thought to be very well until this illness commenced, though she was not what would be called a robust child.

The first impulse in a case of this kind is to diagnose meningitis. But the expression of the child's face, her attitude in bed, and the complete absence of pain in the premonitory stages compelled me to reject this. I had never seen a case of encephalitis lethargica, but the mental picture of it that I had formed as the result of slight acquaintance with the literature was recalled by this case. Sequelae of injury and ear disease were evidently out of the question; and so was any disease of vascular origin. There was nothing to suggest nephritis or diabetes, though unfortunately I never examined the urine. Neither did I perform lumbar puncture. It might have been difficult to do on account of the rigidity, and I doubted if one would get information of value, but it would have been more satisfactory. One could also definitely exclude any form of poisoning. However faulty my line of reasoning may have been I came to the conclusion that I had to deal with a case of encephalitis lethargica, and I gave an extremely gloomy prognosis. I knew of course that mild cases did occur, and that recovery under various lines of treatment, or with none at all, had happened, but this was not helpful.

So far as treatment was concerned, I contented myself that evening with ordering nutrient enemata, and directing that nothing should be given by the mouth as it was obviously dangerous. When I got home I looked up what literature I had by me, but found nothing I could get material help from. Hexamine seemed to be the only drug likely to be of any value, and I searched for information about it. I found there was a general consensus of opinion that it was rapidly absorbed from the stomach into the blood, and that it rapidly passed into the tissue fluids. Some said it passed into the cerebro-spinal fluid, others that it did not. Then there was also a general opinion that it only acted by liberating formaldehyde, and that it only did this in acid media. If this is so then it is difficult to see how it can be of any service either in the tissue fluids or cerebro-spinal fluid, as these are always alkaline. Then I remembered hurriedly reading an article in the January number of the *Medical Review* about intravenous injections of this substance, and looked it up. It was an abstract of an article in the *Wiener klinische Wochenschrift* of November 6th, 1919, by F. Deutsch. In this abstract Deutsch is credited with the opinion that the bactericidal action of urotropine is much greater *in vivo* than *in vitro*; also that sufficiently large doses cannot be given by the mouth, as the stomach will reject them. He had used large doses of urotropine intravenously in acute rheumatism—as much as 90 grains daily for six or seven doses—with nothing more serious than a transient rigor and rise of temperature, and usually with no untoward symptoms at all. I came to the conclusion that this was a possible line of treatment for my case; but before finally deciding I would see the patient again. I saw her the next morning (January 26th). The condition was unchanged. The mother said that once during the night she had put her hand to her neck and said something about beads, otherwise she had lain just as I left her. I therefore decided I would try the drug, and the same evening gave her 45 grains dissolved in 10 c.cm. of normal saline in the left median basilic vein. She winced a little as the needle was passing through the skin. I noticed not the slightest change in her condition while I stayed there.

January 27th—Morning: No change in her condition; not retaining the enemata; passes urine unconsciously. Evening: No change.

January 28th—Morning: There is certainly less rigidity of the limbs and the pupillary and corneal reflexes are more lively. Knee-jerks less marked, and Babinski's test yields a feeble but distinctly flexor response. Mental condition unchanged. Gave a second dose of 45 grains of hexamine. Evening: About the same.

January 29th—Morning: Distinct improvement. Has spoken several times, and seems to have some idea of things about her. Rigidity less, and moves her limbs a little. Cannot be roused to answer.

January 30th—Morning: Still better; asks for things, and answers when spoken to, but in a weak, tremulous voice and not alertly. When speaking there is marked tremor of the jaw. Rigidity everywhere is much less; pupils react very well. Gave a third injection of 45 grains as before. Gave marked evidence of feeling the needle.

She was able to swallow a little water, and now she began to have liquid food.

February 2nd and 5th: Had fourth and fifth injections respectively. From this time onwards improvement was steady and uninterrupted. She began to ask for solid food and for her toys, and in a few days was able to sit up in bed. At the end of the third week she was able to get up and sit in a chair for a short time, and was quite bright and cheerful. My last visit to her was on March 4th, when she was going about the house and quite lively. I have seen her on several occasions since. She began to go to school half-time in June, but after three weeks complained of headache, which disappeared again when she stayed at home. She seems now to be as well as ever she was.

From one successful case of this kind it is easy, of course, to draw extravagant conclusions as to the value of the line of treatment adopted. I do not wish to do that, but in any similar case, or even in a case of meningitis, whatever its nature, I should without hesitation try the method. It is only by repeated trials that the value of any treatment can be verified. As regards this line of treatment, I have satisfied myself that it can be used without fear of any serious ill effect following. None whatever followed in this case, and in certain other cases in which I have tried it, of quite different nature, I have given it with impunity, though I have occasionally seen a rigor follow, usually about four hours later, and accompanied by a rise of temperature up to 101° or even higher. The effects have always passed away in about twelve hours. I should certainly not try it in any case enfeebled either by long illness or any other cause.

