ment, which did not involve manual labour, with intervals of rest until the early part of 1892, when he caught a violent cold and cough, which was followed by shooting pains in the neck and left arm, and a rapid bulging of the aneurysm at the site of the episternal notch. Since his discharge he had had no medical treatment. He was admitted again in May of that year, the tumour being then of the size of a tangerine orange. The pupils and pulses were equal on the two sides, and the vocal cords wanting in tension, though not paralysed. The temperature became elevated, and the patient dyspnoic and dysphagic, so that his condition was regarded as "imminently serious." The iodide treatment was resumed, with the result that the pressure symptoms gradually became less marked, and in three weeks the man was able to take solid food. The prominence at the episternal notch decreased, and after two months rest in bed the patient was allowed up, and a little later discharged. He continued under the care of Dr. T. T. Whipham until February, 1895, when he had an attack of pleurisy and pneumonia, and was laid up in the hospital for a period of six months. From this time the aneurysm became markedly worse.

In February, 1897, he returned, having been at work on and off, and was admitted under Dr. Isambard Owen with an increase in the size of the tumour especially on the right, where it projected for $2\frac{1}{2}$ inches from the normal level of the chest wall. After five months rest he was again discharged improved, and continued at work till the beginning of 1899. In August of that year a swelling as large as a hen's egg appeared in the course of a week on the left of the original tumour. The skin became discoloured, but the protuberance disappeared as rapidly as it came, leaving two leaking areas. In the following month he was again taken in, the prominence on the right being then $1\frac{1}{2}$ inch high, while from the other side there oozed a thin watery discharge. There was still no *bruit* to be heard over the aneurysm, and there were no pressure symptoms beyond slight stridor and a brassy cough. The discharge soon ceased and the patient was sent home after a month.

He was admitted for the last time in February, 1901, the aneurysm having increased during the previous year to the size of a man's closed fist, and presenting three lateral projections. The centre of these was the most prominent, and the skin over it was tense and shiny. Between the middle prominence and that on the left was a small ulcerated surface where pulsation was marked, and from which there oozed a small quantity of blood. Anginal pain had been severe, but not so marked as in 1886, and pressure as shown by the voice, cough, and dyspnoea was more in evidence though no difference in the pulses could be detected. Venesection relieved the symptoms to some extent, and potassium iodide and calcium chloride were given internally. The temperature soon became irregular and the patient had much pain in the neck, possibly caused by ulceration, for occasional hæmoptysis took place. After a month the temperature subsided to normal; the aneurysm became more conical in shape, and the leakage of blood, which had ceased, recommenced. The superficial ulceration gradually extended though without pyrexia until April 8th. On the following day the patient had a rigor, and sixty hours later a large conical mass of laminated fibrin, the whole of the superficial part of the aneurysm, became detached leaving a considerable cavity in the chest in which no definite pulsation could be seen. There was only slight leakage, and the patient continued fairly comfortable with the exception of pain for another nine days. The aneurysm then suddenly burst externally, and the man died in about a quarter of an hour.

At the necropsy the whole of the ascending and transverse portions of the arch were found to be greatly dilated and very atheromatous. From the upper and anterior aspects of the arch there arose a sacculated aneurysm as large as a cocoanut, three parts full of laminated clot, which passed forwards and communicated with the exterior. The trachea was eroded about three-quarters of an inch above its bifurcation, and the lungs showed signs of bronchitis. The heart was slightly dilated, but not obviously hypertrophied, the aortic valves alone being a little thickened. There was no evidence of pressure on any part of the neighbouring structures, and nothing worthy of note in the other thoracic or abdominal viscera.

The remarkable points about the case are (1) the length of time during which the patient was known to have had an aneurysm. For full fifteen years he was kept under observation, and during the whole of that time he had a large external tumour, though the aneurysm had evidently been forming a year, and perhaps more than a year before that. The longest recorded case that I know of is one mentioned by Sir W. Gairdner, which was known to have existed for twelve years, and that under circumstances entailing considerable cardiac strain; (2) the frequent and at times rapid variation in the size of the aneurysm, which on several occasions seemed likely to cause an abrupt termination to the patient's life; (3) the marked benefit which accrued from prolonged periods of complete rest and treatment, both medicinal and dietetic; (4) the recovery from an intercurrent attack of pleurisy and pneumonia; (5) the fact that the entire external portion of the aneurysm sloughed and came away, after which the patient lived for nearly nine days; (6) the termination by rupture externally, which is by no means a common cause of death in these cases, even though such a contingency may appear imminent.

It is only fair to the patient to state that he was a very sensible man and realised the gravity of his condition. He bore his periods of enforced rest cheerfully, and voluntarily restricted his diet both in the hospital and out, the amount of fluid ingested being left largely to his own discretion. To the extension of the aneurysm in a forward instead of a backward direction must be attributed of course in great measure the possibility of such prolongation of life as occurred in the present instance.

REFERENCE.

¹ Allbutt's *System of Medicine*, vol. vi.

