by mixing the grated coconut with hot water and manually squeezing out the oil. To reduce the fat content, the mothers were instructed not to add the milk obtained by the initial squeeze, but to discard this and add hot water to the grated coconut. This weaker coconut milk was used for the preparation of the child's curry. The fat-deficient diet was continued for a few weeks after the stools became normal.

Summary

Forty cases of pathologically proved *E. histolytica* infection in infants in Colombo and its environs are presented. Of 291 cases of infantile diarrhoea in children under 2 years of age 15.9% were infected with *E. histolytica*. Fourteen cases were 1 year of age and 26 between 1 and 2 years. Twenty-nine of the cases were infected with *E. histolytica minuta* and the others with the larger type. Half the cases were of the acute and half of the chronic and relapsing variety. Treatment given was by emetine parenterally and carbarsone orally. Of the cases followed up 80% indicated satisfactory results.

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ACUTE PHLEGMONOUS CAECITIS

BY

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Acute phlegmonous caecitis is not described in any of the standard textbooks of surgery or pathology. Although it is rare it is possible that the small number of cases reported may be due to the condition's not being recognized at laparotomy, or it may be that some cases thought to be of "appendix abscess" which subside on conservative treatment are in reality cases of acute phlegmonous caecitis. The subject was discussed in an excellent article by Spivack and Busch (1943), who reviewed 35 cases recorded up to that time and described two cases of their own. A few more have since been reported.

The purpose of this article is to draw attention to this condition and to describe two cases met with at this hospital. Both patients presented with severe continuous abdominal pain which started in the epigastrium and later shifted into the right iliac fossa. They were not seen until the disease had been in progress for 48 hours, and in each of them a well-defined and extremely tender mass was present in the right iliac fossa. A provisional diagnosis of acute appendicitis was made, but it was felt that the early appearance of such a tender mass was an atypical feature. Operation revealed acute phlegmonous caecitis, with a normal appendix in both cases. In Case 1 the disease was of the diffuse form, the whole of the posterior wall of the caecum being affected and the borders of the phlegmon

merging imperceptibly with the normal bowel. Case 2 is of the circumscribed form of the disease, a localized phlegmon of the posterior wall of the caecum being differentiated fairly sharply from the normal bowel. The two cases correspond well with the diffuse and circumscribed forms of the disease described by Spivack and Busch.

Case 1

A married woman was admitted to hospital on March 6, 1948. She had walked to the doctor's surgery in the morning, and on admission gave a 58-hours history of abdominal pain which started in the upper abdomen and later shifted into the right iliac fossa. She vomited once at the onset. The bowels had not been opened since the onset of the pain, and an aperient had been taken without result. She had slight scalding pain on micturition, which was otherwise normal. There was no previous history of similar pain.

On examination her temperature was 100.4° F. (38° C.), pulse 112, and respirations 18. Her tongue was dirty. Herpes labialis was present. An extremely tender mass was palpable in the right iliac fossa in the position shown in Fig. 1, while the remainder of the abdomen seemed normal. Rectal examination revealed no abnormality. The chest and cardiovascular systems were normal, as was the urine. With a provisional diagnosis of acute appendicitis operation was performed under general anaesthesia.

The abdomen was opened through a grid-iron incision. There was no free fluid in the peritoneum. A firm mass the size of a golf ball was found in the posterior wall of the caecum, which was very inflamed. It was grossly oedematous and its surface had a grey necrotic appearance. The edges merged imperceptibly with the normal bowel. The appendix was macroscopically normal and was removed. A small fragment of the caecum was taken for microscopical examination. There was no evidence of obstruction due to the mass and there were no enlarged glands. A corrugated rubber drain was placed down to the mass and the incision closed.

Post-operative Course.—Intramuscular penicillin, 40,000 units three-hourly, was started and continued up to a total of 1,750,000 units. A course of 24 g. of sulphamerazine was also given. There was very little discharge from the drain, which was removed on the fifth day. The patient made an uninterrupted recovery, the wound healing by first intention. White blood cells on March 17 numbered 10,350 per c.mm. (polymorphs 63%, lymphocytes 29%, monocytes 6%, eosinophils 2%). After two weeks scarcely any mass could be felt in the right iliac fossa, and when she was discharged from hospital on March 31 nothing abnormal was palpable.

The pathologist (Dr. W. W. Walther) reported: "This appears to be an acute pyogenic infection. There is no evidence of tuberculosis or streptothrix after prolonged search." During the next year the patient was seen at intervals. She remained perfectly well, and had put on weight; nothing abnormal was palpable in the abdomen. On April 26, 1949, after an opaque meal and follow-through, the radiologist (Dr. P. Tettmar) reported: "Nothing abnormal detected in the stomach and duodenum. In the follow-through the caecal region appears normal."

Case 2

A boy aged 15 walked into the out-patient department on February 16, 1949, giving a history of severe continuous abdominal pain for the last 48 hours, which had begun in the epigastrium and later shifted into the right iliac fossa. There was no nausea or vomiting. The bowels had been opened twice since the onset of the pain. Micturition was normal. There was no previous history of similar pain.

On examination his temperature was 98.4° F. (36.9° C.), pulse 100, and respirations 18. His tongue was dirty and foetor oris was present.

FIG. 1.—The position of the tender mass in Case 1.

FIG. 2.—The position of the tender mass in Case 2.

An extremely tender mass was palpable in the right iliac fossa in the position shown in Fig. 2, with no resistance or rigidity or any other abnormality in the rest of the abdomen. Rectal examination revealed nothing abnormal. The chest and cardiovascular systems and the urine were normal. A provisional diagnosis of acute appendicitis was made and operation was performed under general anaesthesia.