In the August number of *Medical Science* there is a long series of abstracts from various sources about the disease, amongst others from certain articles by Netter of Paris, an admitted authority. He apparently regards hexamine as the best drug to use, but recommends oral administration in preference to intravenous. In this case it could not have been given that way. I do not know in what doses he gave it intravenously, and that may conceivably make a difference.

I have recently seen the master of the school she attends. He thinks she is altered in disposition and mentally, not being so bright, and wanting to keep away from the other children. Her mother says she will not go out to play with her friends as they are "so noisy."

TWO CASES OF INTESTINAL TUMOUR: OPERATION: RECOVERY.

BY

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I HAVE had recently in the Cottage Hospital, Fleet, two cases of intestinal tumour which seem to have distinctly interesting features.

CASE I.

A. G., a widow, aged 52, with four children, a thin spare woman, accustomed to land work, gave no previous history of illness of any kind, except that she had suffered much from constipation. A few days before admission she had pain in the right lower quadrant of the abdomen, but kept at work for three or four days longer until the pain got so severe she could only work kneeling. She then consulted Dr. Alban Ward of Crondall, who found a large swelling in the region indicated and sent her into hospital.

A hard tumour could be felt a little above the caecal region; it was fairly movable laterally, and a provisional diagnosis of possible malignant disease of ascending colon was made. There was no sickness nor other signs of obstruction. An exploratory operation was advised, and in performing it the honorary secretary of the hospital, Surgeon Rear-Admiral Axford, C.B., kindly assisted me.

On opening the abdomen in the middle line an intensely hard tumour was felt, about the size of a large hen's egg, immediately behind and partly embracing the ascending colon. Although freely movable with the bowel, it had all the appearance *in situ* of malignant disease of the colon, and a decision was at once come to to excise freely. The appendix was seen to be quite healthy and some distance from the growth. An end-lateral anastomosis was made between the ileum and the transverse colon and the gut removed from the hepatic flexure to the caecum. The tumour, when cut into, was found to be of scirrhous-like hardness, but though attached to the wall of the bowel, had not invaded it.

The pathological report from the Clinical Research Association was as follows: "The tumour consists of a fibrous wall of granulation tissue, in the midst of which there are the remains of the appendix. There are large collections of what appear to be proliferating peritoneal cells, but no signs of new growth."

On my pointing out that the appendix had been seen to be quite healthy, an amended report was submitted as follows:

"The centre of the tumour contains an organ which shows all the characters of the atrophied mucous membrane of the appendix. In view of the fact that the organ was not involved, the only possible explanation is the presence of some intestinal diverticulum which may have become separated from the lumen of the intestine."

The patient made a rapid and uninterrupted recovery. As she is shortly about to emigrate to New Zealand I thought it advisable for her to take documentary evidence with her.

The diagnosis of diverticulitis is obviously the correct one. Unfortunately the whole specimen was not preserved for further examination, but only a section saved.

From the knowledge derived from the recent interesting discussion on diverticulitis at the Royal Society of Medicine, the case seems of interest owing to the situation of the tumour on the ascending colon and not on the sigmoid; the absence of any other diverticuli; the absence of all clinical symptoms except constipation until a few days before operation, though the growth must have been there for a long period previously; the absence of any adhesions, the growth being confined to the mesentery, and freely movable with it; the ease with which it was excised. This is contrary to the experience of most of the speakers in the recent discussion, but one feature it has in common—namely, its mimicry of carcinoma before and during operation.

I cannot help comparing it with a case we had in hospital in 1910, under my late partner, Dr. P. E. Adams. A gardener, aged about 45, gave a three weeks' history. He attributed his symptoms to the severe exertion of turf cutting. A large swelling was found in the left lower quadrant, and, as symptoms of obstruction supervened, the abdomen was opened by Mr. Bowreman Jessett. A large mass with a multiplicity of adhesions was found; a diagnosis of carcinoma was made and a colotomy was performed, and the family prepared for the worst. The man is now in perfect health, though the colotomy opening is still present, and all defaecation occurs through this.

CASE II.

H. M., a spinster lady, aged 68, had suffered for two years with abdominal pain and constipation. The latter symptom, which had troubled her most of her life, had become much aggravated. She had lost 2 st. in weight and altered much in appearance. She herself attributed all her symptoms to "rationing."

