D.A.H. without Symptoms.

Patients diagnosed D.A.H. unaccompanied by symptoms are quite frequent, but may nearly always be discharged to full duty after a short period of training. The most common is the "youthful type of arrhythmia." In many cases these patients are admitted to hospital with a febrile illness, and during convalescence the heart is found to be irregular and the diagnosis is then changed to D.A.H. "by new disease supervening." The cases which exhibit this physiological irregularity most markedly have slower pulse rates than the normal 72. They are rapidly advanced to full duties and remain free from symptoms. The importance of an accurate diagnosis in these cases cannot be over-emphasized. With a diagnosis of D.A.H. they are regarded as "heart" cases, and I have received them after being evacuated through several hospitals and all the time as stretcher cases.

In addition to these cases, there is a further group which is diagnosed D.A.H., and is comprised of patients with extrasystoles. One of these patients gave a history of having been in a stationary hospital for a mild attack of dysentery. After treatment he was discharged to duty, where he was examined by his medical officer, who found an irregular rhythm, diagnosed D.A.H., and sent him back into hospital. He was evacuated down river some five hundred miles as a stretcher case. On examination, his pulse rate was 82, with frequent irregularities occurring in an otherwise regular rhythm. A polygraphic record showed these irregularities to be due to extrasystoles. When questioned as to symptoms, he maintained somewhat indignantly that he felt quite fit. He was allowed to get up at once, and on the second day after getting up, though he had been a bed patient for three weeks, he was sent for a five mile walk, and came back fresh and none the worse. In a few days he returned to his regiment and remained on duty for at least eight months.

Patients with extrasystoles are usually free from symptoms, and, when there are no other physical signs, may be allowed to lead a normal life. Occasionally the patient seeks advice when he discovers this irregularity by accident. He may be reassured and carry on without any break in his work.

Textbook descriptions of beri-beri frequently speak of the irregular pulse. Graphic records were taken at different periods of the earlier stages of this disease in twenty-five cases, and in no case was any arrhythmia found apart from the "youthful type." This was disappointing, as the investigation was undertaken at a time when the shade temperature varied on the different days between 110° and 122°, and assistance was required to divert the streams of perspiration trickling down the face.

Conclusion.

While these experiences relate only to military cases attention is drawn to the fact that the only respect in which they differ from cases seen in civil practice is in the proportion falling under each group. There is an increase in the tachycardias with regular rhythm, whereas the severer forms of disordered action indicating serious disease are comparatively rare, and there is no group peculiar to the soldier's heart as a separate clinical entity.

PERITHELIOMA SIMULATING PANCREATIC CYST.

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THE following interesting condition is recorded to add one further type of pseudo-cyst of the pancreas, so closely simulating a true cyst of that organ that it was only at the necropsy and by tissue section that the true pathological condition was determined.

For a month before admission to hospital the patient, a man aged 29, complained of discomfort after food, with recurring bilious attacks. He noticed a tumour in the upper part of the abdomen in the middle line, which increased in size, gradually at first but more rapidly in the last fortnight. He lost weight steadily and his general condition began to fall off.

He came to hospital on August 6th, 1918, as a walking case; shortly after admission he vomited about two pints of stomach

contents, suggesting gastric stasis, rather than intestinal obstruction. The vomiting persisted in spite of lavage and rest.

A large, rounded, semi-solid mass, easily movable laterally, but less so in the vertical direction, filled the whole of the epigastric and part of each hypochondriac region.

There was dullness over the mass, tympanicity above and below, and slight dullness in the flanks. No definite thrill was elicited. The liver dullness was normal. The stool after an enema did not suggest chronic parenchymatous pancreatitis. Cammidge's test was not carried out.

The diagnosis was made of a pancreatic cyst between the stomach and colon, causing stomach stasis, and probably intestinal stasis, by kinking one or other viscus. As the patient's condition was fair, operative measures were immediately resorted to.

Operation.

A paramedian incision was made on the right side over the mass, through the thinned abdominal wall. The mass was packed off and a little free fluid cleared from the abdomen.

A large semi-cystic tumour was exposed with the layers of the gastro-colic omentum stretched over it. The stomach was pushed high up with the pylorus kinked, and the colon was thrust down by the neoplasm.

The layers of the gastro-colic omentum were divided, and the cyst proper brought into view. Free blood in the interior aroused the suspicion of retroperitoneal sarcoma, and this was made certain on opening the mass and evacuating the contents, which consisted of about two pints of semi-solid "brain-like" tissue freely mixed with organized blood clot. The lesser sac was not involved, the foramen of Winslow was patent, and the pancreas apparently normal. Ablation of the mass was impossible, and as shock was very marked, rapid marsupialization was completed and the sac drained and packed. The abdomen was closed in the usual manner.

