MEDICAL NOTES FROM THE IMPERIAL YEOMANRY HOSPITAL AT PRETORIA.

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DURING the last few months a number of interesting medical cases have been admitted into the Imperial Yeomanry Hospital at Pretoria, of which a short account appears to be worth recording.

EPIDEMIC JAUNDICE.

A very large number of cases of jaundice occurred in Pretoria during January and February, and I am informed that similar cases are prevalent in the Orange River Colony.

The disease runs a definite clinical course. The patient complains of nausea and of great aversion to food and smoking. The nausea may be accompanied by vomiting or by pain, which is situated over the right of the epigastric area, but is not definitely localised. The patient always feels exceedingly wretched and depressed. In some cases there is moderate pyrexia, while in others the temperature remains normal throughout. The tongue is covered with white fur, and the bowels are either regular, loose, or constipated.

After these symptoms have continued for three or four days jaundice appears. The jaundice is usually intense and the motions clay-coloured. With its appearance the other symptoms as a rule subside, although they may continue for a day or two longer. The jaundice continues for a few days and then disappears. As recovery invariably ensues, one can only surmise as to the pathology of this affection. The nausea, vomiting, and abdominal pain suggest an inflammation of the duodenum, which leads to a blocking of the orifice of the bile duct and thus causes jaundice. According to this view, the jaundice is a more or less accidental sequela, and this is supported by the fact that a number of cases occur in which there are similar initial symptoms but no subsequent jaundice.

As to the causation of this affection, all one can say is that its occurrence in epidemic form points to some infective agency.

It is interesting to note that jaundice is stated to be prevalent at the present time among horses in Pretoria.

ENTERIC FEVER.

There are several points of interest in connection with enteric fever here. Constipation is the rule, and it is uncommon to get diarrhoea or hæmorrhage. Phlebitis is of very frequent occurrence, and is very much more common than in England. Patients who have been exposed to excessive fatigue and those who have been conveyed long distances in an ambulance during the early stages of the disease frequently succumb ultimately to cardiac failure, although the attack has not otherwise been severe. I have had the opportunity of watching a number of cases of enteric fever from the beginning, and I have frequently noticed that they have been preceded by short attacks of pyrexia. These attacks occur during what is usually considered to be the incubation period—that is to say, during the fortnight preceding the onset of enteric. As an example I will quote the following case:

An officer, 27 years of age, who was taken ill on January 11th with *malaise* and pains all over the body, was admitted into the hospital on January 14th, the temperature on that evening reaching 101°. From January 14th to January 19th the evening temperature was about 100°, and the morning temperature normal or subnormal. During this period there were no particular symptoms, and not the slightest indication of enteric fever. The bowels were constipated and required an aperient. On January 20th the temperature was subnormal, and remained so for four days, during which time the patient was feeling perfectly well, was up, and was taking ordinary diet. The temperature rose again on the evening of January 24th to 100.2°, and from this time it gradually rose in a staircase fashion, and a typical attack of enteric fever developed.

I have observed these cases both among the inoculated and the non-inoculated. What is the actual nature of this primary fever? Is it simply an indication of changes occurring during the incubation period of enteric, or changes certainly must be taking place during this period, or is it quite an independent affection such as influenza? We can readily suppose that the body is especially liable to a chance infection, or to a recrudescence of any latent disease during the

incubation period of enteric fever. In one case of which I have full notes a well-marked attack of remittent malaria with parasites in the blood occurred during the incubation period of enteric fever. The patient had previously suffered from many attacks of malaria.

Inoculation.—With regard to the value of inoculation, I am satisfied from clinical observation that it does not modify the disease. Mild, severe, and fatal cases occur among the inoculated and non-inoculated, and, as far as one can judge, with the same frequency. Whether inoculation diminishes the incidence of enteric fever can only be determined by extensive statistics. From my own personal experience I should not think that the incidence is diminished. It is possible that inoculation protects for a few months, and that it may thus be of some limited utility; but in view of the pain and inconvenience caused by inoculation, I cannot feel that it will be of much practical value in the future. In this connection I may note that I have observed a not inconsiderable number of second attacks of enteric occurring within a year, and in one case, at least, the second attack was fatal.

DYSENTERY.