Dr. Alban Ward first saw her on October 27th, 1919. She then had abdominal pain and persistent sickness. Next day, in spite of high enemata, the symptoms were not relieved; the sickness was more persistent, and the vomit had changed from green to dirty brown. There was no abdominal distension. I saw her, with Dr. Ward, in the afternoon. On rectal examination we both felt, at the extreme tip of the finger, what appeared to be an indurated tumour. A diagnosis of high rectal cancer was made. She was at once removed to the hospital and operated on directly after arrival. An incision was made as for inguinal colotomy. On opening the abdomen the sigmoid was found quite empty and collapsed, and no growth could be detected in the rectum. Two distended coils of small intestine were found deep down in the pelvis, and delivered through the wound. One of these contained a hard growth, in the interior of the bowel, about the size of a Tangerine orange. This was obviously what we had felt from the rectum. The other contained about one yard of intussuscepted gut, which was easily reduced. An incision was made into the bowel over the growth, and the tumour, which was found to be pedunculated, was removed; as it was so intensely hard I decided for safety to resect the bowel, and an end-to-end anastomosis was made.

The pathological report showed the tumour to be a fibro-lipoma.

The patient made a rapid recovery, and left the hospital within three weeks. One interesting feature was the complete disappearance of the constipation which had troubled her for so many years.

I have related this case, with the other, on account of the strong mimicry of cancer. A growth of the intestine in a patient past middle life is almost invariably diagnosed as cancer, and in ninety-nine cases out of a hundred generally rightly so.

This growth, which must have been present for many years, had apparently caused little trouble but constipation and vague abdominal discomfort, until by the weight and persistent drag it brought matters to a climax by producing an intussusception and consequent symptoms.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

PERFORATED GASTRIC ULCER WITH EXTRA-PERITONEAL ESCAPE OF CONTENTS.

A MAN of 47, who gave a history of indigestion extending over several years, was admitted to Duke Street Hospital on January 17th. The night before there had been sudden onset of severe epigastric pain, with sickness and vomiting.

On admission he was pale and anxious-looking, and complained of severe pain in the epigastrium, extending round to the back on both sides. The epigastrium was tender to palpation, and the abdomen was flat, rigid, and board-like. The temperature was 99.2°, the pulse was 140, and the respirations were 36. Dr. Scott, the resident physician, reported some dullness at the bases of the lungs posteriorly, and also suggestions of friction. These signs were not clear but pointed to the possibility of acute basal mischief in both lungs. The diagnosis was thus uncertain, but as the man was obviously very ill, and the doubtful lung signs did not appear to account for the condition, an exploratory laparotomy was made. The abdomen, opened in the middle line above the umbilicus and rapidly explored, was found to be perfectly normal; this applied to so much of the stomach as could be seen, both anteriorly and posteriorly. When traction was applied to the stomach in order to bring the lesser curvature into view, the patient suddenly stopped breathing. As the anaesthetist sharply compressed the chest with a view to re-establishing respiration, there was a sudden gush of a quantity of characteristic gastric fluid from the region of the diaphragm, and respiration was restored. The stomach being brought further down a large ulcer was found on the lesser curvature, close to the point of entrance of the oesophagus. The ulcer was dealt with in the usual manner; the parts were carefully cleaned out, and packing was inserted. The patient made a slow but uneventful recovery, and was discharged well in April.

The interest in this case lies (1) in the difficulty of establishing a definite diagnosis between possibilities of thoracic and abdominal affection—the basal dullness was probably due to the diaphragm being pushed very much upwards, and the friction to spread of infection through the diaphragm; (2) in the normal condition of the peritoneal cavity—it would have been very easy to conclude from the exploratory operation that the mischief lay in the chest, and that the abdominal cavity was free from infection; (3) in the rarity of the condition. Perforating ulcers are generally classified as affecting either the greater or lesser sac; but in this case, owing to its peculiar position, the ulcer opened on a small portion of stomach uncovered by peritoneum, and discharged between the layers of the lesser omentum; the discharge was therefore strictly extraperitoneal. To this fact recovery was doubtless in great measure due, as perforation had occurred twenty-four hours before operation.

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EXPULSION OF FULL-TERM FETUS WITH UNRUPTURED MEMBRANES.

I THINK the following case may be worth recording, as I am sure it is of rare occurrence. I was called at 1 a.m. to a multipara, aged 42—fifth pregnancy—living in a village three miles away. The message I received was that the baby was born, but they did not like the look of it and dare not touch it. I arrived about 1.30 a.m. and found that the placenta, with an unruptured bag of membranes containing a full-time fetus, had been expelled complete. The child, which weighed about 5½ lb., was of course dead, but it was born alive, as the woman with her noticed the movements. The history was that the patient had only three or four violent pains and the fetus was expelled; there had been little haemorrhage, and when I arrived the uterus was firmly contracted.

Hitchin.

JAMES H. GILBERTSON.

A PASTEUR institute has been founded at Manáos, Brazil, under the direction of Professor Astrolabio Passos, Director of the University.

AN International Institute of Anthropology has been founded at Paris. The first general meeting will be held at Liège in September, 1921.