He was given three 0.25-g. capsules of chloramphenicol on the first day, followed by one capsule twice a day to a total of eleven (2.75 g.). The dark field was negative at 24 hours and again at 48, 72, and 96 hours. The lesions healed very rapidly, and after a week he was discharged under observation.

Two cases of gonorrhoea—one simple and one complicated—were also treated with chloramphenicol.

Case 5: Simple Gonorrhoea

A young male native reported with a profuse purulent urethral discharge of seven days' duration, in a smear of which Gram-negative intracellular diplococci were demonstrated. The urine was hazy in both glasses; there were also two small sores on the glans penis, and the right inguinal glands were enlarged and tender. Dark-field examinations of material from the sores and the serological tests for syphilis were negative, and it was considered likely he had a superadded chancroidal infection.

He was given a single capsule of 0.25 g. of chloramphenicol, and 24 hours later there remained only a watery urethral discharge in which no gonococci could be found; the small sores had practically disappeared and the inguinal glands were no longer tender. Some urethral moisture persisted during the next three days, but no gonococci were seen in the smears. The urine, however, did not clear, and a microscopical examination revealed the eggs of *Schistosoma haematobium*, for which condition he was subsequently treated.

Case 6: Gonorrhoea Complicated by Prostatitis and an Abscess of Cowper's Gland

An indigenous native of Southern Rhodesia reported with a purulent urethral discharge of only two days' duration in which gonococci were found without difficulty. The urine was hazy in two glasses, and in addition there was an abscess of the left Cowper's gland, which had burst and was discharging. No gonococci were seen in smears taken from the abscess, although there was an abundance of pus cells. Rectal examination revealed an enlarged, boggy, tender prostate.

He was given one 0.25-g. capsule of chloramphenicol orally twice daily for three and a half days (total, 1.75 g.). The urethral discharge abated at once and urethral smears taken from the mucoid urethral discharge at 24 hours, or from the dry urethra at 48 and 72 hours, contained no demonstrable gonococci; by that time the urine was also quite clear. The abscess likewise rapidly healed, and a rectal examination performed before discharge, just six days after the onset of treatment, showed that the prostate had decreased markedly in size and was no longer tender.

Chancroid

Except for the unconfirmed examples of mixed infection already quoted there was unfortunately not enough of the drug available to employ on definite clinical cases of soft sore. However, advantage was taken of the experimental infection, for if 0.05 ml. of unsterilized fluid taken from a chancroidal bubo is injected intradermally it will produce within 48 to 72 hours a pustule which, if the patient is untreated, will assume the characteristics of a chancroidal ulcer. If, on the other hand, penicillin and sulphonamides are systemically administered while the condition is in the pustular stage ulceration will be avoided. Also if drugs curative to chancroid, such as penicillin, sulphonamides, streptomycin, and aureomycin, are given at the time of inoculation, the entire reaction is aborted, apart from an occasional non-tender papule at 48 hours.

Three of the above syphilitic patients treated with chloramphenicol were therefore inoculated with bubo fluid of proved virility immediately before their treatment with the antibiotic. The reactions on their arms were entirely negative. An additional case of granuloma inguinale was also treated, apparently successfully.

Summary

Four cases of early syphilis—one of sero-negative primary, one of sero-positive primary, and two of secondary syphilis—have been treated with 7–12 capsules (1.75–3 g.) of chloramphenicol over three to five days. In all of them dark-field examinations showed *T. pallidum* before treatment. In three the dark fields became negative within 24 hours and in the fourth at 72 hours. All of the lesions healed in an average of 6.25 days.

Two cases of gonorrhoea—one simple and one complicated by an abscess of Cowper's gland and prostatitis—were also treated with chloramphenicol with satisfactory results.

The drug successfully prevented the experimental inoculation of chancroid in three cases.

Although it is not suggested that the amounts given are necessarily curative, it is concluded that chloramphenicol is another powerful weapon in the treatment of venereal diseases.

The above work was carried out in the course of a venereal diseases investigation conducted for the Health Department of the Government of Southern Rhodesia, to whom due acknowledgments are expressed. I would like also to thank Dr. A. J. V. Wilkins, Medical Officer of Health, Salisbury, Southern Rhodesia, and the staff of the lazaretto for their assistance.

Medical Memoranda

Traumatic Enlargement of Clitoris

The unusual appearance of the clitoris and the dexterity of the young patient in producing this effect are reasons for recording this case.

CASE REPORT

A girl aged 11 was seen one evening in the casualty department of the Radcliffe Infirmary, Oxford, suffering from a tender swelling of the vulva. On questioning, she said that she had felt some discomfort whilst at school in the morning of the day of admission, and on going to the lavatory noticed a swelling. The swelling had not been present on the previous day, nor had she injured herself in any way. Since the morning the swelling had increased in size, making walking or playing games difficult, and she had been sent home from school during the afternoon. She had no real difficulty in passing water.

The patient was a healthy well-developed intelligent child. Past history revealed that she had been admitted to hospital at the age of 5, suffering from traumatic asphyxia after being

knocked down by a lorry. She slept with a younger sister aged 4. She enjoyed the companionship of other children but on the whole preferred to read books by herself.

On examining the vulva a tense swelling, deep red in colour and at least 1 in. (2.5 cm.) in diameter, arising from the region of the clitoris was seen. Further examination was limited by the tenderness of the swelling and the nervousness of the patient. The diagnosis to my mind lay between strangulation of the clitoris, haematoma of the clitoris, and prolapse

Photograph showing the appearance of the clitoris after the constriction had been released.

of the urethra : the last possibility was unlikely because of the freedom from urinary disturbance.

