnosis of pneumonia was a clinical one, using the generally accepted criteria confirmed soon after admission by radiograph in all cases except three in which there was only radiological evidence of bronchitis, but which were included on the definite clinical evidence of changes in medium and smaller bronchioles. A pharyngeal swab was taken on admission and cultured. A total and differential white blood cell count was made as soon as possible. A Mantoux reaction either of strength 1/1,000 or 1/100 solution of old tuberculin was completed, being negative in all except two who had received previous B.C.G. vaccination.

Treatment.—The group treated with terramycin received orally 20 mg. per lb. (44 mg. per kg.) body weight per day in four divided doses. The "standard treatment" group was given 0.5 g. of sulphadimidine orally at four-hourly intervals, and 300,000 units of procaine penicillin G ("distaquaine G") intramuscularly at 12-hourly intervals if over the age of 3 years. If less than 3 years 0.5 g. of sulphadimidine was given immediately and 0.25 g. four-hourly with 150,000 units of procaine penicillin G at 12-hourly intervals. Treatment was continued until the clinical condition was satisfactory and the temperature had been normal for 48 hours.

Comparability.—The various factors of importance which influence the course of pneumonia are compared for the two treatment groups in Table I. The severity of the

TABLE I.—Comparability of Treatment Groups

	Terramycin Group	"Standard Treatment" Group
No. of Cases	25	25
Male	16	17
Female	9	8
Average age in years	3.2	2.1
Type of pneumonia:		
Lobar	12	13
Broncho	13	12
No. of severe cases	6	6
Average duration of illness before admission:		
< 72 hours	8	13
> 72 hours	17	12
History of previous chest infection	13	11
Average temperature on admission (° F.)	101.3	102.7

pneumonia was assessed clinically; a severe case was one in which the patient was thought likely to die within 36 hours and required oxygen therapy. The differentiation of bronchopneumonia and lobar pneumonia in children is a difficult one to make. In this series lobar (or segmental) pneumonia was diagnosed when there was clinical and radiological evidence of a localized area of consolidation. Bronchopneumonia was believed to be present when there were generalized signs in medium and finer bronchi and bronchioles, with patchy consolidation clinically and radiologically. Unless such evidence was present the diagnosis was thought to be bronchitis and the case rejected from the series (except for the three instances mentioned above), although it was appreciated that there is little division between a severe bronchitis, bronchiolitis, or an early bronchopneumonia.

Results of Treatment

The effectiveness of treatment was assessed on the duration of fever, the average stay in hospital, the development of complications, and the mortality (Tables II and III). From these results it can be seen that there is no significant difference in the duration of pyrexia or length of stay in hospital for the whole group or for the severely ill cases.

There was one death in the series which occurred in a mongol of 8 months of age who succumbed within three hours of admission.

TABLE II.—Results of Treatment in the Two Groups

	Terramycin Group	"Standard Treatment" Group
Average duration of pyrexia for all cases	3.1 days	3.0 days
Average period in hospital:		
All cases	10	9.9
Severely ill cases	12.2	11.6
Mortality	0	1

TABLE III.—Complications of the Two Treatment Groups

	Terramycin Group	"Standard Treatment" Group
Thrush infection	4	0
No of cases staying in hospital longer than 10 days	9	7
Due to delayed pulmonary resolution	8	2
" gastro-enteritis	1	2
" social reasons	0	2
" subsequent plastic operation	0	1

Complications.—The complications occurring, and an analysis of the causes for children staying in hospital longer than the average period of 10 days, are shown in Table III. It is probably significant that there were eight instances in the terramycin group of delayed pulmonary resolution compared with two in the standard treatment group. A thrush infection of the mouth developed in four of the terramycin group, which emphasizes the risk of this infection during antibiotic therapy, especially with chloramphenicol, aureomycin, and terramycin. It is suggested that when these drugs are given to infants and small children the mouth should be painted with 1% aqueous gentian violet solution daily and the vitamin-B complex added to the diet. There were no other complications during treatment. Terramycin was in fact well tolerated by all patients and did not give rise to anorexia, diarrhoea, or vomiting *per se*.

Discussion

The difficulty in obtaining sputum in children is well known, and during this trial the use of a pharyngeal swab proved unsatisfactory to determine the infecting organism. This may have been partly due to antibiotic therapy before admission, because it was observed that in those cases known to have had some previous therapy no specific infecting organisms were obtained except in the mongol, who received one penicillin injection before admission and was found to have a haemolytic *Staphylococcus aureus* infection which proved fatal.

In eight instances pneumococci were isolated. The culture from the pharyngeal swab was often a mixed one, *Streptococcus viridans* being present in 30, haemolytic streptococci in 12, *Staph. aureus* in 6, and coliforms in 3. As Macaulay (1951) has shown that cold agglutinin tests and staining of swabs of pharyngeal epithelium for cytoplasmic inclusion bodies are unreliable as evidence of a virus infection in pneumonia, no attempt was made to differentiate pneumonia of virus origin.

It was also observed that the white-cell count was of little diagnostic value except to exclude the possibility of pertussis infection, as in 14 patients (28%) the total white blood cell count remained under 10,000 per c.mm.

It is believed that, in view of the comparability of the two groups, there is no evidence from the results of the two treatment groups that terramycin is any more effective than the "standard treatment." In fact there was a greater incidence of delayed pulmonary resolution with terramycin, although the average age in this group was higher and likely to favour a better response. The drug did, however, avoid the unpleasantness of giving injections to children and the possibility of toxic renal or haematological effects of sulphonamide, though none were observed in this series.

From the results obtained in this trial, especially on account of the expense and limited availability of terra-

mycin, it is suggested that penicillin and sulphonamide therapy remains the most satisfactory treatment for bacterial pneumonia in childhood.

Summary

A clinical trial of pneumonia in 50 children, using terramycin or a "standard treatment" of penicillin and sulphonamide, has been made.

The two groups are considered to be comparable and the results of treatment in each group assessed.

It is suggested that penicillin and sulphonamide remains the most satisfactory treatment for pneumonia in childhood.

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A CASE OF LIPOMA OF THE PAROTID GLAND

BY

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Lipomata of the parotid region are very rare. They may occur adjacent to the parotid capsule, inside the capsule, or within the substance of the gland. Occasionally an intracapsular lipoma may be associated with fatty transformation of the gland, and a specimen illustrating this condition is in the museum of St. Bartholomew's Hospital Medical College. The diagnosis of an intracapsular lipoma must always be a matter of difficulty, and confusion with mixed parotid tumours is unavoidable. The softness of a lipoma may suggest an adenolymphoma of the gland or its vicinity.

Case Report

The patient, a woman aged 35, was referred to me by her dental surgeon on account of a swelling in the right cheek. About two years previously, in the summer of 1941, she had had two or three attacks of swelling of the cheek lasting for a few days. Her local dental surgeon thought the right lower wisdom tooth might be the cause. Slight tenderness and swelling in the middle of the right cheek had persisted since the early part of 1942. In March, 1943, the right lower wisdom tooth was extracted, but the swelling remained unchanged. In September, 1943, she consulted a London dental surgeon, who thought the swelling was connected with the right parotid.

When the patient came under observation in September, 1943, the swelling was not increasing in size and there had been no pain since the extraction of the wisdom tooth. The swelling did not alter with meals, and there was no bad taste or dryness of the mouth. Her previous health had been good, apart from a tendency to frequent colds and occasional mild sore throats.

The patient was a very healthy woman. There was a visible fullness over the lower and anterior part of the right parotid gland. Palpation revealed an ovoid swelling 1½ by ½ in. (3.8 by 1.3 cm.), running backwards and downwards