A CASE OF THROMBO-PHLEBITIS MIGRANS

BY

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Since Moorhead and Abrahamson¹ in 1928 published four cases under the title of thrombo-phlebitis migrans, and Ryle² in 1930 brought before the Association of Physicians the notes of five cases (which were subsequently published), it is probable that typical examples of this condition are being generally recognized. The etiology, however, is obscure; so that the notes of another patient with recurrent thrombo-phlebitis may be worth recording.

Ryle points out that the phlebitis usually appears in small lengths of superficial peripheral veins and frequently in the lungs and abdomen; more rarely the heart or the brain is involved. The disease runs a tedious course, with fever accompanying each fresh development; but the prognosis is favourable. There is no difficulty in the diagnosis of a typical example, but a visceral attack occurring alone may be obscure. Blood culture has proved negative, but it would seem probable that some focal sepsis is the most likely cause, and, if found, should be dealt with when a particular attack has subsided. Ellison³ has recently described two cases following mild scarlet fever, which are of considerable interest, as they suggest a streptococcal origin.

HISTORY OF CASE

A married woman, aged 37, was sent by Dr. Wills of Darley Dale to the Derbyshire Royal Infirmary on September 28th, 1931, for phlebitis of the right arm. She is the mother of two healthy children, the younger 7 years old. There had been no serious illness until two years ago; but for about ten years she has frequently had small ulcers in the mouth and in the vagina, which have improved lately. Two years ago she was in a cottage hospital for six weeks with a headache; the pain was severe, and felt as if it was in the bones of the skull, all over the head, and her doctor says she was semi-comatose for several days. She recovered gradually, but since this attack has always been tired and depressed. In February, 1931, a sharp pain developed in the back, coming through to the abdomen, which was tender. Soon afterwards phlebitis developed in the back of the right thigh, and then in the left; on April 15th, 1931, she entered the Darley Dale Hospital under Dr. Wills for this phlebitis, with intermittent pyrexia up to 100° to 101° F., which lasted several weeks. The swelling of the legs gradually subsided, and she returned to her duties, but in the middle of September the right arm began to swell, and she was admitted to the Derbyshire Royal Infirmary on September 28th.

Examination.—General condition good. The right upper arm was swollen, tender, discoloured, and about 2 inches more in circumference than the left; but the hand and forearm were not swollen. The temperature was normal; but three days later the tenderness and swelling extended up the right side of the neck over the external jugular vein, and the temperature rose to 101°, and was remittent for about ten days, after which the swelling and redness subsided, having been present for three or four weeks altogether from the history of onset.

The following tests were carried out during the pyrexial stage. Blood Wassermann reaction, negative. Blood culture, negative. Blood count—haemoglobin, 110 per cent.; red blood corpuscles 5,760,000 per c.mm.; white blood corpuscles, 11,200 per c.mm. Neutrophils, 61 per cent.; lymphocytes, 31 per cent.; mononuclears, 5 per cent.; eosinophils, 1 per cent.; basophils, 2 per cent.; blood platelets, 250,000 per c.mm. Bleeding time was one and a half minutes. Coagulation time was three and a half minutes. Blood calcium—12 mg. per cent. Fractional test meal: normal acidity and emptying time, but mucus in first four specimens.

Examinations for focal sepsis (undertaken during convalescence) showed that the mouth was clean; there had been only one small ulcer during her stay in hospital. There was no pyorrhoea, and radiological examination of the teeth

revealed no apical sepsis. X-ray examination of the nasal sinuses showed nothing abnormal, and Mr. R. L. Flett reported that the nose and throat were healthy. Mr. N. L. Edwards found a small septic erosion on the cervix uteri, which he cauterized. No ulcers were present in the vagina (of which the patient had given a history). She was discharged from hospital on November 13th, 1931, having made a complete recovery, at any rate for the time being.

SUMMARY

The case here recorded presents the following features: (1) prostration and headache with pyrexia lasting several weeks, suggesting venous cerebral thrombosis, in 1929; (2) abdominal pain and tenderness immediately preceding the phlebitis in the legs; (3) thrombo-phlebitis first at the back of one thigh and then the other in March and April, 1931; and (4) thrombo-phlebitis of the right upper arm and neck in September and October, 1931.

If some septic focus is the explanation of the attacks of phlebitis, the only possible source would appear to be an erosion on the cervix uteri.

REFERENCES

- ¹ Moorhead, T. G., and Abrahamson, L.: *British Medical Journal*, 1928, i, 586.
- ² Ryle, J. A.: *Lancet*, 1930, ii, 731.
- ³ Ellison, J. B.: *Brit. Journ. Child. Dis.*, July-September, 1931, 207.

TREATMENT OF ERYSIPELAS BY INJECTIONS OF MILK

BY

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Subcutaneous or intramuscular injections of milk are known to produce a general reaction. They are thought to have considerable anti-infective value, and have been used in certain skin affections. It seemed possible, therefore, that intradermal injections of milk near the site of infection in erysipelas, by producing a local reaction, might set up a line of defence, forming a barrier to the further spread of the inflammation. They were tried in thirteen patients. In most cases a spreading and a receding margin was found, the distribution being usually most rapid in the direction of the lymphatic supply. In some cases the spread was general.

METHOD

The value of the method of treatment is based on the results of ten cases of erysipelas on parts of the body other than the head, and on three cases of erysipelas of the face. Details of these cases are given below. Fresh milk is kept at boiling point for four minutes. It is then cooled to body temperature and strained through sterilized gauze. From 5 to 15 c.cm. is injected as far as possible intradermally, the remainder subcutaneously. A long fine needle is introduced, parallel with, and about 1½ inches from, the spreading margin, the milk being injected at intervals along the line. If successful, the skin round the site of the injection is blanched, hyperaemia following in about five minutes.

The spreading margin is first found by marking the skin round the affected area, and examining two to four hours later. Injection at the receding edge is unnecessary. In erysipelas of the face intradermal injection is impracticable; it is replaced by intramuscular injections with a view to the production of a general reaction.

In nine of the first ten cases the infection did not spread beyond the line of intradermal injection. In one (Case 5), in which one injection was subcutaneous, the infection spread about 2 inches beyond that site of injection.