There are five main tribes in Gambia, and all cases of this disease which have been seen have been restricted to one tribe.

Gambia occupies a unique position in West Africa, as it lies on the fringe of the tropical rain-belt. The average annual rainfall in Gambia is 42 in. (107 cm.), with a dry season extending over eight months, while 45 miles (72 km.) to the south the rainfall is 73 in. (185 cm.), and 83 miles (134 km.) to the north the rainfall is 21 in. (53 cm.). The mean temperature in Gambia is 81° F. (27.2° C.). Therefore it is likely that the climatic conditions in Gambia, which are intermediate between those in tropical West Africa to the south and those in the desert to the north, are suited to the transmission of both yaws and the so-called endemic syphilis. This theory tends to be supported by the present observations on the occurrence of the two diseases side by side in a relatively small territory.

Our thanks are due to Dr. A. E. Wilkinson, of the M.R.C. V.D. Reference Laboratory, who undertook the serological investigations.

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General Peritonitis after Subgluteal Abscess

The following case is reported as no previous reference to such a case can be found in the literature.

CASE REPORT

A man aged 33 was admitted to hospital as an emergency case with a provisional diagnosis of general peritonitis due to a burst appendicular abscess. Twelve days previously he had gone to bed at home with fever and headache. Three days later, in addition to the fever which continued, he developed a pain in the left buttock. He called in his own doctor, who diagnosed influenza, which was prevalent at the time. Five days later his doctor saw him again. He was still feverish and the pain in the left buttock was worse and was thought to be due to sciatica. He was also constipated and was given a strong aperient, which caused a copious evacuation of the bowels two days later. The pain in the buttock continued to get worse, until on the morning of admission it suddenly disappeared. In the afternoon he developed stomach-ache, felt especially in the right iliac fossa and across the hypogastrium under the ribs. There was no vomiting or cough.

His previous medical history was that he had had a pyogenic folliculitis of the hair of the left leg for six months. This had now cleared up. In 1941 he had suffered from severe non-specific dysentery while serving with the Forces in West Africa. This was followed by a poly-arthritis affecting especially the hip-joints. He was invalided out of the Forces, but had been quite well since working as a telephone supervisor.

On examination in hospital he was seen to be well built and well covered. He looked ill and had rapid gasping respiration. His temperature was 103.8° F. (39.9° C.), and pulse 114. His tongue was dry and the abdomen tender all over, but especially in the right iliac fossa. There was guarding of both recti, but no board-like rigidity. Examination per rectum was painful, but no mass could be felt. The left buttock appeared quite normal and was not tender on pressure. The movements of both hip-joints were full and painless.

At operation the same evening the abdomen was opened through a long right paramedian incision. The peritoneal cavity was found to contain a large quantity of frank yellow pus. Large quantities of pus were sucked from the right paracolic gutter and the pelvis. The appendix, duodenum, stomach, gall-bladder, and bowel were examined without revealing any abnormality. The abdomen was therefore

closed with drains into the pelvis and below the right lobe of the liver. He made a good recovery with the aid of chemotherapy and intravenous fluids.

One week after operation he complained of a recurrence of the pain in the left buttock. Twelve days after operation there was a distinct tender swelling under the gluteus maximus between the great trochanter of the left femur and the sacrum. He was given a general anaesthetic and the fibres of the gluteus maximus were split to drain a large abscess cavity. On inserting a finger, the posterior surface of the neck of the femur was directly felt. X-ray examination of the bony pelvis and femurs showed no sign of osteomyelitis. A culture of the pus from the abscess grew anaerobic streptococci and the coliform organisms. One month later, when the incision in the buttock had healed, he developed a pelvic abscess, which was successfully drained per rectum. A culture of the pus grew non-haemolytic streptococci.

Three weeks later there was a recurrence of pain in the left buttock. The abscess was reopened and drained. Further radiographs showed no infective focus of bones. He then made rapid progress and was discharged home one month later, though the buttock incision was still discharging slightly.

He finally returned to work six months after the onset of the illness. Both hip-joints had full painless movements and there was no residual disability of any sort.

