CASE II.

This patient, aged 14 years and 2 months, was admitted to the Royal Samaritan Hospital for Women on February 17th, 1929, under the care of Dr. John Gardner.

History.—Seven days before admission she complained of a low backache, which she ascribed to sitting on a high stool at piano practice. This continued slightly and intermittently until the evening before admission. She retired to bed at the usual hour, but was awakened at 2 a.m. with severe colicky pain in the lower abdomen. This continued almost continually throughout the night, but there was no sickness or vomiting. About 7 a.m. she complained of a strong desire to urinate, but passed only a small quantity of urine (amount unspecified). From that hour until admission to hospital at 6 p.m. on the same day there was marked vesical tenesmus and complete inability to micturate.

On examination the patient was found to be well nourished. She was obviously in great discomfort and the lower abdomen was markedly distended, the percussion note being dull to within an inch of the umbilicus. Twenty ounces of urine were withdrawn by catheter, and the patient immediately and spontaneously declared her great relief and comfort. There was no albumin or any abnormality in the urine. The temperature was 97.6° F. and the pulse rate 92. The ostium vaginae was occluded by a reddish bulging membrane, which showed a marked impulse on coughing. Rectal examination revealed a fairly firm mass, palpable through the anterior rectal wall. No tumour could be felt through the anterior abdominal wall, and there was only slight suprapubic tenderness. The case was diagnosed as simple haematocolpos.

Treatment.—The hymen was incised vertically, and each edge sutured to the adjacent skin. About five ounces of thick menstrual fluid escaped. No douching was employed, but daily swabbing of the vulva with mild antiseptics, and recovery was uneventful.

Comment.

The features of special interest in Case i are: (1) the unusually early age of the patient to have haematocolpos and haematometra—13 years 8½ months; (2) the predominant symptom that caused the girl to be sent to hospital—severe abdominal pain, probably caused by spasmodic contractions of the uterus; (3) marked epistaxis on the day before the onset of pain.

The feature of note in Case ii is undoubtedly the very acute retention of urine; and, of course, the absence of any previous monthly disturbance or premonitory symptom, except the slight backache of one week's duration.

I am much indebted to Mr. Hugh Donald for permission to publish Case i, and to Dr. Gardner for Case ii.

REFERENCES.

- ¹ Eden and Lockyer: *Gynaecology*, 1920, p. 175.
- ² Munro Kerr, Haig Ferguson, etc.: *Obstetrics and Gynaecology*, 1923, p. 611.
- ³ Ibid., p. 612.
- ⁴ De Sahn: *La Clin.*, November 18th, 1907.

A CASE OF ALEUKAEMIC LYMPHATIC LEUKAEMIA.

BY

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THE case here recorded revives the controversy as to the existence of really acute lymphatic leukaemia to which one of us, in conjunction with L. E. H. Whitby, refers in a paper, "Some difficulties in the diagnosis of leukaemia," published in the *Lancet* of June 18th, 1927 (p. 1279). The present patient was in good health until October 1st, 1928; the duration of her illness was six and a half weeks; cases of acute myeloblastic leukaemia, it is true, may terminate even more rapidly. The degree of haemorrhage no doubt largely controls the period of survival.

A single woman, aged 25, employed as a monotype operator, was first seen professionally in 1925. She was then found to be chlorotic. She took but little outdoor exercise, and was advised to play games and go walks. The adoption of this advice led to rapid improvement, and she enjoyed good health until the beginning of October, 1928. The conditions under which she worked were quite satisfactory, but she had always had a "delicate throat," was very sensitive to the smell of smoke, and could not tolerate gas fires. Her previous medical history revealed nothing of importance.

Present Illness.

On October 1st, 1928, she developed a "feverish chill" and was sent to bed; a week later the symptoms were chiefly gastric, and by October 15th she was up and about again. On October 22nd she was referred to a throat specialist on account of a complaint of foul-tasting discharge from the nose, but nothing was found in the nose, nasopharynx, or sinuses to account for her symptoms. On October 27th she developed what appeared to be a typical attack of rheumatism, the pains flying from joint to joint and yielding to sodium salicylate. On November 2nd she was seen on account of bleeding from the gums and the passage of tarry stools; no evidence of valvular disease of the heart was found. The haemorrhage continued, uninfluenced by calcium—by the mouth and intramuscularly—or haemoplastin.

On November 9th enlargement of the spleen was detected, and some discomfort was complained of in that region. Petechiae on the buttocks now appeared, and diarrhoea with dark stools and haematemesis occurred. Her condition rapidly deteriorated. She was admitted to the Cirencester Memorial Hospital on November 12th; from that time until her death, two days later, her temperature ranged between 100.6° and 103° F.

