silver disulphonate without any preliminary cleaning, followed, as with all other antiseptics hitherto employed, by the insufflation of acetarsol compound powder in non-pregnant cases, together with the use of acetarsol compound pessaries daily during the course of treatment. In none of the cases was a relapse reported within six months.

Dinaphthalene methane silver disulphonate in 1% solution is now used as a routine in all cases of trichomonal vaginitis and also for pre-operative and post-operative sterilization of the skin in obstetrical and gynaecological operations.

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(ni'odin) has produced a most satisfactory percentage of cures with *S. haematobium* infections it has not been as successful with *S. mansoni*.

Our thanks are due to Dr. D. M. Blair, of the Schistosomiasis Research Laboratory, Salisbury, for his helpful advice, and to Messrs. Burroughs Wellcome and Co. for a supply of tabloid nilodin.

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Medical Memoranda

Schistosoma Mansoni Infection

The success which attended the treatment of urinary schistosomiasis in African school-children with a short concentrated course of miracil D (Blair *et al.*, 1949) suggested that the drug might be given a trial in two cases of *Schistosoma mansoni* infection in European children in Kenya. Both cases had previously been resistant to treatment with antimony preparations. The children probably contracted the infection in 1946, when paddling in a stream within the Nairobi Municipal Boundary.

CASE REPORTS

Case 1.—A boy aged 10½, weight 37 kg. on May 20, 1949, had had 108 injections of various antimony preparations at different times in the past three years. Examination of his faeces in May, 1949, still showed large numbers of viable eggs. Following the advice of Dr. Blair he was given miracil D orally, 27 mg. per kg. of body weight daily, for three days. The drug was dispensed in gelatin capsules, each containing 200 mg. to minimize the gastric irritation sometimes produced by the plain powder or tablet. In spite of this precaution he vomited repeatedly after the third dose. Some milk was given, which seemed to allay the sickness, and the treatment was continued. The remainder of the course was marked by only a little nausea and vomiting on the third day. Some discoloration of the skin was apparent, reminiscent of that seen during mepacrine prophylaxis of malaria, but this faded and disappeared within a week. There was no jaundice and neither the liver nor the spleen was enlarged. The urine during treatment was an orange-yellow colour. For a week after treatment he was lethargic and uninterested in his food, but thereafter became his usual cheerful self.

Case 2.—A brother of the patient in Case 1, aged 12, weight 33.6 kg. on June 5, 1949, also had viable eggs present on examination. He had not had as many injections as his younger brother, as at one time he was thought to have been cured. He was given "tabloid nilodin," an enteric-coated preparation of miracil D, in the same dosage—that is, 27 mg. per kg. of body weight daily for three days. Apparently nilodin causes much less gastric irritation than miracil D in capsules, for he had very little nausea and no vomiting during the course.

Weekly stool examinations for two months disclosed no ova. The Cercarial antigen test (Blair and Ross, 1948) was performed on both cases in July, 1948, with locally prepared antigen (after the formula of Blair *et al.*) and was then strongly positive. The tests were repeated on July 27, 1949, some two months after treatment, and were found to be negative. Many further samples of stools have been examined since then, the last occasion being in March, 1950. All have been negative, so one may take it that the cure is complete.

S. mansoni infections in the past have been notoriously resistant to treatment with antimony. While miracil D

Association of Achalasia of Cardia with Oesophageal Carcinoma

In view of the fact that I have seen a second case of this condition so soon after reporting a similar case (Baer and Sicher, 1947) it seems desirable to record the details.

Although two such cases hardly show that the condition is a frequent one, the rapid appearance of this second case does lend weight to the previous suggestion that achalasia produced conditions favourable to the subsequent development of carcinoma, and that if the possibility of its occurrence was more widely recognized it would be discovered more often. The difficulties of diagnosis are certainly very real, and the importance of oesophagoscopy in checking any doubtful cases cannot be over-emphasized.

CASE REPORT

A married woman aged 49 had panhysterectomy on November 27, 1947, for carcinoma of the body of the uterus; this was followed by deep x-ray therapy. The pathological report revealed a highly differentiated papillary adenocarcinoma. She was followed up and found to be progressing satisfactorily. On her visit in April, 1949, she reported "tightness across the chest" and difficulty in swallowing solid foods. On closer interrogation she admitted that she had had this swallowing difficulty on and off for about 10 years; recently, however, it had been increasing in severity, and the periods free from it had become shorter. She could take fluids and semi-fluids with ease, but the solid food caused the discomfort. In the last six months she had lost several pounds in weight.

On examination, her general condition was found to be good; no abnormal signs were found on physical examination, and a straight x-ray film of the chest was normal. The report on the barium swallow was as follows: "Marked dilatation in the oesophagus due to cardiospasm. Constriction in the oesophagus at the junction between mid and lower thirds with ? filling defect on the right below this."

Oesophagoscopy was performed on May 27, 1949, with the following findings: "Oesophagus full of food: ulcerating growth at about 7 cm. from cardia: cardia in spasm. Dilated with bougies and a Negus hydrostatic bag." A biopsy was carried out and the pathological report was: "Section shows the features of an exceedingly cellular and anaplastic squamous carcinoma."

The patient was then referred to Mr. J. Leigh Collis for the opinion of a thoracic surgeon, and was admitted to the Queen Elizabeth Hospital, Birmingham. Pre-operative investigations revealed a secondary anaemia with haemoglobin at 68%. Electrocardiography indicated no cardiac defect. A further oesophagoscopy showed a "typical appearance of achalasia: massive growth seen at 31½ cm." She was given a blood transfusion, and oesophagectomy and gastro-oesophagostomy was performed on June 18.

A large growth was found midway between the arch of the aorta and the diaphragm. It was resected and continuity of the alimentary tract was established by an anastomosis between the stomach and the oesophagus. The whole operation went satisfactorily and the patient was in fair condition in the