A CASE OF THROMBO-PHLEBITIS MIGRANS

BY

HUGH BARBER, M.D., M.R.C.P.

PHYSICIAN, DERBYSHIRE ROYAL INFIRMARY

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

IBRAHIM ABD EL SAYED

GRADUATE OF THE FACULTY OF MEDICINE, CAIRO

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.

CLINICAL CASES

Case 1.—A patient with erysipelas of the thigh and buttock was injected intradermally and subcutaneously with milk on April 25th, 1931, $1\frac{1}{2}$ inches below the lower margin. On the following morning there was no spread downwards near the site of the injection, but the upper margin infection was spreading equally all round; at 10 p.m. it was still spreading upwards; on the morning of April 27th there was intradermal injection along the centre of the upper margin. Next day there was no spread along the line at which the injection was made, but the infection had extended in the form of a horn on either side. The temperature returned to normal on the same day.

Case 2.—A patient with erysipelas of the right arm had received omnadine and anti-streptococcal serum for three days without benefit. On the fourth day an injection (intradermal and subcutaneous) of milk was made at the distal margin. Next day the temperature was normal, and the infection had subsided.

Case 3.—A patient with erysipelas on the inner side of the left elbow (temperature 103.7° F.) was cured in one day by a milk injection at the proximal margin.

Case 4.—To a patient with erysipelas of the left leg was given one injection (intradermal) of 8 c.cm. of milk. No spread at the site of injection ensued, but there was some spread on the mesial aspect. The next day the patient was cured.

Case 5.—Erysipelas of the left leg and thigh was treated by an intradermal injection of milk at the upper margin and by a subcutaneous injection at the lower margin. There was no spread at the former site, but there was a spread for 2 inches below the latter.

Case 6.—A patient with erysipelas of the left leg received an intradermal injection on the inner side of the leg. Spread ceased in that area, but continued in front and on the outer side to 1 inch above the knee, where the infection stopped.

Case 7.—Erysipelas of the left leg and thigh was treated by an intradermal injection on the inner side. There was no extension of erysipelas in that region, the infection spreading only on the front of the thigh. An injection along the upper margin on the front of the thigh was given three days later; there was no further spread, and the condition cleared up.

Case 8.—The patient had erysipelas of the left thigh and buttock. An intradermal injection was made at the upper and outer margin. No further extension ensued at the line of injection, but there was spread on either side. The condition cleared up in two days, the vesicles drying up.

Case 9.—A patient with erysipelas of the breast, which rapidly extended to the back, was treated with anti-streptococcal serum and omnadine for five days without any benefit. The general condition became bad and there was toxæmia. Milk was then injected at the margin of the left loin. Further spread in that region ceased, but the disease progressed into the right buttock. Three days later milk was injected at the lower margin on the right buttock. There was no further spread of the infection, and the temperature fell, oscillating for some days. The urine was normal, and a blood culture was found to be sterile. An abscess which had formed at the site of one of the injections was opened, after which the temperature became normal.

Case 10.—An injection of 10 c.cm. of milk was made along the upper margin of an erysipelatous patch on the mesial aspect of the left leg. On the following day no extension was found in that region, but the infection had spread on the anterior, external, and posterior aspects. Two days later milk was injected on the antero-lateral aspect of the left thigh. The infection ceased along the site of the injection, but spread on either side for about 8 inches. The condition then cleared up.

The following cases of facial erysipelas were treated by intramuscular injections.

Case 11.—The patient was treated with serum and omnadine for five days without beneficial result. An intramuscular injection of 10 c.cm. of milk was then given. On the following day the condition had cleared up.

Case 12.—Erysipelas affected the nose only. An intramuscular injection of 10 c.cm. was given; there was no spread, and the condition cleared up.

Case 13.—Nearly half the face was affected by erysipelas. An intramuscular injection of 5 c.cm. of milk was given on the first day, and 10 c.cm. on the second; these injections cleared up the condition, no further spread taking place.

CONCLUSIONS

1. Intradermal injections of sterile milk made parallel with the spreading margin in erysipelas produce a local reaction, which prevents further extension of the infection at the site of injection, and improves the condition elsewhere.

2. The intramuscular injection of milk in facial erysipelas sets up general reaction which is curative of the condition.

I wish to express my thanks to Dr. Garas Bey for access to his section for the purpose of these observations, and to Professor A. K. Henry for his advice.

CHOREA IN THREE CHILDREN OCCUPYING
SAME BEDROOM

BY

R. G. WALLER, M.R.C.S., L.R.C.P.

WANDER SCHOLAR AND REGISTRAR TO THE CHILDREN'S DEPARTMENT,
WESTMINSTER HOSPITAL

The following cases of chorea occurring in three children occupying the same bedroom are put on record as tending to support the contention of Paterson and Horn¹ that rheumatism may be contagious under overcrowded conditions.

CASE I

A girl, aged 16 years, sister of Cases II and III, was, at the age of 11 years, in April, 1926, admitted as an in-patient to Westminster Hospital with rheumatic fever, with a past history of sore throats and growing pains. The tonsils and tonsillar glands were found to be enlarged. Mitral regurgitation was present. After seven weeks in the ward the tonsils were enucleated, and a few days later, in June, the patient was discharged much improved. In July she was seen again as an out-patient, and was found to be suffering from chorea, for which she remained under treatment until October, since when she has not been seen at the hospital. She has always slept in the same bedroom with her two younger sisters (Cases II and III).

CASE II

A girl, aged 9 years, was, at the age of 6 years and 8 months, in September, 1929, admitted as an in-patient to Westminster Hospital with an attack of typical chorea, which had commenced eight days before admission. No past history of sore throats or growing pains was elicited. The tonsils and tonsillar glands were enlarged. Numerous carious teeth were present. There was no cardiac involvement. One month after admission the tonsils were enucleated; the carious teeth were also removed during the child's stay in hospital. In October, the child was discharged after five weeks in the ward, but was readmitted as an in-patient fourteen days later (November) with recurrence of choreic movements. On this occasion she remained in the ward for six weeks, during which time no cardiac abnormality was observed. She was much improved at the time of discharge in December, 1929. She continued to attend the hospital as an out-patient, and was free from signs of chorea until March, 1931, when choreic movements recurred and she was sent to a convalescent home. Seen again at the beginning of October, she was free from signs of chorea, but at the beginning of November there was a further recurrence of choreic movements, for which the patient is now under treatment (November, 1931).

CASE III

A girl, aged 6 years and 8 months, was, at the age of 5 years and 10 months, in June, 1931, admitted as an in-patient to Westminster Hospital with an attack of typical chorea, which had commenced seven days before admission. No past history of sore throats or growing pains was elicited. The tonsils were enlarged, as also were the tonsillar glands; numerous septic teeth were present. There was no cardiac