COMMENT

It seems probable that the general peritonitis in this case was caused by pus from the subgluteal abscess tracking along the left piriformis muscle and bursting into the peritoneal cavity through the pelvic peritoneum. This probability seems strengthened by the fact that a pelvic abscess developed six weeks after the initial drainage of the peritoneal cavity, and shortly after the first external drainage of the abscess had ceased. Presumably a second overflow of pus reached the pelvis, where it was walled off before reaching the general peritoneal cavity.

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Torsion of Hydrosalpinx at 14 Years of Age

Torsion of the Fallopian tube, although not a rarity (de Solderhoff, 1949), is still uncommon enough to be worth reporting. Wolf (1951) recorded that just over 120 cases had been described since 1890. Neel *et al.* (1943) saw torsion of the tube in a child aged 3 years. Tauber (1949) undertook a review of the subject of tubal torsion, and stressed that the history of repeated attacks of pain was the most significant feature. Shaw (1949) believed that the condition differed from torsion of an ovarian cyst in that "shock" was absent. Novak (1949), quoting Anspach, stated that a hydrosalpinx in childhood may be secondary to (a) vulvovaginitis, (b) one of the exanthemata, or (c) tuberculous infection.

CASE REPORT

A girl aged 13 years 8 months was admitted to hospital in June, 1952, complaining of colicky pains in the left iliac fossa for 13 hours. She had vomited four times. There was no disturbance of her bowel or urinary functions. She had suffered from most of the common exanthemata. There was no history of previous attacks of abdominal pain. Her mother stated that from infancy until a year previously the child had had repeated episodes of vulvar inflammation, without any discharge. It had always responded to bathing and the application of talcum powder. There was no relevant family history.

On examination the temperature was 99.4° F. (37.4° C.), pulse 92. Tenderness, guarding, and rigidity were present in the left iliac fossa. Rectal examination revealed no

abnormal findings. The white blood cells numbered 14,000 per c.mm. (86% polymorphs). A straight x-ray film of the abdomen and an intravenous pyelogram showed no abnormality. A catheter specimen of urine was sterile and the deposit normal.

Streptomycin, 0.5 g. twice daily, was prescribed for four days. The temperature was 100° F. (37.8° C.) on the morning after admission, but thereafter all signs and symptoms resolved. Six weeks later she was continuing well.

One evening in February, 1953, she was again admitted complaining of colicky pains, radiating from the left loin to the left iliac fossa. There was nausea and retching with each spasm of pain. Micturition caused lower abdominal discomfort. The bowels had acted normally. Menstrual history: 12, 5/30; regular; moderate flow; no dysmenorrhoea. Menstruation had started on the day of admission, three days later than expected.

On examination her temperature was 98° F. (36.7° C.), pulse 86. The cardiac apex beat was on the left. There was tenderness with guarding in the left loin and left iliac fossa. A provisional diagnosis of renal colic was made. Pethidine, 100 mg., and atropine sulphate, 1/100 gr. (0.65 mg.), were given by injection. The patient vomited once during the night. The next morning she still complained of colicky pains. Her temperature was 98.6° F. (37° C.), pulse 80. The tongue was clean. There was tenderness with guarding in the left iliac fossa. No area of dullness was detected on abdominal percussion. The vulva was normal and the hymen intact. On rectal examination no pelvic tumour or localized tenderness was detected. The white cells numbered 15,000 per c.mm. (92% polymorphs). A catheter specimen of urine was sterile and the deposit normal. A straight x-ray film of the abdomen showed no urinary calculus.

By that evening the patient had become flushed, the tongue was furred, the temperature 100° F. (37.8° C.), and pulse 120. There was acute tenderness in the left iliac fossa, with guarding and rigidity. Rebound tenderness had now developed.

Under a general anaesthetic it was possible to palpate a sausage-shaped tumour in the left iliac fossa. A right lower paramedian incision was made. The left Fallopian tube was found to be plum-coloured and grossly swollen, having twisted twice in an anti-clockwise direction. The left ovary was not involved in the torsion. The right tube and ovary, the uterus and the appendix were normal in appearance. No Meckel's diverticulum was found. A left partial salpingectomy and appendicectomy were performed. The patient's convalescence was uneventful. A gonococcal complement-fixation test was reported to be negative.

