On admission for further investigation the boy felt perfectly well, the diarrhoea having ceased. He was thin and rather pale, and was afebrile; pulse 90. The tonsils were slightly enlarged, as were the glands of the left side of the neck, which were discrete and rubbery. The spleen and liver were not palpable. There were no symptoms or signs referable to the nervous system. No other abnormality was noted, except that on Nov. 7 the white cell count was 52,300 (76.5% small lymphocytes). The Wassermann reaction, Mantoux test, and Paul-Bunnell reaction were all negative.

By Nov. 20 the white cell count had dropped to 11,100 (51% small lymphocytes, 40% neutrophil polymorphs, and 3% eosinophils). He was then discharged to the out-patient department, and on Nov. 26 the white cells numbered 13,300 per c.mm. (lymphocytes 25%). He felt well and there were no abnormal signs.

COMMENT

This case is typical of infectious lymphocytosis, especially in the mild abdominal symptoms, the paucity of physical signs, the cervical adenitis, the leucocytosis with relative and absolute lymphocytosis due to increase in normal small lymphocytes, lasting three to five weeks, and the negative heterophile agglutination test. If the disease is due to a virus, as is to be supposed in the absence of a demonstrable bacterial agent, the blood changes are very unusual, since viral infections are characterized by leucopenia, the apparent lymphocytosis being only relative. As in the cases reported by Finucane and Philips a mild eosinophilia appeared as the total count fell.

I should like to thank Dr. Kenneth Tallerman for permission to report this case, which was under his care.

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Pseudo-Hypertrophic Muscular Dystrophy

The commonest type of muscular dystrophy seen in clinical practice is pseudo-hypertrophic muscular dystrophy, and its features are fairly constant. The following case is of interest because of the late onset of symptoms and the slow progress of the disease.

CASE REPORT

The patient, a man aged 68, was admitted to hospital complaining of difficulty in walking. At the time of admission he could walk only with the greatest difficulty, and the slightest obstruction to his progress caused him to lose his balance. The first symptoms appeared at the age of 28, when he experienced difficulty in climbing stairs. He was then employed as a locomotive fitter, an occupation involving a considerable amount of climbing on and off engines. The progress of the disease was so slow that he was able to continue at his employment until he retired at the age of 64.

Since his retirement, however, a rapid deterioration in his condition has taken place, until now, at the age of 68, he is almost completely crippled. He is an only son, but a maternal uncle had been similarly affected since childhood. The patient has two sons, aged 28 and 30, who so far show no signs of the disease.

Examination revealed the characteristic combination of muscular hypertrophy and wasting found in this condition. Pseudo-hypertrophy was present in the gastrocnemius, deltoid, and infraspinatus muscles. Wasting was evident in the supraspinatus, pectoralis major, and biceps brachii, but there was no involvement of the masseter or of any of the other facial muscles. The pupils were central, circular, and equal, and reacted to light and accommodation. The cranial nerves were normal; the knee-jerks could not be elicited, but the ankle reflexes were present; and the plantar responses were flexor. There were no signs of disease in the cardiovascular, respiratory, or alimentary system. The Wassermann reaction was negative, and a glucose-tolerance test normal. Section of the pectoralis major showed an almost complete absence of muscle fibres with replacement by fat. Section of the gastrocnemius revealed swelling of the muscle fibres with proliferation of the sarcolemmal nuclei.

COMMENT

Pseudo-hypertrophic muscular dystrophy is said to have the least benign course of all the dystrophies, and generally shows a progressive deterioration. Death usually ensues in 10 to 15 years from secondary pulmonary complications following paralysis of the respiratory muscles. Most cases of this type of dystrophy start about the middle of the first decade. A precocious onset of symptoms is said to forebode a bad prognosis

with a rapid deterioration, and, conversely, a late onset often indicates a more favourable course. In the present case the onset was delayed until the age of 28, and the course of the disease has so far extended over 40 years. Moreover, there seems to have been an arrest of progress during 36 years.

It is likely that, had the patient been seen 10 years ago, recovery might have been reported, and this is a possible explanation of some of the cases of cure which have been recorded in the literature. The rapid progress of the disease at the end is also an interesting feature of the case.

Most of the cases in which arrest of the disease has taken place have been examples of the Landouzy-Déjerine type or of the Erb juvenile type. Since the essential pathology of the dystrophies is the same, it is to be expected that a similar course would be followed by other types of dystrophy, and the case here described is a good example of the slow course and temporary arrest seen in the other types of muscular dystrophy.

I wish to thank Dr. H. H. MacWilliam, medical superintendent of Walton Hospital, for permission to publish this case.

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Empyema of Frontal Sinus simulating Osteomyelitis

In the following case the history and clinical signs resembled osteomyelitis of the frontal bone, and for that reason I submit it for publication.

CASE REPORT

Madame A, aged 50, was admitted to hospital complaining of a discharging sinus above the right eyelid for five months. There was no pain and the discharge was preceded by a swelling of the right upper lid for two weeks. She had had headaches over the right side of the forehead for one year. Six years previously she had had similar headaches and swelling of the right upper lid, but no discharge.

On examination a narrow sinus discharging yellow pus was observed immediately beneath the centre of the right eyebrow. *Staphylococcus aureus* was found on direct examination and culture. A probe was passed easily through the sinus, which proceeded above the superior orbital rim in the direction of the posterior ethmoidal cells for a distance of 2 in. (5 cm.) over the right frontal surface of the frontal bone. There was slight depression, oedema, and tenderness on pressure. Skiagrams showed what appeared to be an abnormally large right frontal sinus; the left frontal sinus was apparently absent. The right superior orbital margin was depressed about one-third of an inch (0.8 cm.), and marked widening and shortening of the right superior orbital fissure were found. There appeared to be a doubtful sequestrum at the medial margin of the sinus. A lateral view showed an abnormal depth to the sinus.

The frontal bone was approached through a Howarth incision opening the discharging sinus. The orbital rim and floor of the frontal sinus were intact but very thin. The pus was evacuated through the discharging sinus, and an empyema of the right frontal sinus was found occupying an oval cavity about $3\frac{1}{2} \times 2 \times 2$ in. ($8.75 \times 5 \times 5$ cm.), which had completely eroded the roof of the orbit to the level of the superior orbital fissure. The pulsation of the frontal lobe of the brain and meninges was clearly palpable through the mucous lining of the empyema. There was an erosion of the anterior wall of the sinus, and through this the sinus discharged.

The fronto-nasal duct was enlarged in routine Howarth fashion and the anterior ethmoidal cells were removed. A 1/2-in. (1.25-cm.) drainage-tube was inserted into the wound through the enlarged fronto-nasal duct to the nostril. A full course of sulphathiazole and 3,000,000 units of penicillin were given over a period of a week. Recovery was uneventful.

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At the Eighth Congress of Scientific Films held in Paris in October, 1946, the Institut de Cinématographie Scientifique, Paris, and the Scientific Film Association, London, and observers from UNESCO, Czechoslovakia, Poland, Sweden, and the U.S.A., agreed that it was necessary to establish an international scientific film association. After preparing a draft constitution, the British and French organizations have been meeting in Paris to complete arrangements for an inaugural congress, to which all countries are being invited. This will be held in Paris at the beginning of October, 1947. It is hoped that the proposed association will assist in the provision of a number of practical and urgently needed services.