On November 13th a blood examination was made. The blood was extremely thin, and with the Dare haemoglobinometer the haemoglobin value was found to be about 9 per cent.; the red cells 1,050,000 per c.mm.; colour index 0.5; leucocytes 1,100 per c.mm. A differential count of 250 leucocytes gave:

	Per cent.
Polymorphonuclears	0.4
Neutrophile premyelocytes	2.4
Neutrophile metamyelocytes	2.4
Eosinophile myelocytes	0.4
Myeloblasts	1.6
Lymphocytes (mostly small forms)	84.4
Türk's cells	1.6
Lymphoblasts	6.0
Large mononuclears	0.0
Eosinophils	0.0
Unclassified	0.8
	100.0

No nucleated red cells were found. There was a moderate degree of anisocytosis and slight poikilocytosis. A few basophilic red cells were present. A film stained by Graham's oxidase method gave: oxidase granule containing leucocytes 8 per cent., non-granulars 92 per cent.—a finding which agrees closely with the differential count from a Leishman-stained film described above.

Post-mortem Examination.

At the necropsy on November 15th, twenty-one hours after death, small subcutaneous haemorrhages were noted on the left upper eyelid, on the buttocks, and one on the right thigh; rigor mortis was present. The body was not emaciated. Subcutaneous fat was fairly abundant and of normal colour. No enlarged superficial glands were detected. There was no excess of free fluid in the abdomen.

The spleen was enlarged, about 8 in. long, and of normal consistence. Malpighian bodies were visible; on section nothing noteworthy was found. There was much perisplenitis, but only slight thickening of the capsule. The liver was of normal size; on section it was greasy-looking and pale. The pancreas was normal, as also were the kidneys.

In the great omentum and in the portal fissure were a number of enlarged glands, mostly about the size of filberts; they were pale pinkish on section, and some showed haemorrhages. There were several small subperitoneal haemorrhages in the course of the intestinal tract, and two large ones, one extending over about two inches in the mid small intestine and another about the caecum.

There was slight excess of free fluid in the pericardial sac, yellow in colour; several petechial haemorrhages on the visceral pericardium. There were no valvular changes. The lungs were pale, with no adhesions; two or three subpleural petechiae were present. The marrow in the ribs appeared red.

Portions of the liver, spleen, a gland from the mesentery, and of a rib were fixed in Helly-Maximow fluid and sections stained by Ellermann's method, as described by Piney in *Recent Advances in Haematology*; other portions from the same sources were fixed in formal saline and stained by haematoxylin and eosin. The report on these was as follows.

Liver.—The portal canals are everywhere infiltrated with leucocytes which, in places, penetrate a little way into the outer parts of the lobules, some liver cells being cut off, as it were, by them. A similar invasion is seen in the deeper part of the capsule of Glisson. Some of the liver cells round the hepatic venules show vacuolation (fat globules, dissolved in dehydration).

Gland.—There is but little indication of lymph nodes and germ centres, lymphocytes being fairly evenly distributed throughout cortex and medulla, though they are somewhat denser under the capsule. Besides lymphocytes there are many larger rounded or oval cells with large round nuclei; some of these cells contain two or three nuclei. Some of the trabeculae are thickened, and the larger cells are, in places, disposed along the trabeculae.

Spleen.—Malpighian corpuscles small and inconspicuous; phagocytic cells scanty. No fibrosis. Lymphocytes everywhere abundant.

Rib.—The marrow consists mainly of lymphocytes, some larger cells (? myeloblasts) seen. Red blood cells not numerous.

We think that there can be no question of the correctness of the diagnosis of lymphatic leukaemia, though we can find no record of a case with such extreme leucopenia. The sections of the liver were typical of lymphatic leukaemia, those of lymphatic gland and spleen very suggestive of that condition. The sections of the rib were less successful and convincing.

We have to thank Dr. L. E. H. Whitby, M.C., for examining the sections and giving his opinion on them.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

CONCOMITANT CONVERGENT STRABISMUS: EPITOME OF TREATMENT.

SQUINT is a preventable defect. At about 3 years of age judicious use of a collapsible tube of atropine ointment permits predisposing refractive errors to be discovered and provides an effective mode of preventive treatment. The left eye tends to deviate more often than the right.

Unfortunately all children are not examined before they go to school. The amblyopia of an established squint concerns the brain rather than the eye, hence glasses are slow to cure it; an occluder of Chavasse's 6/60 glass is usually prescribed for the straighter eye until fusion training becomes worth while.