The patient's general condition improved for forty-eight hours, during which time large quantities of sero-sanguineous fluid was discharged from the remains of the growth. This oozing continued, and the general condition gradually failed. During the last six hours vomiting of a toxæmic rather than an obstructive type was a marked feature. He died six days after operation.

Post-mortem examination of the abdominal organs only was permitted. The liver, spleen, and kidneys were normal. The suprarenals, carefully examined in section and by the naked eye, were normal, as were the stomach and intestines. The pancreas was normal macroscopically and microscopically. Metastasis was noted at one point in the mesentery.

The remains of the growth consisted of a small solid mass in the retroperitoneal connective tissue, but attached to no organ, lying across the spine and above the pancreas. The rest was a mere shell, having been depleted of its contents at operation.

The growth had no definite capsule, except some feeble granulation tissue. The mass and its contents showed numerous blood spaces lined by large malignant cells radially arranged and spreading in solid masses from the blood spaces. There was much degeneration at the points distant from the spaces. The malignant cells are large with deeply staining cytoplasm; nuclei large, pale, and showing an active mitosis.

The growth is a perithelioma or an encephaloid carcinoma with degeneration at the points remote from the blood spaces.

AVOIDANCE OF RELAPSE IN GONORRHOEA.

BY

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THERE have long been signs of medical dissatisfaction with the older methods of dealing with gonorrhoea. I believe the dominant weakness of nearly all existing methods of treatment is the long time required before the last gonococcus is overcome. In spite of careful and conscientious irrigations or injections relapses are common, and the disappointed patient often realizes that the discharge has returned within a few days (and usually less than fourteen days) after cessation of such treatment. At the present time the methods of irrigation or injection are the most widely used for obvious reasons. Taking irrigation first, its operation suggests the ability to wash out from a tube the morbid material it contains. No doubt some of the gonococci, and their enemies the pus cells, are removed at each irrigation in this way. But it is clear that it is only slightly effective. If it were possible for the incoming stream of the liquid used in lavage to enter the very numerous mucous crypts and recesses of the urethra, and if this liquid, having entered, were able to balloon these recesses and to wash out their contained gonococci, then the disease would obviously be overcome by one or two irrigations. If repeated often enough each day recovery must be ascribed to an overtaking of the gonococcal populations faster than they can multiply. It is difficult to recognize a germicidal effect in the process, or to see a compensation in the method for the dilution and loss of the invaluable

antibodies to gonococci which nature provides and distributes by the blood and lymph to the infected areas. Injections are less dramatic in appearance, but do not seem to remove the antibodies to the same degree as irrigations. By either method, however, when the visible discharge has become quite small or non-existent, the operator usually and naturally has little confidence that discharge will not reappear as soon as the treatment is withheld. This being so, these processes of lavage or injection are continued for a relatively long time, apparently in the hope of wearing down the vitality of the gonococcus. This continued washing and stretching of the main urethral channel often induces weakness of its vitality. Presently, though the gonococcus may have disappeared, the secondary bacteria of various kinds (which were acquired either at the contraction of the disease as a mixed infection, or in the subsequent operations of treatment) are able to maintain a suppuration of a less acute form than the gonococci, but of a chronic type, constituting a true gleet.

In acute gonorrhoea which recovers promptly there is no gleet stage, and its occurrence must be viewed as evidence of weakening or over-irritation of the delicate urethral membrane during treatment. So that we are in the presence of certain facts—namely, that a percentage of cases of acute gonorrhoea recover after treatment by irrigations or injections continued for a period which varies from one to three or more months. That relapse is undesirable common, and gleet is a frequent sequel after the gonococci have been overcome. This gleet is never a trifling matter, and sometimes causes the victim chronic misery. Yet what treatment can be given in place of these methods? If we had a process which could empty these gonococcal-laden mucous crypts by the gentlest squeezing from their blind ends and so express their contents into the urethral lumen (as by indenting the fingers of a glove), it would be almost ideal. For then one or two streams coming down the urethra, as by the natural lavage of voiding urine, would wash out in the best possible manner the virulent gonococcal populations, and the disease would be rapidly overcome.

