BACTERIOLOGICAL RESULTS.

Occasionally it may appear difficult to reconcile a series of negative results reported by the bacteriologist with the clinical opinion. In one instance five successive specimens were plated before a suspicious colony was picked off, and shown to be the specific bacillus. In other cases, in which an organism was isolated in the early stage of the disease, further bacteriological examinations were almost uniformly negative, though the patients, after treatment, still exhibited ulceration of the lower gut attended by the passage of blood-stained mucus. A positive Widal reaction of 1 in 50 or over frequently confirmed me in the opinion that the case was one of bacillary dysentery, though the examination of the stool was negative. On the other hand, on two occasions the "Y" bacillus was isolated when the serum reaction was 1 in 20 only, and in one instance Shiga's bacillus was obtained when the serum of the patient did not agglutinate the organism even in that low dilution. The strains isolated conformed with the usual sugar reactions, etc., and were tested against specific agglutinating serums of high titre. In what position is one to place inagglutinable strains? In one case the serum of the patient produced clumping of his own strain in the dilution of 1 in 20 when with specific "Y" serum no agglutination was observed in the same dilution.

DYSENTERY CARRIERS.

Two convalescent patients, transferred, were admitted, showing no signs or symptoms. Each had been on full diet for some days and the stools were formed and natural. The Widal reaction was positive 1 in 50 Shiga. In the course of the routine bacteriological examination before discharge Shiga's bacillus was isolated, in one from the first specimen sent, in the other from the second. From three subsequent samples, taken after the administration of a saline purge, no bacillus was isolated in either case and the individuals were discharged.

I beg to express my sincere thanks to Captains C. W. Smith, R.A.M.C., and J. D. Graham Stewart, R.A.M.C., for kindly assistance.

THE IMPORTANCE OF THE EARLY PROPHYLACTIC INJECTION OF ANTITETANIC SERUM IN "TRENCH FOOT."

BY

SURGEON-GENERAL SIR DAVID BRUCE, C.B., F.R.S.

Cases of tetanus following on "trench foot" have lately been numerous. On account of the hurt not being of the nature of an ordinary gunshot or shell wound they have not, until quite lately, received the usual prophylactic dose of antitetanic serum at the front. For the same reason, it may be supposed, they have not received the later prophylactic doses which have been so strongly recommended by the Committee of the War Office for the Study of Tetanus in their memorandum published in the *BRITISH MEDICAL JOURNAL* on November 11th, 1916.

During the last few weeks fifteen cases of tetanus caused by "trench foot" have been reported, but full reports, giving the result, have only been received in eight. The following table gives the outstanding features of these eight cases. A prophylactic injection was not given in any of them.

No.	Incubation.	Duration of Disease.	Died.	Recovered.
1	12 days	2 days	+	
2	12 "			+
3	24 "	2 "	+	
4	?	2 "	+	
5	15 days	1 "	+	
6	?	1 "	+	
7	16 days			+
8	14 "	5 "	+	

From this table it will be seen that of the eight cases only two recovered, and the average duration of the

disease was only 2.5 days. This is a return to the picture of tetanus familiar before prophylactic injections were introduced. The disease wastes no time in local manifestations, but bursts out as generalized tetanus and runs its acute and fatal course in twenty-four to forty-eight hours.

It is to be hoped that no medical officer in charge of a case of "trench foot" will hesitate for a moment in giving a prophylactic injection of antitetanic serum, and repeat the same at intervals of seven days until the wounds are clean. If something is not done speedily, these cases of tetanus following on "trench foot" will run up in a most disastrous way the rate of mortality in tetanus, which every one, by the use of prophylactic and early therapeutic antitetanic serum, is trying to lower.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

AN OVARIAN CYST COMMUNICATING BY A VALVULAR CANAL WITH THE FALLOPIAN TUBE.

On August 26th I removed intact, from a patient aged 34, a small cystic tumour, firmly and extensively adherent in the pelvis. The Fallopian tube, like a pyriform pod, dilated at its fimbriated end to the size of the index finger, was seen coursing the surface of the ovarian cyst. The tube looked like an ordinary hydrosalpinx, and on compressing it clear limpid fluid flowed from its cut uterine end. It was then observed that the ovarian cyst was gradually decreasing in size and that the Fallopian tube remained semi-distended. The ovarian cyst was then opened, and at a spot about two inches from the uterine end of the Fallopian tube there was observed in the cyst wall a crescentic fold, guarding, as it were, a canal of about an inch in length, which opened directly into the tube. The fluid in the cyst presented exactly the same appearance as the fluid which flowed at first from the tube.

I have never before seen a tubo-ovarian tumour of this character. I have heard that ovarian or tubal cysts have been known to empty themselves through the uterus. In the case here described there seems to be no reason apparently why fluid did not escape from the tumour by the uterus, for the uterine end of the Fallopian tube seemed to be quite normal and allowed the fluid to pass, in, it is true, an extremely small stream.

London, W.

JAMES OLIVER, M.D., F.R.S. Edin.

THE TREATMENT OF CANCER BY CUPRASE.

A WOMAN not long past the menopause had four years previously undergone a radical operation for carcinoma of the right breast, which had evidently been very extensive. There was no local recurrence either in the scar or on the chest wall, but there was some involvement of the mediastinum, causing pressure both on the trachea and oesophagus, and also implicating the vagus and sympathetic nerves on the right side; some enlarged glands were to be felt above the clavicle on both sides. X rays had been tried for a time, but without apparent benefit, and the patient had become too weak to undergo the exertion of transport to the radiologist. The prognosis was, of course, hopeless, and alleviation of suffering appeared to be the utmost that medical science or art could offer.

It was at this stage that cuprase suggested itself, if the advertisements and reports supplied by its makers were to be credited, as worthy of trial; at least, according to the reports, and especially to Dr. Herschell's eulogistic statements, it could do no harm. The matter was explained to the patient and her relatives, and although, of course, I would promise nothing in the way of cure, they decided it should be tried. Accordingly I obtained a box of eight ampoules (price 25s.), no less amount being supplied, and no "trial sample" being permitted. I injected the contents of one ampoule according to directions. Not only was the injection immediately painful, but there was very marked local reaction—pain, redness, heat, and swelling—which persisted for nearly a week and caused the patient a large amount of suffering. Not only was there marked local pain, but the patient's general condition was much