The abdomen was opened through a Battle's incision. The mass previously felt externally was found to be an area of considerable thickening and acute inflammation, with oedema and petechial haemorrhages in the posterior wall of the caecum the size of a hen's egg. The area was fairly sharply demarcated from the rest of the bowel. The appendix, which was macroscopically normal apart from a few faecaliths, was removed. There were several firm glands with oedema in the ileo-caecal angle, and one of these was removed for microscopical examination. The abdomen was closed without drainage.

Post-operative Course.—Intramuscular penicillin, 100,000 units four-hourly, was given up to a total dosage of 6,000,000 units. A course of 32 g. of sulphamerazine was also given. On February 18 the white cells numbered 8,400 per c.mm. (polymorphs 75%, lymphocytes 20%, monocytes 4%, eosinophils 1%). On February 23 they numbered 4,000 per c.mm. (polymorphs 60%, lymphocytes 30%, monocytes 3%, eosinophils 7%). Stool examination revealed nothing abnormal.

The patient made an uneventful recovery and the wound healed by first intention. No abnormality was palpable in the abdomen a week after operation, and he was discharged from hospital on March 7.

The pathologist (Dr. W. W. Walther) reported: "The gland shows changes similar to those seen in glands draining areas of established inflammation. There is no evidence of tuberculosis. The appendix shows no evidence of acute inflammation."

The patient has since been seen at intervals, and has remained perfectly well and put on weight; nothing abnormal has been palpable in the abdomen. On April 28, after an opaque meal and follow-through, the radiologist (Dr. P. Tettmar) reported: "Normal stomach and duodenum. The caecum and ascending colon are well filled. No abnormality is seen. Normal rate of passage through the small intestine."

Comment

Two cases of acute phlegmonous caecitis are described. They are essentially similar to those previously reported in the literature as the diffuse and the circumscribed forms.

The condition, though rare, should be borne in mind in the differential diagnosis of acute appendicitis, from which it can be distinguished only by operation. The presence of a well-defined very tender mass in an apparently early case of acute appendicitis should give rise to a suspicion that it may be one of acute phlegmonous caecitis.

In both cases no harm followed appendicectomy and the caecitis resolved rapidly. The masses disappeared rather more quickly than in the cases of Spivack and Busch, probably because of chemotherapy. In the older literature a fatal outcome was recorded in some cases subjected to elaborate procedures such as resection, exteriorization, and lateral anastomosis. On the other hand, some cases recovered after appendicectomy only. Appendicectomy seems to be without special risk in these cases, and removal of the lesion must be regarded as unjustifiable, since resolution may be expected.

No further light is shed on the aetiology of the condition. The theory of abrasion of the mucous membrane, such as by a foreign body, followed by spreading inflammation of the bowel wall seems to be a reasonable one. The condition

is probably essentially similar to the better-known acute phlegmonous gastritis. In this condition, also, radical surgery is no longer recommended (Maingot, 1948), but resolution may be expected with chemotherapy.

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Medical Memoranda

An Unusual Case of Infectious Mononucleosis

The report by Eckstein and Peeney (1949) of a case of rectal haemorrhage associated with infectious mononucleosis prompts me to think that the following case is interesting enough to record. It is a case of infectious mononucleosis which presented with haemoptysis, subconjunctival haemorrhages, severe abdominal pain, and, later, meningitis.

CASE REPORT

A previously healthy male farm-worker aged 17 was admitted to hospital in August of this year; he attributed his illness to a kick on the left side of his chest from a cow one week previously. He had no symptoms immediately following this occurrence, and was able to continue with his work normally. There had been no bruising of the chest wall.

On admission he gave a three-days history of feverishness and shivering attacks. At the onset of fever his legs felt weak and he developed a continuous central abdominal pain, which was sharp in character. One day later he had a slight unproductive cough and a constant severe lower retrosternal discomfort. From then onwards the abdominal pain became worse and was accompanied by vomiting. On the evening of admission he started to cough up blood, and at the same time his family noticed he had "red eyes." This was exactly seven days after his encounter with the cow. There was no past or family history of undue bleeding episodes.

On examination he was ill and apprehensive, though well built. The temperature was 103° F. (39.4° C.), pulse 120, and respirations 44 a minute. The tongue was furred and the fauces appeared normal. There was no anaemia, purpura, or icterus, and no glands were palpable. He was coughing up blood-stained sputum, and had bilateral subconjunctival haemorrhages covering the whole of each sclera.

He was afraid to move because of pain, and it was difficult to gauge whether it was the pain in the chest or in the abdomen that was the worst. However, there were no physical signs in the chest apart from the rapid respiration rate. The abdomen was held tight, and there was generalized guarding, with complaints of pain on palpation, particularly suprapubically. It was impossible to feel the spleen, but there was resonance over the left costal margin. Bowel sounds were present, and rectal examination was negative. There were no signs in the nervous and cardiovascular systems, and the blood pressure was 115/65 mm. Hg. The urine contained no albumin or sugar.

The chest was normal on radiography, and there were no fractured ribs. The haemoglobin was 95% (13.15 g. per 100 ml.), platelets 150,000 per c.mm., and white cells 13,500 per c.mm. (polymorphs 77%, lymphocytes 16%, and monocytes 7%). The blood urea was 70 mg. per 100 ml. The sputum, which was heavily blood-stained, contained no acid-fast bacilli.