He was readmitted in October, 1926, as three sinuses refused to heal; they all communicated, and were probably due to a deep infected ligature. They eventually closed after being injected with various substances, such as brilliant green and crystal violet.

CASE II.

This patient, also a man aged 42, was admitted to the Bristol Royal Infirmary on September 17th, 1927. Three weeks previously he had had a right lower molar tooth extracted on account of pain and swelling in the jaw. Between this time and his admission he had had numerous anaesthetics for the extraction of other teeth, the exploration of his lower jaw, and the opening of sundry abscesses of the face and neck.

On admission the whole of the right side of the face was greatly swollen; large fluctuating abscesses extended from below the right angle of the jaw to the right temporal region, and he was unable to open his mouth. The abscesses were opened freely, actinomycetes was identified microscopically, and he was put on the usual treatment. On October 12th he was discharged healed. Some thickening persisted in the tonsillar region, and it was three months before this had disappeared completely. He has remained well ever since.

CASE III.

A man, aged 23, was admitted as a case of probable actinomycosis on April 4th, 1927. He had a hard swelling over the left side of the jaw, and a history of recurrent abscess formation for seven months previously. The abscess was opened and the pus examined with a negative result. He had been put on the iodine treatment, but in view of this finding, and the fact that the abscess healed rapidly, this was discontinued, and he was discharged.

He returned with another abscess in September, and this time actinomycetes was identified. He was put on treatment again, and the lesion slowly healed, leaving a deep depression in the jaw where bone had been destroyed. He has remained well ever since.

CASE IV.

This case, that of a youth aged 17, was very similar to the last. He first attended the Royal Infirmary on October 8th, 1927, with an indurated swelling over the left side of the lower jaw. This soon broke down to form an abscess, the pus from which was found to contain actinomycetes.

He was put on the same treatment, and his wound rapidly healed. He was last seen on December 13th of that year, but he writes, in answer to an inquiry, to say that he has had no recurrence of the trouble since that date.

REFERENCE.

¹ *British Medical Journal*, December 29th, 1928, p. 1172.

A CASE OF ULCERATIVE ENDOCARDITIS OF PUERPERAL ORIGIN.

BY

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THIS fatal case of puerperal sepsis is interesting because of the almost total absence of pelvic symptoms or signs, and because there were no clinical signs suggestive of heart lesions such as were found at necropsy.

Clinical History.

A primipara, aged 23, was confined in an outlying district on July 21st, 1928; the labour was normal except for early rupture of the membranes. No instrument was used, and there was no trauma. Up to about the tenth day, when the patient was reported by her mother to have had a rigor, the puerperium was normal. She got up on the eleventh day, but further rigors were reported to have occurred on the seventeenth and twenty-fourth days. On the twenty-ninth day she came to Barnsley to her mother's house, and on the thirtieth day had another rigor.

One of us (G. R. M.) was called in on the thirty-first day, and found the following conditions: the temperature was 99° F. and the pulse 120; the uterus was fully involuted, retroverted, and free from tenderness, and there was no uterine discharge. The urine was normal, and no other abnormal signs were found. The retroversion was replaced. On the night of the thirty-third day the patient became orthopnoeic, her temperature rose to 102.6° F., and her pulse to 140. On examination a gallop rhythm was found at the heart, but no enlargement or murmurs were detected. The bases of both lungs were dull on percussion, and auscultation revealed moist sounds and friction rub. An injection of atropine, strychnine, and digitaline was administered. On the thirty-fourth day we both saw the patient in consultation. She was obviously suffering from toxic absorption, but no other abnormality was found. The lungs were now resonant and free from abnormal signs. Material was taken for an agglutination test, which proved to be negative. From now on the patient had numerous rigors. On

the thirty-seventh day she was admitted to hospital. On examination we found that the heart was not enlarged, and there were no murmurs to be heard. There was a reduplicated first sign at the apex and the left border of the sternum. Occasionally sibilant rales were heard in the lungs. The pelvic organs were apparently normal, except for a slight, non-offensive uterine discharge. The patient was given 25 c.cm. of antistreptococcus (puerperal) serum. She was restless that night, and on the morning of the thirty-eighth day she collapsed. She was orthopnoeic, but with stimulant treatment made a partial recovery; her temperature, however, was 107° F. She remained in a typhoid state until her death on the fortieth day. Towards the end the patient's urine was highly coloured with urates and loaded with albumin. Her temperature varied from 103° to 107° F., her pulse became uncountable, and her respiration rate varied from 45 to 75.

Post-mortem Findings.

On September 1st, 1928, a *post-mortem* examination was made. Apart from tumidity of the abdomen there were no external signs of disease.

Abdomen.—There were no signs of peritonitis, and the bowel, though considerably distended, was not ulcerated. The liver was enlarged, passively congested, and showed signs of cloudy swelling; there were no abscesses. The spleen was enlarged, congested, very friable, and free from abscesses; the Malpighian bodies were not visible. The kidneys were pale, the cells being in a condition of cloudy swelling; there were no signs of abscess formation. The uterus was well involuted, the mucous membrane being soft and friable, and slightly septic. The os was slightly patulous, and a recent blood clot was found in the body of the uterus. There was nothing else abnormal in the pelvis.

Lungs.—These were in a state of hypostatic congestion, and at both bases there were recent pleural adhesions to the diaphragm. There were no signs of infarct or abscess formation.

Heart.—The pericardium contained about 3 oz. of greenish fluid with some shreds of fibrin. On the anterior epicardiac surface

there was a serous patch about the size of a threepenny-piece. The heart weighed 7½ oz.; its muscles were rather pale and flabby. The left auricle and left ventricle were normal. The mitral valve showed signs of early endocarditis, with the formation of pink nodules on its ventricular surface. The aorta and coronary arteries were healthy, but the aortic valves showed signs of endocarditis. The papillary muscles of the right ventricle were friable and inflamed. There was (as shown in the photograph) a large suppurating blood clot, weighing 126 grains and measuring 6.3 by 2.2 cm., firmly attached to the anterior cusp of the tricuspid valve. The cusps of the tricuspid valve were greatly thickened and in a state of necrotic ulceration. The right auricle and the pulmonary valve were apparently healthy, but attached proximally to the left posterior cusp of the tricuspid valve, and passing through the pulmonary valve into the pulmonary artery was a thin, recent *ante-mortem* clot, 8 cm. long, and bifurcated at the distal end.

COMMENT.

The clot attached to the tricuspid valve was wedged in the valve ring, and we considered that it was probably acting as a ball valve and had been present for two or three weeks. Of special interest were the site of the chief cardiac lesion and, apart from the reduplicated first sound, the absence of abnormal signs. At no time did the patient complain of pelvic or cardiac pain, nor could any previous history of rheumatism or tonsillar or cardiac trouble be elicited.

We are indebted to Dr. T. E. Francis and Dr. D. H. Hubbs for permission to publish this case.