KALA-AZAR IN THE FAR EAST.

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DURING the past few years our knowledge of the relationship of the peculiar organisms known as the Leishman-Donovan bodies to the many undifferentiated fevers has largely increased.

The chief endemic centre of kala-azar was at first believed to be restricted to the north-eastern part of India, where these forms of fever were fully studied by Leishman, Rogers, Patton, and others. The geographical range has been considerably enlarged by further investigations, and it has been demonstrated by C. Nicholle that in children suffering from a prolonged febrile disease in North Africa analogous organisms are commonly found, produce similar intense blood changes, with enormous enlargement of the spleen and liver, and give rise to a high mortality.¹

In May, 1908, I brought forward a case of a naval patient² who had apparently contracted the disease while on the China station. This man had visited Shanghai, Tientsin, and Hankow. Shortly after arriving in England he began to feel ill; he suffered later from vomiting, anorexia, anaemia, loss of flesh, and irregular fever. He was sent to Haslar Hospital as a case of malarial cachexia. On admittance he was in the third stage of kala-azar, the spleen filled up half the abdomen, the liver was large; the blood count was—red 3,800,000, white 2,000,

Leishman-Donovan bodies in film from liver puncture, Kiukiang, China.

with a relative increase in the large mononuclear cells. The organisms were demonstrated in the fluid drawn off from the liver. Under treatment by atoxyl he improved greatly, being free from fever and gaining weight and strength; later he was well enough to return to Australia, but there the symptoms returned and ended fatally.

I have lately received a blood film from Surgeon G. B. Scott, R.N., taken from a case at Kiukiang, in the Yangtse Valley; this film is swarming with Leishman-Donovan bodies. The patient was a boy at the Convent, coming from a village about twenty miles from Kiukiang; in this place cases with large spleens and livers are common, and many die from a similar disease to that found in this boy. His symptoms were irregular fever, great anaemia, and very marked enlargement of the spleen and liver. Acting with Dr. Lambert, the resident medical officer, the liver was punctured, and from the fluid drawn off the films were made.

It is evident, therefore, that in the upper part of the Yangtse Valley we have another endemic centre of the peculiar disease known as kala-azar, that it is particularly common in young adults, and that it causes a high mortality. I have brought these facts forward as all information relating to the epidemiology of this disease is of importance in studying the condition as a whole, particularly when the evidence is supported by actual demonstration of the causative organism.

REFERENCES.

¹ Archives de l'Institut Pasteur de Tunis, February, 1908. ² BRITISH MEDICAL JOURNAL, May 3rd, 1908.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

EFFLORESCENCE OF UREA IN URAEMIA.

NOTING Dr. Rolleston's statement that efflorescence of urea is a very rare phenomenon,¹ I may remark that a few years ago I attended a young man in the terminal stage of what was apparently a case of small white kidney without previous symptoms.

The patient died of uraemia, profuse diaphoresis occurring partly as result of spasms and partly as result of the therapeutic means used. After death the relatives called my attention to a profuse powdery scurf all over the body. I explained this to them as probably due to urea left by the perspiration after evaporation. Under the microscope the powder showed minute crystals scattered in the deposit, probably those of NaCl. After solution in alcohol, filtering, and evaporation on a glass slide, crystals of urea formed a copious deposit, and gave several of the ordinary micro-chemical reactions. I remarked at the time to the patient's relatives that although free elimination of urea by the sweat had been secured this did not obviate the fatal result, which seems in accordance with previous experience.

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PLACENTA PRAEVIA IN GENERAL PRACTICE.

I WAS interested in the annotation on placenta praevia in general practice, published in the JOURNAL of September 18th, 1909, page 810, for it so happens that I have had as many as three cases during the present month, a fact which constitutes a record in one way, for I can only recollect having had 6 cases altogether during the twelve years I have been in practice.

Some points in connexion with these cases and the treatment adopted may be of interest, hence my reason for trespassing on your space to record them.

The first of these cases is interesting from the standpoint of what Nature will do. I was called to see the patient at 8.30 p.m. on September 8th, the history being that she had severe haemorrhage which came on suddenly in the early morning and then ceased, recurring once or twice during the day. When I was sent for, in the evening, I found the placenta presenting, the haemorrhage at that time not being severe, and the os being about the size of a shilling, and no pains. I gave the nurse instructions to watch the patient, and to let me know at once when pains came on, or if there was any haemorrhage. About 12 p.m. the child was born without any difficulty; the patient only having had two or three pains, a message having been dispatched; but when my colleague, who went down instead of me, arrived, all was over, and mother and child doing well. It may be argued that this was not a severe case, and some may doubt that it was a case of placenta praevia; but I venture to say that if this case had been near a lying-in hospital where it could be admitted, means would have been resorted to for delivery, with possibly not such good results to mother and child.

The second case was one where there had been considerable haemorrhage, and on examination I found the placenta presenting, the os being about the size of rather more than a five-shilling piece, and the woman rather collapsed, as the haemorrhage was free. I immediately sent for my colleague, who gave an anaesthetic, and I was able to deliver with forceps. No further haemorrhage, but the patient was very collapsed; but with the usual treatment for shock and collapse, including saline injections per rectum, the patient gradually rallied, and is now progressing favourably, but has a little phlegmasia dolens, the loss of blood possibly having something to do with its causation.

The third case was one I saw on Friday, September 24th, at 8.30 p.m. Bleeding came on suddenly at 2 a.m., when the nurse was sent for. It then ceased, and came on again in the evening, when I was sent for, and on examination I found the os about the size of half a crown and very rigid, and haemorrhage fairly free. I watched the case closely, gradually dilating the cervix, and eventually delivered with forceps under an anaesthetic.

BRITISH MEDICAL JOURNAL, August 28th, p. 537.