A CASE OF ULCERATIVE ENDOCARDITIS, WITH RECOVERY.

BY
H. E. WHITEHEAD, and H. W. SYERS,
M.R.C.S., L.R.C.P. M.A., M.D. Cantab.

It is always satisfactory to be able to report the details of a case in which the symptoms were such as to render it certain that the malady was of a very serious nature, and yet recovery has ensued. And when the disease is one that is admittedly almost invariably fatal, either during the acute stage or shortly afterwards, it is of special importance that a case of recovery be put on record. For when recovery follows, it leads to some modification of our views as to the invariable outcome of the malady, and at the same time causes us to reflect as to the possibility of the happy result being due in any degree to the treatment, either generally or by drugs.

The following case was one of undoubted malignant endocarditis, and the account of the clinical features of the malady is as given below:

The patient, a man aged 35, had always been in good health, and was a total abstainer.

On October 22nd, 1900, he complained of earache, and was treated for this. He was up and about as usual, but on the 25th he suffered from attacks of shivering, and at the same time it was noticed that his urine was dark and thick.

He was seen on October 29th, being then in bed. The urine was of a dark mahogany colour, and contained a granular detritus, but no complete blood corpuscles. The temperature was now 103° , and a distinct systolic murmur was audible over the aortic area. He remained in much the same condition until November 3rd, when marked rigors set in, and the urine became even darker than before.

On November 5th the right parotid gland was observed to be slightly swollen. There was no tenderness over the mastoid region. The *bruit* in the aortic area was now more distinct, but the discoloration of the urine was somewhat less marked. From this time onwards the temperature presented the most characteristic features of septicæmia, very marked evening ascents being followed by extreme falls the following morning. Thus on two occasions an evening rise to 105° was registered, and the next morning the temperature was 97° and 96.2° respectively.

On November 8th his condition was very unsatisfactory; the afternoon temperature was 103.2° , the right parotid region was the seat of a prominent and tender swelling, and there was evidence of œdema of both lung bases, the crepitation being most marked on the left side. The temperature now began to show very marked daily excursions, and the feebleness of pulse and general debility became very severe. On November 12th the size of the parotid swelling diminished somewhat, and a discharge from the mouth, purulent in character, was noticed. From this time onwards the parotid inflammation gave no further trouble, but the general condition of the patient was in no respect more satisfactory at this date. On the contrary, he was distinctly weaker, and lying lower in the bed.

On November 22nd there was marked dulness over the left lung base no doubt due to the presence of pleural effusion. At this time, the pulse was still weaker, and the outlook seemed as bad as possible. The highest temperature recorded on December 5th was 103.4°, and on the 8th it attained 104°. On December 6th it was noticed that the breath had become very offensive, as was also the expectoration, which was thin and muco-purulent. There was loud friction sound in the precordial region, apparently pleuro-pericardial, and at the angle of the left scapula there were some signs of lung destruction over a small area.

During the whole illness, but especially during the last ten days, the patient had been most carefully fed with easily assimilable aliments, and had been freely stimulated with brandy and champagne, but in spite of all that could be done, he appeared to be in a practically hopeless condition.

But from December 18th a distinct improvement was noticeable, the expectoration ceased somewhat suddenly on December 29th, and did not return. His temperature fell and remained normal from January 6th, 1901, and on the 24th of the month he was able to leave London for the seaside. On examination before leaving it was found that there was a loud systolic murmur in the aortic area and dulness and diminished entry of air over the left base.

The treatment adopted was that by salines, quinine, strychnine, and iron, until December 4th. On this day he was ordered sodium sulphocarbolate in 15-grain doses every four hours, and this drug was continued until he became convalescent.

A study of the history of the case and a reference to the course of the temperature render it certain that this patient was the victim of that form of septicaemia which is known as ulcerative (or malignant) endocarditis. Our experience of this disease, in common with that of most observers, is that it is practically almost fatal. Certainly at several stages of the malady it seemed impossible that this patient could recover. That the careful nursing, feeding, and use of stimulants had much to do with the result is, of course, not to be denied, but it is a question if the treatment by drugs had not some influence in this direction. We refer, of course, to the action of sodium sulphocarbolate which was ordered in frequently repeated doses when the patient was at his very worst. It is worthy of notice that not long after the administration of this drug was commenced the patient began to amend, but, of course, to assume that the improvement was the result of the action of the drug would be rash in the extreme.

Nevertheless, it is upon evidence such as this that by far the larger superstructure of therapeutics is founded. Cases have been reported, too, in which the use of antistreptococcus serum in septicaemia has been followed by recovery, and the result claimed as decisive for the virtues of the treatment. We would point out that had the serum been used in this case such a claim would have been equally justified, and yet what a mistake would have been made!

On the whole this case would seem to be more correctly described as one of the extremely rare instances in which this most fatal disease, malignant endocarditis, spontaneously recovered. Without, however, attaching undue importance to the treatment by sodium sulphocarbolate the coincidence, if it be only a coincidence, is worthy of notice, and would certainly emphasise the advisability of the drug being ordered in a similar case.