No such method is available, but in electrolysis we have a fairly near imitation of such an effect. The only lavage I have ever employed is the patient's own urinary voidance, which visibly removes all mucus and gonococci removable at that moment by the natural act of micturition. By insertion of a perforated catheter and a suitably directed electric current mucous tides are set up within the gland spaces, in which gonococci and leucocytes migrate towards the catheter and seek the anode. These masses aggregate at the instrument's apertures and are visible on its withdrawal. There is nothing so striking in this treatment of acute gonorrhoea as the harvest of gonococci and pus plugs containing gonococci which one removes on withdrawing the electric catheter. Still more is obtained in the subsequent urinary voidance which removes similar material drawn into the urethra, but which did not adhere to the catheter or was detached during its withdrawal. After six years' experience of this method I am satisfied that it attacks gonorrhoea and produces a cure with the minimum of urethral irritation, and that the process does constitute a true assistance to the patient's resistance to the disease. I have already called attention to the remarkable fact of patients' immunity from rheumatism and joint troubles, a fact which I cannot yet explain theoretically.

Coming now to relapse, the main subject of this article, I have been gradually impressed with the confidence gained that the discharge will not return after ceasing the treatment. This, of course, means that the patient's resistance has not been lowered by the method of treatment, and the ultimate victory over the last gonococcus is of course due to the vitality of his leucocytes and the gonococcus antitoxin elaborated for the purpose. As these antibodies have not been irrigated away, and no chemical or other irritation has been induced, electrolysis can only have assisted recovery by a timely removal of the gonococcal populations, associated with a subtle influence on the gonococcus toxin. This latter is, I think, to be inferred as helping to explain the immunity from rheumatism. Nevertheless the process is of course not yet perfect. Although an average of three and a half weeks' treatment is required for an acute case, yet I believe that we should be able presently to overcome the disease in

half or even one-third of that time. When acute gonorrhoea can be cured within seven days of its onset I think medical practitioners will seek the possession of facilities for electrolysis, and will discard older and less efficient methods for a system which is more physiological. Since publication of the process and subsequent monographs on the subject I have realized that numerous colleagues expected something as easy and simple as tipping a tabloid into a tumbler and turning on a switch. Instead of something simpler and quicker than injections or irrigations, electrolysis involves much more work and time and trouble for the operator, who naturally obtains much better results. Like others who have endeavoured to leave the common rut of treatment, I have been amused and grieved at the fearful things done to patients with gonorrhoea in the name of electrolysis both in France and this country. Yet it is inevitable that the old and less efficient eventually gives place to the new, but not until the full realization of benefits which make the extra work well worth while.

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Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

THE DOSE OF COLCHICUM IN GOUT.

Most authorities agree that colchicum is a specific in gout. Dr. Sidney Martin, F.R.S., I think, teaches that "the only drug of any use in gout is colchicum, and the only preparation of colchicum of any use is the wine." My experience leads me to suggest that the tincture is also useful if given in suitable doses. But the most effective preparation of colchicum is the acetic extract.

I suggest that the *B.P.* dose of the extract—namely, $\frac{1}{2}$ to 1 grain—is altogether too small to be of any use, and that, since the acetic extract (*B.P.* 1885) is no longer official, the value of the extract has been lost sight of. The average effective dose of the acetic extract is not $\frac{1}{2}$ to 1 grain, but 2 to 6 grains. This, so far as I am aware, has proved a perfectly safe dose in the following prescription:

R. P. opii ...	...	...	...	gr. j
P. ipecac. ...	...	...	...	gr. j
P. cambog. ...	...	...	...	gr. ij
P. aloes ...	...	...	...	gr. iv
Ext. colch. acet. ...	...	...	...	gr. viij

Misce; fiat pil., div. in 4. Mitte 12 or 24.

Dose: One pill three times a day, or two at night and one in the morning.

I have known many instances in which three pills (and by persons accustomed to take them even four) have been taken for a dose (= 6 and 8 grains of the extract) without any noticeable result other than that desired. But the average dose above mentioned rarely, if ever, fails to relieve rapidly and completely all the symptoms, especially in acute cases.

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"BRACHIAL" NEURITIS AND ITS TREATMENT.

THE able and interesting article by Dr. R. T. Williamson in the *BRITISH MEDICAL JOURNAL* of June 7th, 1919, p. 699, leads me to say that, judging by my own experience, the term "neuritis" has been eagerly seized on by the general public, and the idea seems widespread that neuritis is very difficult to cure. During the past twenty years I have seen many cases of neuritis, and found the majority of them curable, at any rate for a time, many for years. In a very large percentage I have found more or less arthritis. Three cases of primary brachial neuritis with very similar symptoms have recently come under my notice:

1. A woman, aged 41, who for over a year had assisted in nursing a rheumatoid patient, and had worked hard in other ways.
2. Housewife, aged 43, who for a long time has done all the work of a small house, including washing and ironing. This latter form of work is very trying to the right arm, and has been a considerable factor in producing neuritis in other cases.