CEREBRAL ABSCESS FOLLOWING ACUTE
TONSILLITIS.

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THE sequence indicated in the above title is sufficiently rare to make the following case worth recording. No reference could be found in the literature of the subject to a case of cerebral abscess secondary to throat conditions, although foci of sepsis in the lungs, cardiac valves, liver, and bones are mentioned as possible causes. Other remarkable features of this case were the patient's apparent complete recovery after an illness of six weeks' duration, in which he had for a period of a month shown unmistakable signs of an intracranial abscess, and then his comparatively sudden death.

A plumber, a healthy, well-built lad of 18, with no history of previous illness or ear trouble, was first seen on January 11th.

He had been out-of-sorts for several days, and complained of a sore throat. His temperature was 104° F., pulse 120, and respiration normal. The fauces on both sides were intensely injected, together with the posterior pharyngeal wall, which was covered with a muco-purulent exudate. No other physical abnormality could be found. His temperature remained as high for several days, with slight variations in the throat condition, and a good deal of general disturbance. On January 14th the temperature fell to 102°, and remained at this level for the following week, with a relatively slow pulse below 100. On the same day he commenced to have rigors once or twice daily until January 17th, when the tonsillitis began to localize as a peritonsillar swelling on the left side. On January 19th ptosis of the left eyelid and a left internal strabismus were noticed, associated with periods of "sleepiness," although the patient was quite rational when roused. He had some headache, aggravated by attacks of coughing coming on at hourly intervals, in which he expectorated a muco-purulent sputum. On January 18th he was given 1 c.cm. of "S.U.P." intramuscularly, and on January 20th a second injection of this and 25 c.cm. of polyvalent antistreptococcal serum, without obvious effect.

On January 21st he was seen in consultation with Dr. C. E. Lakin, who found rigidity of neck muscles, modified Kernig's sign, left knee-jerk absent, right just present, plantar reflex flexor, ptosis of left eyelid, internal strabismus of left eye, with much congestion of the retinal vessels on this side. The throat still showed some peritonsillar swelling on the left side, but Dr. Lakin detected no abnormality in the chest or abdomen, and suggested the presence either of a cerebral abscess or a basal meningitis. Removal to hospital was advised, but consent was refused.

During the following week the nervous symptoms varied. The ptosis became less noticeable, although the strabismus remained throughout. The neck rigidity continued, with a doubtful Kernig's sign. On January 23rd and 24th all reflexes, except the superficial abdominal, could be obtained. At times the patient seemed sleepy, but he was bright mentally, and his fever continued in the region of 101°, and his pulse rate from 60 to 90 per minute.

On January 25th scattered dry rhonci were found on both sides of the chest, with moist crepitations at both bases, associated with a purulent sputum which, on examination, was found to contain pneumococci, *B. influenzae*, and staphylococci. The cough, which still only occurred infrequently, continued for several weeks, and then entirely ceased.

Nothing further of note happened until the morning of February 2nd, when at 6 o'clock, following an hour's incoherent speech, the patient commenced to have fits. They began by a deviation of the head and eyes to the right, with marked lateral nystagmus and hippus of both eyes. Then followed a clonic convulsion, originating in the right side of the face and spreading to the neck and jaw muscles. Between 6 and 9 a.m. fifteen occurred, and in the more severe ones the convulsion spread to the right and left arms and involved the entire musculature. The knee-jerks remained present, and an ankle clonus was obtained on the right side. No further fits took place, and the next day he was conscious, but at times was "muddled" in his speech. On

February 4th he was very delirious, but by February 8th he was comatose, and rolled his head continually from side to side. The temperature was now subnormal, and the pulse rate varied from 54 to 90 per minute. He had become very emaciated.

He was still unconscious on February 9th, when he was seen with me by Dr. D. G. Leys. He found a bilateral ankle clonus, but could obtain no reliable evidence from the reflexes to point to a unilateral cerebral lesion, nor any definite optic neuritis in either eye, but suggested that exploration of the brain was worth considering after further investigation in hospital. Unfortunately no permission for the patient's removal to hospital could be obtained.

From February 10th to 16th the patient remained in a semi-comatose condition, and nutrition was only kept up by rectal feeds of 5 per cent. glucose. Death seemed the only possible issue, but on February 16th he regained consciousness, began to take nourishment, and by February 18th seemed quite normal mentally, although a little excited. The following day an abscess, which had gradually formed on the back, at the site of the serum injection, was opened, and a greenish-yellow pus was evacuated. By February 25th he seemed well in every way, was eating solid food, sleeping well, putting on weight, and normal

mentally; he was allowed up for half an hour, with daily increments.

It looked as if our interpretation of his cerebral symptoms had been at fault, and that the abscess on his back had acted as a fixation abscess and brought about a cure, for his improvement was uninterrupted until March 11th. During the morning of this day he was getting about the house, but at midday he seemed sleepy, and at 4 p.m. he became unconscious, and remained so until his end was brought about at 6.30 the next morning, by what was clinically an acute oedema of the lungs.

A post-mortem examination, confined to the brain, performed with the help of Dr. Allen Piggot, revealed an abscess about the size of a walnut in the tip of the left temporo-sphenoidal lobe, with some adhesions between the surrounding pia mater and dura. There was no sign of bone infection in the skull.

It may be pointed out that the cerebral symptoms had already appeared before any abnormality could be detected in the lungs, so that it is probable the cerebral abscess was a direct complication of the acute tonsillitis.

Any incompleteness in these notes is due to the fact that they were gathered in general practice, and that, owing to the refusal of the patient's parents to agree to his removal to hospital, the clinical observations and partial post-mortem examination had to be carried out in a small artisan dwelling.

My thanks are due to Drs. C. E. Lakin, D. G. Leys, and Allen Piggot for permission to associate their names with this case.

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

A CASE OF PHYSOPYOMETRA WITH PERITONITIC
ABSCESS.

MOST of the reported cases of physometra (gas in the uterine cavity) have been associated with septic abortions or other complications of the puerperium. In such cases the symptoms are usually very grave and the issue fatal. The organisms concerned are frequently *B. welchii*, anaerobic streptococci, and *B. coli*. Chronic pyometra is a condition more common, and occurs where retained uterine secretions have become infected, as in senile and tuberculous endometritis, malignant disease of the body or cervix, and suppurating fibromyomata.

History of Case.

The patient, a woman aged 65, was admitted, on January 6th of this year, complaining of offensive vaginal discharge and haemorrhage. She was married, and had two children, aged respectively 29 and 24. She had ten or twelve miscarriages before the birth of her first child.