COMMENT

It seems very improbable that this was a case of indigenous amoebic dysentery, and much more likely that it was a relapse from a previously unrecognized infection contracted abroad. That *E. histolytica* may remain dormant for many years before giving rise to symptoms is well known. Many cases of amoebic abscess of the liver are found up to 30 years after the primary infection. It is much less common for amoebic dysentery to recur after such a long interval of freedom. In this case it is estimated to be 28 years, which so far as I can discover is the longest interval on record. Dobell and Stevenson (1918) described a case diagnosed 34 years after the original infection, but the patient had had subacute dysentery for ten years before their investigation and consequent discovery of *E. histolytica* in the stools.

It may be salutary to recall that Manson-Bahr (1943) states that ulcerative or mucous colitis not infrequently follows amoebic dysentery. Perhaps there are other cases of supposed ulcerative colitis like this one, in which an unrecognized infection of *E. histolytica* is the underlying cause of symptoms.

I am indebted to Dr. Carey Lynch, pathologist, Torbay Hospital, for confirming the presence of *E. histolytica* in the stools.

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Two Cases of Paratyphoid Fever Treated with Chloramphenicol

Comparatively few cases of paratyphoid fever treated with chloramphenicol have so far been reported, and there seems to be an impression that paratyphoid infection may be more resistant to chloramphenicol than is typhoid infection (*British Medical Journal*, 1949, 2, 919).

It is, fortunately, not easy, at any rate in this country and at the present time, to find opportunity of trying out the drug on a large series of paratyphoid infections. If a comparatively large outbreak did occur it might be difficult or even unjustifiable on humanitarian grounds to take strictly alternate cases as controls if, as seems likely, chloramphenicol is potently curative. In these circumstances it may be of interest to report the following two cases of paratyphoid fever (both of type B and Vi phage type 1) recently treated with chloramphenicol.

CASE 1

A girl aged 4½ was admitted for investigation on September 1, 1949, in about her tenth day of disease, as a case of continued pyrexia. There had also been malaise, anorexia, headache, stiffness of the neck, and a tendency to several loose motions a day in the three days or so before admission. Examination did not reveal any conclusive physical signs, but toxæmia was fairly marked, the child being pale, limp, and supine, with a temperature of 103° F. (39.4° C.).

Culture of a rectal swab on the day after admission, and a faecal specimen on September 4, gave a growth of *Salmonella paratyphi B*. Blood culture was negative. The Widal reaction was: *Salm. paratyphi B* H, 1 in 500; O, 1 in 250; other groups, negative. There was no history of T.A.B. inoculations. Chloramphenicol was administered from September 4 to 12, a total of 6.25 g. being given, beginning with one capsule (0.25 g.) and following with half a capsule (0.125 g.) every four

hours until the course was terminated. The patient's general condition showed clear improvement within 36 hours, but her temperature, though showing marked decline within this period (indeed the first normal reading occurred as early as 40 hours after the drug was first given), did not reach persistently normal levels until the fifth day of the drug. No further positive cultures from repeated faecal specimens were obtained, and she was discharged home on October 8 apparently in very good health.

CASE 2

A youth aged 19 was admitted on September 22, 1949, in about the twelfth day of disease. His illness began rather suddenly with diarrhoea, which largely cleared up after about five days; there was no diarrhoea after admission. In the meantime, toxæmia had become increasingly evident, and, when admitted, his tongue was dry and brown, there was a profuse crop of rose spots, and his temperature on the evening of the day of admission was 104° F. (40° C.) and pulse 68.

Blood cultures and faeces gave a growth of *Salm. paratyphi B*. The Widal reaction was: *Salm. typhi* H, 1 in 5,000; *Salm. paratyphi B* H, 1 in 5,000; *Salm. typhi* O, negative; *Salm. paratyphi B* O, negative. There was no history of T.A.B. inoculations. Chloramphenicol was started on September 24 with six capsules (1.5 g.), followed in two hours by six more capsules, then one capsule (0.25 g.) every two hours until September 27, then four-hourly until October 1, and six-hourly until October 3—a total of 21 g. The temperature showed a downward trend inside 24 hours of the drug being commenced, and the first normal four-hourly reading occurred in about 48 hours from the start. It became persistently normal on the sixth day of administration, in spite of a temporary return to somewhat higher levels on the fourth and fifth days. This rise followed and may have been related to a decision not to wait for the temperature to become completely normal before making a reduction in the dosage from 0.25 g. two-hourly to 0.25 g. four-hourly at the beginning of the fourth day of treatment. A bolder dosage policy might, therefore, have resulted in an earlier return to normal temperature. Faecal cultures from the patient were still positive on October 26.

COMMENT

Toxic reactions that could be attributed to the drug were not observed in either case, and the drug was well tolerated and easily given. There was a strong clinical impression that improvement in the general condition proceeded at a faster pace than resolution of the pyrexia. It is possible that either of these two cases would have improved during the same period without the drug being given. Nevertheless, it is a fact that they both improved in a similar fashion whilst having the drug, and that clinical amelioration was evident within 24 to 48 hours of the drug being started. In the second case, particularly, toxæmia was sufficiently pronounced to have given rise to the fear of a prolonged and stormy course.

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A scholarship of £100 to £150 will be awarded by the National Association for the Prevention of Tuberculosis to a registered female nurse working at the time of her application in a hospital in Scotland. The scholarship will enable her to spend a period of from three to six months in postgraduate study in hospitals or clinics in (a) Scotland, (b) England, or (c) Scandinavia. Particulars may be obtained from Miss A. J. Weir, Scottish Secretary, N.A.P.T., 65, Castle Street, Edinburgh, 2, by December 1.