of shows for children to one hour, and the prohibition of "repeats." (6) The reservation of the children's seats to the "optimum" position in the hall.

With such provisions the indulgence in a show once a week should do no harm to the eyes of a normal child.

PUERPERAL FEVER TREATED BY VACCINE.

BY
RICHARD KAY, M.B.LOND.,
HARTLAND, NORTH DEVON.

The following case may be of interest in connexion with that recorded by Dr. Grier in the *BRITISH MEDICAL JOURNAL* of September 30th, 1916, p. 454.

Mrs. H., a young primipara, was confined on March 27th. I had been called to see her three days earlier as she had an erythematous rash, without fever or other symptoms. It had almost vanished when she was confined, and there was no subsequent peeling. The head was at the vulva when I arrived, and I was told it had been there some time. The presentation was occipito-posterior unredacted. The child was born in half an hour, and there was a considerable tear of the perineum. The placenta was long in coming and was incomplete. While I was preparing to explore the uterus the patient, who was well and cheerful when the child was born, complained of faintness, and I found her pulseless. There was no marked external hæmorrhage, and the uterus was contracted, but she was pale and restless and had sighing respiration. For two hours I tried to rally her, with no success. As she then passed a large clot, I gave chloroform and removed the rest of the placenta, which was lying loose at the internal os; the uterus was then douched and pituitary extract was injected; saline was injected per rectum and afterwards into the axillae, but with no result, and I left her six hours after the birth of the child still practically pulseless. Twelve hours later she had rallied; she was warm, her pulse was 120, and the temperature normal. She had an angry blister, the size of half a crown, on the left buttock, three or four inches from the vagina, and stated that she had felt some discomfort there for several days. To this I attribute the fever which followed.

Next morning she felt better, but had a headache; the pulse was still 120, the temperature was 99°. In the evening the temperature was rising, and the perineal tear looked sloughy. Remembering the rapid and possibly inadequate exploration of the day before, I explored the uterus again after cauterizing the perineal tear with carbolic acid. I found nothing, but caused a rigor.

Next day, as the patient was obviously worse, Dr. Pearson of Bideford kindly saw her with me; he also found that the uterus was empty. I then injected antistreptococcic serum,

A = Rigor; temperature not taken. B = Consultation. C = Serum, 30 c.cm. D = Serum 20 c.cm. E = Cough; serum, 30 c.cm. F = Urticaria. G = V.E. swab from cervix H = Measly rash; delirious. I = Polyvalent vaccine; negative phase. J = sweating.

with excellent results as shown by the chart, for a few days; the pulse came down to about 100, and the patient was indomitably cheerful. She then developed a slight cough, the temperature began to rise in the evenings and presented a septic character. A few days later the morning temperature also gradually rose, and she developed an urticarial serum rash, ten days after the first injection of the serum, and on the thirteenth day of the illness. The cough continued, but all that I could find was slight diminution of entry of air and diminished resonance at the base of the right lung; the breathing was not quickened. The perineal tear was clean, there was a slight discharge from the cervix, but no smell; the blister was still angry and painful. Aspirin had been prescribed for a few days, and afterwards quinine, and a vaginal douche was given twice daily.

When the urticaria disappeared and the morning temperature remained high, it became evident that the latter was not a

serum phenomenon. Moreover the pulse began to rise above 100, and the patient lost her pluck. I was unwilling to put her to the expense of an autogenous vaccine, but I felt further delay would be dangerous. A swab was taken through a Fergusson's speculum, and this apparently caused a considerable increase in the fever. Three days later the Clinical Research Association reported that so far no virulent bacteria had developed.

On the twentieth day of the illness the patient developed a third rash which was measly in type and doubtless septic. In view of the negative bacterial report I tried to find an internal abscess, but failed, nor could Dr. Pearson discover anything of the kind. Next day the patient became delirious, and the Clinical Research Association reported that a few streptococci had developed and that they were sending a stock vaccine at once. The marvellous result of that stock vaccine, after a slight negative phase, is shown by the chart. The patient had a crisis and was well. The cough, never troublesome, cleared up. Only the obstinate sore on the buttock remained, and when the autogenous vaccine arrived and was injected that cleared up at once; evidently the vaccine was specific as regards the blister.

The patient, I think, must have had a low form of septic pneumonia, although the physical signs were never definite. A septic pneumonia does not usually end by crisis, but apparently the vaccine stimulated it to do so. The initial collapse was puzzling. In the absence of cyanosis and struggling for breath I hesitated to diagnose embolism of the lungs; perhaps there was some embolism of the heart, or a massive septic infection. There was a little more bleeding than usual, but not much. There were never any abdominal symptoms except slight tenderness over the uterus.

A CASE OF "TRENCH FEVER," CONTRACTED IN ENGLAND.

By R. D. MACGREGOR, B.A., M.B. OXON.,
CAPTAIN I.M.S. (RETIRED).

The case of "trench fever" here described is recorded because the patient has never been out of England, and has contracted the disease while in hospital in attendance upon cases of trench fever from France. As has been the case in a number of instances occurring abroad, the patient is an R.A.M.C. orderly.

Pte. A., R.A.M.C., has been employed for some months at this hospital as a ward orderly, and bears a good character. He is 54 years of age, and has had no serious illness except appendicitis, for which he was operated upon. He has never had rheumatism.

On August 30th, 1916, he had acute pain in his legs all night. For three days before this he had had some aching in the legs, but had carried on with his duties. On the morning of August 31st his legs were so acutely painful that he could not stand, and was brought to the hospital on a stretcher. The fronts of the legs were found to be very tender, the tenderness being most marked along the inner border of the tibiae. There was headache, and some tenderness and pain over the front of the thighs. The temperature in the evening was 100°; the next evening it was 101°, the symptoms continuing the same. On the fourth day the temperature came down to normal, and remained so thereafter, but there was little remission in the pain. He was not able to stand with ease until about the seventh day. In addition to the leg pains, headache was frequent, and pains began to be experienced in different parts of the body—transversely across the chest below the nipples, in the neighbourhood of the hips and of the shoulders. On November 5th there was pain, which he described as "cruel," in the left shin, but none in the right. There was pain also in the right shoulder. The pains were usually worse at night and in damp weather. Throughout the illness there were no pathological signs except the initial pyrexia.

CHART 1.—Pte. A.; "myalgic" type of trench fever (contracted in England).

The case is fairly typical of the "myalgic" type of trench fever. Trench fever, as so far described, has no completely uniform character, but presents a symptom-complex easily recognized and divisible into a number of well-marked types. McNee, Renshaw and Brunt,¹ and Hurst² have described a "long" and a "short" type of