Pathological Report.—Macroscopically the specimen consisted of a contorted Fallopian tube, the tissues of which were swollen and of a deep purple colour. The dilated parts of the tube contained blood-tinged yellowish fluid. The medial 15 mm. of the tubal lumen was of normal dimensions, but gave place laterally to a uniformly dilated section 95 mm. long and 20 mm. in diameter. The mucous membrane lining this part showed longitudinal ridges representing the mucosal plicae. These were widely separated by intervening strips of smooth mucous membrane. At its lateral extremity a transverse septum separated this loculus from another, 20 mm. long and 15 mm. in diameter. This latter cavity was lined by smooth and shining mucous membrane and did not communicate with the peritoneal cavity. The tubal fimbriae, firmly matted together, were adherent to the peritoneal aspect of its wall.

Histologically, sections from all the areas examined showed much oedema combined with haemorrhage, especially in the subserous layer, moderate polymorphonuclear leucocytic infiltration, and recent venous thromboses. The arteries examined were all patent. Section of the medial end of the tube showed a normal mucosal pattern. Section of the wall of the lateral loculus showed a thin lining of fibrous tissue clothed with a single layer of cuboidal epithelium.

The fimbriae had multiple points of fusion, one to another, indicative of past inflammation. No evidence of recent sepsis was seen in any section.

The findings were in keeping with torsion of a hydrosalpinx which had occurred long enough before operation to allow reactive polymorphonuclear infiltration to follow the oedema, haemorrhage, and venous thrombosis.

COMMENTS

The torsion of the Fallopian tube here reported was undoubtedly related to its pathological condition. The aetiology of the hydrosalpinx was not certain. The history of vulvitis was not conclusive. The first episode of pains in the left iliac fossa may have been due to a partial torsion of the normal tube, which settled down spontaneously, after causing enough tissue reaction to produce the hydrosalpinx. The intermittent colicky nature of the pain, and the absence of "shock" in torsion of the Fallopian tube not involving the ovary, were well illustrated.

My thanks are due to Professor Ian Aird and to Mr. R. H. Franklin, under whose care the patient was admitted, for permission to publish a report of this case, and to Dr. G. A. K. Missen for the pathology report.

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A Case of Bacterium Friedländeri Meningitis

The comparative rarity of this condition seems to justify publication of another case similar to that of Eberlie (1953).

CASE REPORT

A dock worker aged 48 was admitted to hospital on January 15, 1952, with a febrile illness of 10 days' duration, characterized by general malaise with headache and a troublesome cough with jelly-like sputum. There was nothing of note in his past history, except for an attack of nephritis in 1950, from which he had made an apparently complete recovery.

On admission his temperature was 103° F. (39.4° C.), pulse 80, and respirations 20. Sensorium lucid, but cerebra- tion slow. Herpes labialis. Fauces injected. Tympanic membranes normal. Scattered rhonchi in lung fields. Neck rigidity and inability to kiss his knees. Pupils reacted to light and accommodation. Fundi normal. No cranial-nerve palsy and no other evidence of focal lesion in the nervous system. C.S.F. opalescent, containing an excess of pus cells and what appeared at first sight to be Gram-negative diplococci. Treated with sulphadimidine, 2 g. four-hourly for the first 24 hours, and then 2 g. six-hourly. The temperature fell by crisis, and on January 17 he was afebrile, much more alert, and appeared clinically to be well on the road to recovery. That day the laboratory reported that from the C.S.F. an organism had been grown with the cultural and morphological properties of *Bacterium friedländeri* (*Klebsiella pneumoniae*). A similar organism was cultured from the sputum. As the clinical condition of the patient had so greatly improved, it was decided to continue treatment purely with sulphadimidine, and the events justified this decision. The patient was, in fact, discharged home well on February 2, and when seen a month later at the follow-up clinic demanded to return to work. Before his discharge from hospital, radiographs of the chest showed no evidence of parenchymal involvement, and radiographs of the sinuses were also clear.