Operation.—One hour later the child was taken to the theatre and anaesthetized and a further examination was carried out. The swelling had increased in size, and purple-black areas, in addition to a large blister, were present on its surface. It comprised the prepuce and glans clitoris, which were much engorged and presented as two distended shiny prominences. At the base of the swelling one could feel a firm constriction, so beneath this a probe introducer was placed and the constriction divided. A fine thread about 1 in. in length, with closely cut knot at one end, was found to be the cause of the strangulation. The urethra, vagina, and rest of the vulva were normal.

The following morning the swelling was less congested, and 10 days later the clitoris had assumed its normal appearance. I was very puzzled to know how the thread came to be round the clitoris. After a short conversation with the child she admitted that she had twisted a piece of cotton round the skin in front, but gave no reason for doing so.

It is interesting to note that for homework she had to write an essay on "life in hospital." We may assume that her brief visit to the Radcliffe Infirmary would add considerable local colour to this literary effort. Should this young lady contemplate taking up surgery as a career, her ability to tie knots in any situation would be, I think, unchallenged.

This case was shown at the Section of Obstetrics and Gynaecology of the Royal Society of Medicine on March 18, 1949.

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Pyometra after Pelvic Floor Repair

Pyometra is a well-recognized complication of carcinoma of the body of the uterus or of the cervix, especially after stenosis by radium, but the following case seems to be unique.

CASE REPORT

A married woman aged 65 was admitted to hospital on October 30, 1948, suffering from acute retention of urine. In January, 1948, she underwent operation at another hospital for removal of a cervical polyp and repair of the pelvic floor. Nine months later she was readmitted on account of rectal discomfort, and underwent a second perineorrhaphy. Two days after her discharge following this second operation she developed complete retention of urine, and had been catheterized twice daily for five days when I first saw her. The last two attempts at catheterization had failed to produce any urine.

On examination she looked ill and complained of considerable abdominal pain. She was extremely dehydrated, with a dry brown tongue and dry lips. Her temperature was 100.4° F. (38° C.) and pulse 96. The fundus of the bladder, which was acutely tender, was just below the umbilicus. Pelvic examination showed a pronounced forward displacement of the posterior vaginal wall, which was oedematous. The stump of the amputated cervix was just palpable and felt normal. Rectal examination revealed a tender cystic mass which was not displaceable filling the pouch of Douglas. The provisional diagnosis was a twisted ovarian cyst incarcerated in the pelvis and presumably by this time gangrenous.

An anaesthetic was required for the passage of a catheter, which produced 45 oz. (1.28 litres) of foul-smelling urine containing macroscopic pus and shreds of mucosa. The whole picture was one of obstructive retention of urine, with severe secondary cystitis and commencing sloughing of the bladder mucosa.

At operation, after the patient had received 3 litres of glucose-saline intravenously, the pelvic mass was found to con-

sist of the body of the uterus in the shape of a large soft thin-walled sac of a dusky mottled colour lying retroflexed and firmly incarcerated below the promontory of the sacrum. With difficulty this was manoeuvred out of the pelvis and a subtotal hysterectomy carried out. During the process of displacing the uterus upwards the posterior wall, which was completely necrotic along the line of retroflexion, ruptured and about 1 pint (568 ml.) of foul-smelling purulent fluid poured into the lesser pelvis. This was removed by suction and swab, and there was no soiling of the major abdominal cavity. Examination of the cervical stump showed no evidence of neoplasm. A drainage tube was inserted through the posterior fornix and the cervical stump covered with penicillin-sulphonamide powder before closing the abdomen.

Examination of the excised uterus revealed several intramural myomata, with one submucous myoma the size of a pigeon's egg. The pathologist reported that the uterine cavity had been completely denuded of endometrium by an acute inflammatory process. There was also acute myometritis but no evidence of any malignant change. Culture of the pus was sterile.

The post-operative progress was surprisingly uneventful, and catheterization was required only once. The urine was free of pus cells at the end of ten days, and the patient was out of bed on the fourteenth day.

When re-examined at the follow-up clinic two months later, she had put on 10 lb. (4.54 kg.) in weight, and the pelvis appeared quite healthy. Cystoscopy showed a healthy bladder mucosa and both ureters functioning normally.

COMMENT

The following facts emerge from this case : (1) Pyometra due to cervical stenosis is presumably often sterile, and pelvic spill of the contents is not a major disaster. (2) Amputation of the cervix, which is part of the standard procedure in the Fothergill type of operation, should be carried out with due care to prevent subsequent stenosis, even in patients well past the menopause, and elimination beforehand of uterine pathology is particularly important.

Two conditions are essential for the development of pyometra—secretion from the endometrium, and obstruction at the outlet.

It seems probable that amputation of the cervix would result in many more cases of pyometra but for the following facts. (1) Before the menopause, as has now been shown by Sjövall (1938) and by Wollner (1942), the tall cylindrical epithelium of the endocervix reacts to the oestrogenic stimulus, and under this influence rapid regeneration takes place. Thus opposing raw surfaces are rapidly epithelized and adhesions are prevented. This rapid epithelization also prevents the local ingress of infection, with its follow-up of adhesion of opposing granulating surfaces or of fibrosis and rigidity of the cervix. (2) After the menopause the normally atrophic endometrium is non-secretory; therefore, even with complete cervical stenosis, there is no intrauterine accumulation.

It is conceivable that some cases of trigonitis which persist after a good anatomical pelvic floor repair are due to lesser degrees of this type of stenosis endometritis, as the lymphatic and blood vessels of the lower uterine segment are in intimate communication with those of the base of the bladder.

I would like to express my thanks to Mr. Melbourne Thomas, the medical superintendent, for permission to publish this case, and to Dr. D. C. Taylor for the report on the pathological details.

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