As a last resort a modified recession operation has yielded good results in 200 consecutive cases. With the aid of a miniature-eyed strabismus hook, made to my design in stainless steel (Weiss), the internal recti are ligated, detached from their insertions, and sutured to the tough outer layers of the sclera further back, as shown in the accompanying diagrams. The suture material is 000 twenty-day chromic catgut (Davis and Geck). Both eyes are covered for forty-eight hours, and the formerly fixing eye is kept covered for three weeks.

The organization of the Bradford School Medical Service ensures effective following up of the cases.

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ALOPECIA AREATA ASSOCIATED WITH FRONTAL SINUS DISEASE.

THE following case is of interest in view of the recent work of Wright,¹ who has shown that the theory of reflex irritation as a cause of alopecia areata is untenable and that it is unlikely that this disease is a trophoneurosis.

A healthy-looking man, aged 30, consulted me in January of this year on account of a patch of baldness the size of a penny situated in the left temporal region. He stated that the hair had begun to fall in October, 1928, but that the baldness was limited to this spot and that no other area had been involved.

On examination the condition was found to be alopecia areata and the patch corresponded, according to Jacquet,² with the site of maximum predilection for the disease. The patient stated that he had had much domestic trouble during the past year owing to the illness of his wife. In February, 1928, he had had severe pain in the right frontal region, which lasted for several days and then completely disappeared; further attacks had occurred in September, 1928, and January, 1929. On my advice the patient saw Mr. E. Watson-Williams, who reported that a skiagraphic

examination confirmed the diagnosis of right-sided frontal sinus disease. As the patient was unwilling to undergo an operation, the scalp was treated by local measures. At the beginning of April he had on one occasion a free discharge of pus from the right nostril. He has had no further symptoms of sinusitis since January, and when seen at the end of April hair was beginning to grow on the bald patch. No new areas of alopecia have developed.

It would be difficult to explain the relationship in this case between a right-sided frontal sinusitis and a left temporal patch of alopecia on the basis of reflex irritation, and we are therefore led to the conclusion that the focal infection *per se* was responsible for the disease.

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AN EXTRAORDINARY TUMOUR.

HAVING read the note on "an unusual tumour" by Dr. R. L. Paterson in the *British Medical Journal* of January 5th (p. 16), I have been reminded of a case of mine which was very much like the one there described.

A Pathan woman, aged about 50, came to me in August last with a large, pendulous, pear-shaped growth on the left side of her body. It started a little above the costal margin in a comparatively narrow skin pedicle, increasing in size from above downwards and reaching down to the middle of the thigh. The growth was lobulated and of soft consistency; there were multiple old scars over its dependent part, and some varicose veins over its surface. The growth had commenced twenty years previously, and apart from its objectionable bulk caused no great inconvenience.

The tumour was diagnosed as a lipoma, and was removed. The patient left the hospital on the ninth day after operation, well gratified with the result.

The accompanying photograph, taken just before the operation, illustrates the extent of the growth, and may be of interest.

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A CASE OF THREE-LOOP INGUINAL HERNIA.

CONSTITUTING as it does a trap for the uninitiated, I thought it well to publish the following case in order to impress juniors with the necessity, when operating on a hernia with a double loop of bowel in the scrotum, to bring down and examine the intervening abdominal loop, no matter how healthy the portions in the scrotum appear to be. I would also commend to juniors the method of dealing with a very doubtful loop by enveloping it in oiled gauze. It may not constitute brilliant surgery, but it enables a very rapid and efficient operation to be performed, even when the patient is critically ill, and has been used with success in cases where the patient was very old and very ill, and yet, although the loop went gangrenous, the patient recovered.

A labourer, aged 24, was admitted to the Eastern District Hospital, Glasgow, in December, suffering from a huge strangulated inguinal hernia of the right side. He stated that he had had this hernia as long as he could remember, and, although it grew gradually larger, he was always able to reduce it until the day of admission, when it suddenly became very much larger, painful, and irreducible.

At operation three loops of small intestine, probably ileum, were found, involving fully three feet of bowel in all. Two of these loops were only separated from one another by about six inches of bowel, but they again were separated from the third loop by an intra-abdominal portion about eighteen inches long. While the portions in the scrotum looked healthy, that which was withdrawn from the abdomen was black, and so much affected that its vitality appeared doubtful. The doubtful portion was therefore enveloped in oiled gauze, and the patient returned to bed. Two days later it was inspected, found to be recovering, and was returned to the abdomen, and the wound closed, but radical cure was not performed, as the patient's condition was still unsatisfactory. About six weeks later the scar was excised and the radical cure performed, the patient making an uneventful recovery.

So far as I am aware, Lauenstein of Hamburg was the first to draw attention to these double-loop, or W, herniae,

¹ Wright, C. S.: *Arch. of Derm. and Syph.*, 1929, p. 365.

² Jacquet: *Ann. de Derm. et Syph.*, 1902, p. 362.