was unable to give details. Salicylates are known very rarely to cause thrombocytopenic purpura. It is assumed that in this case a mild inhibition of red-cell production also occurred and accounted for the anaemia. Although no studies of haemolysis or liver function were made, the case seems worthy of a brief report so that prompt action may be taken in similar cases before platelet counts are reduced to such dangerous levels.

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Traumatic Fore-quarter Avulsion

Avulsion of the entire fore-quarter with survival is uncommon enough to justify the record of the following case.

CASE REPORT

At 3.30 a.m. on February 21, 1951, the sleeve of a Polish mine-worker aged 43 was caught in the conveyer belt and the left arm torn off. He was brought to hospital at about 5.30 a.m. in a pulseless condition due to shock. He was bleeding a little, but did not appear to have lost nearly as

much blood as might have been expected. He was admitted to the wards, and after resuscitation at 6.30 a.m. the blood pressure was found to be 110/70 mm. Hg. At 9.30 a.m. he was given an anaesthetic and taken to the operating theatre.

On removal of his clothing the left upper limb was found to be missing from a large skin envelope. The wound, which extended from the middle line of the back from the level of the sixth cervical spine obliquely

downwards to the outer side of the left nipple and for an inch or so below, was explored, and it was found that the clavicle had been fractured about its centre and the outer half of the clavicle, the entire scapula, and the left arm had been avulsed. All the muscles had retracted and the bony thorax was bare. The brachial plexus was not seen, but the subclavian vessels were sought for and ligated. The subclavian artery had been torn at about the spot where it becomes the axillary artery, and bleeding had been arrested by clotting and retraction of the vessel. The rough end of the fractured clavicle was trimmed and the wound closed with a continuous stitch after providing for drainage. There was some doubt about the viability of the skin, and as much as possible was retained in case of sloughing. From the time of admission until 6.15 p.m. 3 pints (1.7 litres) of blood were administered. At that time there was only minimal oozing and the blood pressure was 134/80, and the pulse rate 100. Apart from a little sloughing of the skin, which required trimming on March 12, the patient's progress from this time was uninterrupted. On the day following the accident it was noticed that he had a Horner's syndrome. On March 29 the wound had healed and he was discharged.

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Unusual Length of a Plasmodium ovale Infection

Relapses of *Plasmodium ovale* infection are known to occur up to two years. A case has been reported by Jeffery *et al.* (1954) in which relapses with the Donaldson strain of this malarial parasite continued up to three and a half years. In the following case a relapse due to *P. ovale* occurred 52 months after possible exposure.

CASE REPORT

The patient, an Englishman aged 31, was admitted to hospital on June 24, 1957, with a history of severe throbbing occipital headache, vomiting, rigor, and fever the previous day. He had been getting attacks of headaches periodically every fortnight or so during the previous four years. He served in the British Forces at Kaduna, Nigeria, from July, 1951, to February, 1953. In September, 1952, he suffered from an attack of malaria and was treated in the Military Hospital at Kaduna. He took prophylactic proguanil every day until he arrived home in February, 1953.

On physical examination he looked ill but his temperature was normal. Systematic examination did not reveal any abnormality. A day after admission his temperature rose to 104° F. (40° C.), initiated by rigor. A blood film showed a heavy infection with *P. ovale*. Some of the red cells contained two or three ring forms. With prolonged staining Schüffner's dots were seen. The schizonts contained 8 to 10 merozoites arranged irregularly. (Diagnosis was confirmed by Professor P. C. C. Garnham.)

After a full course of chloroquine phosphate the patient has become symptomless, except for migraine.

COMMENT

This patient's history excludes any possibility of reinfection with malaria during the 52 months he lived in the British Isles. There seem to be no clinical grounds for regarding the headaches which occurred at fortnightly intervals as other than simple migraine. The headaches which necessitated his admission to hospital were accompanied by rigor and fever, and appeared clinically to be the first attack of malaria since September, 1952. A relapse of *P. ovale* infection has been shown to be accompanied by 18 to 20 merozoites (Garnham *et al.*); in this patient they numbered 8 to 10. This fact, combined with the clinical evidence, seems to indicate a primary infection after a prolonged interval rather than a simple relapse. Whichever interpretation is accepted, 52 months is the longest period recorded.

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The home population of England and Wales as at June 30, 1958, was 45,109,000, of whom 21,744,000 were males and 23,365,000 were females, according to the Registrar-General's latest estimates. The total is 202,000 more than in mid-1957. Within the conurbations there has been a continuation of the movement from the centre to more open residential areas outside. Thus the Administrative County of London lost 29,000 between 1957 and 1958, and other losses were in Birmingham C.B. (8,000), Liverpool C.B. (6,300), Manchester C.B. (5,100), Newcastle upon Tyne C.B. (2,700), Wolverhampton C.B. (2,100), East Ham C.B. (1,800), and Salford C.B. (1,700).