REMARKS ON A CASE OF INFANTILE SCURVY.*

By JOHN McCRAW, M.D., L.R.C.P.,

Senior Physician, Belfast Hospital for Sick Children.

INFANTILE scurvy or scurvy rickets presents such well marked signs and symptoms in the majority of cases that little difficulty is, as a rule, experienced in correctly diagnosing the affection. I have, however, recently seen an example of this disease in which the classical symptoms were all but absent, and an opinion had to be given based upon the presence of one symptom supported by the history of the case.

I was asked to see Baby McG., aged 10 months, on April 3rd, 1901, in consultation with the regular medical attendant of the family.

History.

The child had been in his usual good health until a week previously at which time he became ill with what was considered to be a mild gastric attack: the temperature never exceeded 101.5° F. The pulse was good and about 100, and the bowels were inclined to be relaxed. However, a short time before I was called in he vomited a considerable quantity of blood, and this was followed almost immediately by a copious, loose motion, which was undoubtedly largely composed of altered blood.

On examination there was evidence of loss of blood, but I was struck with the strength of the pulse and of the apex beat. I learned on inquiry that the child had been fed from birth upon condensed milk, and later upon a proprietary food and oat flour: that it had never been given any fresh milk or other food of an antiscorbutic kind whatever.

* Read before the Society for the Study of Disease in Children.

Treatment.

Infantile scurvy was diagnosed and the treatment modified to meet that condition as follows: One teaspoonful of orange juice to be given every two hours, to have whey and cream at frequent intervals and in small quantities, with one teaspoonful of raw meat juice every four hours. I advised the application of the icebag to the epigastrium for half an hour, the effect to be carefully watched. I saw this child again the following day: he had passed a good night and was much better in every respect. The orange juice was taken with avidity, and the nutrients mentioned were taken and retained, his temperature was 100.2° F., pulse 98 and stronger, no more vomiting had occurred, but one loose motion had been passed which contained altered blood. Eight days afterwards I was asked to see the case again, and it is hardly too much to say that I saw a different child—so marked and striking was the change for the better in every respect. I now advised that he should have a mixture of arsenic and iron (Fowler's solution and vin. ferri cit.) in suitable doses, as well as a small quantity of scraped potato or other fresh vegetable in his soup, and further that he should be taken to the seaside. He made a satisfactory recovery.

Remarks.

I think this case is noteworthy for the absence of the more prominent symptoms usually seen in scurvy rickets: no periosteal swelling could be found anywhere at any time though carefully looked for, the gums were quite normal in every respect and two upper and two lower central incisor teeth appeared healthy, there was no proptosis of either eye nor was there any ecchymosis or oedema of either eyelid.

Subcutaneous hæmorrhages never took place, not even petechial spots on the trunk or lower extremities, nor were any bruise-like marks ever seen. The child never made any complaint or evidenced any pain on being handled or lifted, and, with the exception of a slight beading of the ribs, the distinctive signs of rickets were entirely absent. Up to the onset of his illness this child was looked upon as a healthy, vigorous specimen of his age, and though he was anæmic-looking it could not be said that he was fat or flabby or full-tissued. His is another instance of scurvy occurring in a child fed on condensed milk and patent food, and he further exemplifies the curious point that the disease is met with chiefly amongst the children of the better classes, indeed to put it in another way, it would scarcely be too much to say that he was starving in the midst of plenty.

CONTRACT PRACTICE AND ITS DIFFICULTIES.*

By ARTHUR E. LARKING, M.D.,

Folkestone.

LET me at once set your minds at rest, and assure you that I am not going fully into the question of contract practice. If I were to do so, I should open up such a huge subject that no practical good would come of it; also that I am not going into the question of so-called Medical Aid Societies in which the services of a medical man are farmed out by a lay committee. We all agree as to putting a stop to this. I propose to deal mainly with so-called club practice, and incidentally to touch upon parish appointments and other work done by contract.

"CLUB PRACTICE."

My main object in bringing this matter before you is because it is a question that the British Medical Association will sooner or later have to face. Already negotiations are in progress to form a so-called "Conciliation Board," composed of representatives of our profession and also of the Friendly Societies. Communications have taken place, and all got on fairly well, until the question of a wage limit was broached. Then the Friendly Societies would go no further; they will not hear of such a thing, and thus the matter rests.

There is no doubt whatever that the medical profession of the present day looks upon clubs as a sort of necessary evil. Everyone who has held a club appointment knows it does not repay him pecuniarily for the trouble he gets, and yet he does not quite see his way to giving up clubs. Yet there are numerous instances in which medical men have determined to do without clubs, and have found out afterwards that their fears were groundless, and that they earned just as much money and did about half as much work as beforehand!

Let me give my personal experiences. I practised for nine years in a country town and district of about 9,000 inhabitants. I commenced *de novo*, and at first had no patients at all. Then one came and then another (mostly people who

* Read before the East Kent District of the South-Eastern Branch of the British Medical Association.