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.

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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