During the past three or four months the cases of dysentery have been few and of a mild type. An interesting point sometimes arises in connection with diagnosis. During recovery from dysentery it is not uncommon to get an accumulation of faecal matter in the intestines. On the other hand, chronic constipation—due, no doubt, to the nature of the food—is common here, and in some of these cases the accumulation of faeces gives rise to dysenteric symptoms—tenesmus and the passage of mucus and blood. Such cases can be distinguished from true dysentery by a careful inquiry into the history, although it must be admitted that the diagnosis is sometimes difficult. In both cases the treatment is the same—the careful administration of enemata and purgatives.

PHLEBITIS.

I have already mentioned that phlebitis is an exceptionally frequent complication of enteric fever in South Africa. I have also seen a number of cases in which it has followed upon some other condition or has arisen without any definite cause. In one instance a severe case of phlebitis of the femoral vein followed a short febrile attack which I had diagnosed as influenza; and in other cases a doubtful gouty diathesis was the only assignable cause. There appears to be something in the food—the absence of fresh vegetables or the presence of some ingredient in tinned foods—which predisposes to phlebitis.

UNDETERMINED FEVERS.

It is probable that there are several specific fevers in South Africa which have not yet been recognised. At any rate, one frequently meets with cases of fever which cannot be relegated to any definite disease. Some of these are cases of moderate pyrexia, lasting a few days, the only symptoms being those of *malaise*. Possibly these cases are abortive attacks of enteric or some other specific fever, but there is no evidence to show whether this is so or not. A more or less definite entity is a fever lasting a week or ten days, the temperature going up to about 100° in the evening and coming down to normal in the morning. With this pyrexia there is *malaise* but no definite symptom. There are, in addition to these mild fevers, severe and prolonged cases of pyrexia bearing a resemblance to enteric fever and general tuberculosis, but which do not belong to either of these diseases. I will give short notes of two cases of this nature which have come under my care:

CASE 1.—A civil medical officer, aged 35, was admitted into the Yeomanry Hospital, Deelfontein, on May 14th, 1900, with *malaise* and pyrexia.

History.—He had suffered from enteric fever twenty-two years earlier. He had not been inoculated. He arrived in Capetown on March 1st, there a few days, and had since been at Deelfontein. He had never been abroad before. Since his arrival in South Africa he has enjoyed fairly good health, but had had several acute attacks of diarrhoea, and had frequently been troubled with loose motions.

Symptoms.—The principal symptom during his stay in hospital was irregular pyrexia, lasting between four and five weeks, the temperature being frequently normal in the morning, and varying between 99.4° and 102° in the evening. At the end of ten days the temperature came down and remained normal for a few days, but it again rose, and on one occasion it was as high as 103° in the morning. There were never any physical signs; the spleen was not enlarged, the abdomen not distended, there

were no spots, and the joints were not affected. The bowels were irregular, sometimes requiring an aperient; the tongue for the most part was clean, but was for a short time thickly coated. Towards the latter part of the pyrexial period the patient lost flesh and became anæmic. Convalescence was slow, and he did not recover his usual health before the end of July.

Treatment.—He was treated with quinine, salol, and tonics without appreciable result.

Examination of the Blood.—His blood was examined by me on two occasions, once about the middle and once towards the end of the pyrexial stage. Malaria parasites were not found, and the blood did not agglutinate the typhoid bacillus in dilution of 1 to 20. In the early part of December, four months after complete recovery, Dr. Dodgson examined the blood, and found that it agglutinated the Malta fever coccus in dilution of 1 to 40.

CASE II.—A civil medical officer, aged 28, was admitted into the Yeomanry Hospital at Pretoria on October 5th.

History.—He arrived at Capetown in July, was at Deelfontein for a few weeks, and had since been in Pretoria. He had not been abroad before. He had never had enteric fever and had not been inoculated. He suffered from diarrhoea shortly after arriving in South Africa, and the motions have been liquid or pulsatious ever since.

Early Symptoms.—For a week before admission he was laid up with malaise and pyrexia, the temperature rising to 101° or 102° in the evening and falling to normal in the morning. On admission (October 5th) there were no physical signs, but he complained of pain in the back of the neck, which lasted for a few days and then disappeared. On October 18th the spleen could be felt just below the costal margin, and the tongue was slightly dry and brown. On October 24th the spleen was a trifle larger; the tongue was now moist but still brown.

Examination of Blood.—On October 27th the blood was examined by Dr. Dodgson; it agglutinated the Malta fever coccus in dilution of 1 to 80, but gave no reaction with the typhoid bacillus.

