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.

We wish to thank Professor F. M. B. Allen and staff of the Royal Belfast Hospital for Sick Children for their assistance in this trial, and Professor J. H. Biggart, of the Department of Pathology, Queen's University, Belfast, and Dr. Gladys L. Hobby, of Charles Pfizer and Co. Inc., New York, for making available a supply of terramycin.

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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

from the centre of the cheek towards the angle of the jaw. The swelling was soft in consistency, its edges were fairly well defined, and there was no fixation to the skin but only slight mobility over the deeper tissues. The parotid duct and orifice were natural, and no other local abnormality could be made out.

The patient was admitted to a private hospital for investigation. A probe passed easily along the right parotid duct. Cannula saliva was profuse in amount; it contained an occasional epithelial cell, but no organisms were present and cultures were sterile. Skiagrams and a sialogram were normal. There was a moderate degree of secondary anaemia.

A diagnosis of a tumour of the parotid gland was made, but there were certain unusual features. First, the tumour was situated further forward and lower than is usually the case with mixed tumours; and, secondly, it was soft in consistency. Both immediate operation and a period of observation were considered. It was eventually decided to give a course of deep x-ray treatment and to operate two weeks later. After completion of the treatment the patient's comments were that the tumour had become firmer, a little smaller, more rounded, and that it stood out more. These findings were confirmed on examination. The changes in the physical signs were interpreted as confirmatory evidence that the tumour was of the mixed parotid type. Operation was advised.

Operation.—This was carried out on October 19, 1943, under endotracheal gas, oxygen, and ether. The right parotid region was exposed through the usual curved incision passing from the zygoma downwards, slightly behind the angle of the jaw, and forwards to the anterior border of the masseter. The whole region was very vascular. The tumour was situated in relation to the lower and anterior part of the gland, and about two-thirds of it was within the capsule. In appearance the tumour was lobulated and resembled a lipoma. The anterior part of the tumour went just through the buccinator muscle and was in close contact with the duct, the outer part of which was cut across during removal. Both ends of the duct were probed. The wound in the duct was closed with three fine catgut sutures to the mucosa and three to the adventitia. The whole region was then covered with fascia, and the subcutaneous fat was sutured carefully. The skin was closed with horsehair.

Pathology.—The tumour itself was an irregular mass of fatty tissue, $1\frac{1}{2}$ in. (3.2 cm.) in diameter, with a lobulated surface, and of rather flattened spherical shape. Histologically it was a simple lipoma.

Post-operative Course

There was a moderate degree of swelling of the whole of the right side of the face after operation. The duct was probed daily and the flow of saliva appeared to be unobstructed. The local swelling started to subside on October 24, when a small haematoma was evacuated from the middle of the wound. Two days later there was a trace of pus at this site, and on November 3 it was thought that a few drops of saliva were coming through the wound. A jaw bandage was applied and the patient was put on fluids. The external wound then healed normally, but by November 8 the saliva from the duct was turbid. Next day all the dressings were removed and the patient was taking ordinary diet. By November 10 there was again a moderate degree of swelling of the right side of the face, but this disappeared after the duct had been probed. This swelling recurred daily, but was always temporarily cured by passing a probe, which produced a small amount of blood-stained saliva. A few days later the probe was slightly obstructed at about the hilum of the gland. At this stage it was noticed that when the facial swelling was at its worst there was a considerable fluid swelling in the subcutaneous tissues. The patient found that for a few hours after the probing she could empty the swelling by pressure, but after several hours this ceased to be possible. By November 23 the local swelling was getting very tense.

On November 29 the fluid coming along the duct was purulent and blood-stained. On the following day No. 1 catgut was passed along the duct, and was kept in position for 30 hours. During this time the swelling was less tense. Catgut was reinserted on December 1 and remained in for 24 hours. This was changed daily till December 6, when there was a small amount of salivary discharge from the mid-portion of the wound. On the following day the wound was dry, there was little local swelling, and the probe passed easily. After this the condition steadily improved, and the wound remained healed. The patient left hospital on December 12. There was no further trouble in the face, and the scar became almost imperceptible. The patient was seen in April, 1952, and in the intervening period there had been no change in the local condition.

Comment

In the above case the deep x-ray treatment was given because of the position and softness of the tumour and the doubts about the exact diagnosis. The subsequent sharper definition and increased firmness after irradiation tended to confirm the diagnosis of a mixed tumour.

The vascularity of the region, the softness of the growth, and the passage of its anterior part through the buccinator muscle made a preliminary and complete separation of the duct impossible. The post-operative troubles were due to the leakage of saliva at the suture line in the duct despite the daily probing. The gradual development of the tense subcutaneous swelling produced complete obstruction of the outflow of saliva during the course of the day. Resolution of the complication followed the use of indwelling catgut which was changed daily. The ultimate result was entirely satisfactory.

Medical Memoranda

★ A Case of Tick Typhus ★

Tick typhus is very rarely encountered in Britain and may therefore be forgotten when a differential diagnosis is made. The high fever, toxæmia, indurated "boil," and polymorphonuclear leucocytosis can lead to a diagnosis of pyogenic septicaemia. This is doubly regrettable, as not only is specific treatment denied but the administration of sulphonamides may possibly be harmful. The following case illustrates these points.

CASE REPORT

A woman aged 21, recently arrived from New Zealand via Panama, was admitted to hospital with diarrhoea and vomiting of three days' duration; also a septic boil on the right buttock, for which she had been receiving penicillin and sulphamerazine from her own doctor for the past 24 hours. There was no history of previous illness. Sixteen and fifteen days before admission she had been ashore at Colon and Cristobal respectively. Thirteen days before admission she had been ashore at Curaçao, where she sat on a rough stone wall at dusk wearing shorts. These were the only shore contacts during the previous four weeks. There were no similar illnesses aboard ship. Eight days before admission a boil developed on the right thigh with inguinal adenitis. Five days later headache, vomiting, and diarrhoea began.

On examination there was obvious toxæmia; the temperature was 103° F. (39.4° C.) and pulse 130; the conjunctivæ were injected. On the outer aspect of the right thigh was a pustule $\frac{1}{2}$ in. (1.25 cm.) in diameter with a black necrotic centre, the whole surrounded by an indurated haemorrhagic area 4 in. (10 cm.) in circumference. Nothing else abnormal was found; the spleen was not palpable, and the skin was clear. There was a polymorphonuclear leucocytosis of 24,000, but blood taken for culture at this time proved sterile. Penicillin was given.