without any passage of blood, either macroscopically or microscopically. On November 28, in addition, half a cup of milk with half a cup of tea twice a day was started, and on the 30th bleeding per rectum recurred, continuing until the milk was stopped on December 2. Then only fruit juice, soft-boiled eggs, biscuits, and mashed potatoes were given for two days, during which there was no bleeding. On December 5 three cups of milk were added to the diet, and next day bleeding recurred, and continued until December 8. Thereafter the patient was given the routine hospital diet except that milk was stopped in all forms: the bleeding did not recur. On December 16 sigmoidoscopy showed that the ulcer had completely healed and that the colon looked perfectly healthy.

It was decided to test the sensitivity of the skin to milk and to try to desensitize the patient by small doses. However, the husband was impatient to take his wife home and she was discharged with advice to start taking one drop of milk a day and to increase it daily by one drop, as advised by Andresen (1953). The patient reported again three and six months later, when she said that, by gradually increasing the amount of milk by one drop every day, she was able to take milk in her tea (she had not ventured to take a larger amount) and that the bleeding per rectum had stopped completely.

Summary and Conclusions

The case is described of a woman aged 38 with an unusual history of bleeding per rectum every day for seven years. Any possibility of malingering was dispelled by punctate bleeding all over the colon, which led to the belief that it was probably an allergic manifestation. Milk allergy was suspected.

All diet was stopped except fruit juice and water, and for the first time in seven years the bleeding stopped. Further tests showed that bleeding restarted whenever milk was given.

An apparent lag of 24–48 hours between bleeding and starting or stopping of milk might be explained by the products of milk digestion coming in contact with the mucosa of colon (Gray *et al.*, 1940).

The patient has apparently been desensitized to milk by gradually increasing the amount by one drop a day.

Our thanks are due to the Superintendent, B. D. Petit Hospital, for permission to publish this case

REFERENCES

- Andresen, A. P. R. (1953). *Gastroenterology*, 23, 20.
Antia, F. P. (1953). *Indian J. Med. Sci.*, 7, 247.
Gray, I., Harten, M., and Walzer, M. (1940). *Ann. intern. Med.*, 13, 2050.

A good year, continuing the progress of the last few years, is reported by the British Empire Leprosy Relief Association for 1954. Every request for financial help to build homes for child patients was met, and by the end of the year 1,916 children were in the care of Belra in 23 different centres. The policy for treating adults has been to concentrate on out-patient care rather than on enforcing isolation, because the application of sulphone treatment depends on early diagnosis, which out-patient care facilitates. Two rural centres have been established in Tanganyika, a nurse has been posted to Northern Nigeria and a worker to Southern Nigeria to open treatment clinics throughout these neighbourhoods, and the number of Belra men on the Gold Coast working with the Government has been increased from one to eight. Many cases still need institution treatment, and for these a pilot leprosarium and a Red Cross Hospital are due to be opened in Tanganyika. Research on leprosy and in the allied field of tuberculosis is being carried on with the co-operation of the East Africa High Commission and the Medical Research Council.

Medical Memorandum

Ischaemia of Lower Limb as Cause of Motor Accidents

In view of the appalling number of road casualties in this and other countries, and the constant search for remedies, it is thought that the case described here will be of interest. It illustrates a possible cause of motor accidents which is not widely recognized.

CASE HISTORY

A lorry driver aged 58 was referred for medical examination because he had been involved in numerous minor accidents. The nature of these accidents suggested either that his eyesight was defective or that he was grossly careless. He denied any eye trouble, or that he was unfit in any other way. He attributed his accidents to "bad luck" or "bad judgment."

On examination he was a grey-haired, rather elderly-looking man. His visual acuity and colour vision were normal. The only abnormal physical signs were a grossly deficient blood supply to the right foot—the right dorsalis pedis and posterior tibial arteries being impalpable—and diffuse loss of sensation over the sole and medial four toes of the right foot.

After the examination he admitted that his foot occasionally felt numb, so that he was unable to feel the brake pedal or accelerator when he was driving. Henceforth he was not allowed to drive on the public highway, but only on his firm's private roads. His private doctor was told of the disability, but the patient was not referred to a hospital for further investigation.

Five months later his right big toe became septic after minimal trauma, and he was treated at a hospital casualty department. When he reported for work a few days later his toe was partly gangrenous; he was referred to another hospital, where he was admitted. Here he was found to have an inflamed swollen hallux with a slough of the top part of the nail-bed. The right dorsalis pedis and posterior tibial arteries were still impalpable; and there was impaired sensation over the sole of the foot, which was inconstant and disappeared when the foot was warmed. A radiograph showed bony destruction of the tip of the phalanx of the right hallux, but the results of other investigations were normal.

Subsequently the dead bone in the toe was excised, and after graduated exercises he was discharged. He was no longer allowed to drive.

COMMENT

Arteriosclerosis is so common and widespread a disease that cases similar to the one described are probably not uncommon; especially when so many old people are allowed to drive cars.

In this case it was thought that the impaired blood supply to the foot caused an ischaemic neuropathy. As Cohen (1954) has pointed out, patients with ischaemic nerve lesions can present with slipper anaesthesia of the foot, a delayed response to pain or pressure, or wasting and paresis of the intrinsic muscles of the foot. Recovery from an ischaemic nerve lesion is slow, and the sole of the foot may remain numb.

Doctors should bear in mind the potential liability of such patients to their employers, and their potential danger to the public if they are allowed to drive motor vehicles. Casualty officers should always look for peripheral vascular disease as a cause of chronic infection or ulceration of the feet and toes. A gangrenous toe is usually recognized as such; but the fact that it may indicate a major arterial block high up in the limb (Leriche, 1940) is not so widely appreciated.

F. L. DAVIES, M.B., F.R.C.S.

REFERENCES

- Cohen, S. M. (1954). In *Progress in Clinical Surgery*, edited by R. Smith, p. 311. Churchill, London.
Leriche, R. (1940). Quoted by Cohen (1954).