Progress.—Up to this period the patient had not felt ill, and with the exception of slight enlargement of the spleen there was no physical sign. The temperature had run an irregular course, being normal during part of each day, but always being raised to 101° or 102° some time or other in the day. On the morning of October 28th the temperature was normal, but from that time it gradually rose and reached 104° on the evening of October 31st. From October 20th until November 20th there was continuous pyrexia, the temperature varying between 100° and 103° . On November 10th the temperature was normal, and continued so with the exception of a rise to 103° on November 11th, and slighter rises on November 12th, 14th, and 17th. During the period between October 28th and November 10th the patient felt ill and became emaciated, and his condition gave rise to anxiety. There was no definite physical sign with the exception of gradual enlargement of the spleen. This organ on November 11th could be felt nearly 3 inches below the costal margin, and was decidedly hard.

Second Examination of the Blood.—The blood was examined by Dr. Dodgson on November 11th, when it agglutinated the Malta fever coccus in dilution of 1 to 60, but gave no reaction with the typhoid bacillus.

Recovery.—After November 11th the spleen rapidly diminished in size, and in a few days no enlargement could be made out. The patient gradually improved, and he was discharged on December 11th from the hospital, whence he proceeded to Capetown. After a few weeks he had quite returned to his normal state of health. During the illness the abdomen was never distended, and there were no typical enteric spots. The motions were sometimes liquid and sometimes pulsatious, and were never typical of enteric fever.

Treatment.—He was treated with quinine, sodium salicylate, salol, arsenic, potassium iodide, and other drugs without appreciable effect.

I feel sure from clinical observation that neither of these patients was the subject of enteric fever, and this is supported by the negative result with the agglutination test. In both cases, towards the end of the pyrexial period, the question of general tuberculosis was raised, and in Case II the hard, enlarged spleen was in favour of such a diagnosis. The complete recovery which ensued put general tuberculosis, however, out of court.

I think that these cases resemble Malta fever more closely than any other disease. The only absolutely certain means of determining Malta fever is to obtain the cocci from the spleen, but in lieu of this we have the positive test of the agglutination of the cocci by the blood. I do not know how far this test is reliable, and consequently I do not know how much value to place upon it.

Nearly a year ago, when I was in Kimberley, I heard of cases which I considered to be most probably Malta fever, so that it is not unlikely that this disease occurs in South Africa.

Two other cases which I have seen out here resembled Case II in many respects. In neither case did the blood agglutinate the typhoid bacillus, and in one case it failed to agglutinate the Malta fever coccus, but in the other case this test was not applied.

Pretoria, March 12th, 1901.

PRESENTATION.—A handsome writing table was recently presented on the occasion of his marriage to Dr. Charles Herbert Gunson, the House-Surgeon of the North Cambridgeshire Hospital, by the trustees, Committee of Management, honorary medical officers, matron, nurses, and staff of the hospital.

REMINISCENCES OF THE WELSH HOSPITAL IN SOUTH AFRICA (SPRINGFONTEIN AND PRETORIA).

Abstract of Addresses delivered before the Barry Medical Society, January 16th, 1901; and the Cardiff Medical Society, March 1st.

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I HAVE already recorded my views¹ regarding the organisation of and the work done by the Royal Army Medical Corps in South Africa, and now we have perused the Report of the Royal Commission which was sent out to investigate the sensational and adverse charges made by a member of the British Parliament against it, and are pleased to find that it is in harmony with the verdict of the majority of the civil surgeons, who had ample opportunities and time to observe and to study the work done by that branch of our profession.

Methods of Pitching Hospital Marquees.

[After exhibiting a lantern slide showing the appearance of a hospital pitched according to the plan described in Regulations and Instructions for Encampments and Cantonments, Mr. Thomas showed one of the Welsh hospitals which was pitched according to a method introduced and carried out by Lieutenant-Colonel A. H. Keogh, R.A.M.C., the able administrator of the Welsh Hospital.] I venture to draw especial attention to this method (Fig. 1), as it presents some important and decided advantages over the "regulation plan" (Fig. 2).

Fig. 1.—Lieutenant-Colonel Keogh's method. Ground plan of the pegs: + weather line pegs; × bracing line pegs; 1, 2, 3, position of the three standard poles.

Fig. 1 is a ground plan of the pegs of the marquee according to Colonel Keogh's method. The first thing to do is to fix the weather-line pegs which form the angles or corners of a rectangular parallelogram, the sides of which are 50 feet by 33 feet, that is, the regulation distances of the weather-line pegs. The next step is to find the point of intersection of the diagonals by means of two pieces of string, and place the centre of the ridge pole upon it. The strings are then