SUPPURATING GONOCOCCAL EPIDIDYMITIS.

REPORTS OF THREE CASES.

BY

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THESE three cases of suppurating gonococcal epididymitis are recorded on account of the rarity of the condition. They are taken from a total of 1,982 new cases seen in the past seven years. Many of the modern textbooks, such as Thompson's¹ and Luys's,² do not mention it as a complication; Reith Fraser³ states that in a purely gonococcal infection there is never suppuration. Harrison⁴ mentions it, but states, as is borne out by the experience in this clinic, that it very rarely results in abscess formation. It is, however, a possibility that should not be altogether forgotten.

CASE I.

A seaman, single, aged 25, first attended the clinic on July 17th, 1919. He had had a urethral discharge (in which gonococci were found) for about a fortnight, and a primary sore. He received the usual treatment for each condition, and went away to sea a few days later, where he kept up the irrigation. He returned in about a month, and attending at the syphilis sessions had no special treatment for the gonorrhoea, which gave him no trouble until September 25th, when he was found to have an acute epididymitis of the right side and a slight discharge containing gonococci. He was admitted to hospital, and an abscess in the epididymis burst during the night. A smear of the pus from this showed numerous gonococci and no other organisms. The abscess cavity was lightly scraped and sewn up; by October 14th it was quite healed, and there was no discharge. He went out of hospital, but did not attend the clinic again.

CASE II.

A club steward, married, aged 28, first attended on November 21st, 1924. He had had a urethral discharge for a month, which he was treating by syringing with Condy's fluid. Numerous gonococci were present in a slightly purulent discharge; the first urine was hazy, the second clear, and there was a non-tender thickening of the left epididymis. He was shown how to irrigate, and given a mixture of potassium iodide, but did not attend again until January 18th, 1925. He stated that he had kept up the irrigation for a few weeks, and then, as the discharge had ceased, gave it up; it had now appeared again. There was no discharge, but the first and second urines contained many threads and the left epididymis was enlarged and tender. He attended regularly, but on February 9th the swelling burst. He was admitted, and next day the opening was enlarged and lightly scraped. Scrapings were examined by the pathologist, who reported no evidence of tuberculosis in the sections, nor the presence of any of the ordinary pyogenic micrococci, but that some of the cells seemed to contain Gram-negative ovoid bodies strongly suggestive of the gonococcus. On February 25th he was seen by the tuberculosis physician and tested with tuberculin. The reaction was quite negative. The wound soon healed, and he went out of hospital, continuing to attend the clinic for vaccines, etc. On March 12th there was no discharge; the urine was clear, containing a few threads only, in which were no gonococci or other organisms, and only a few epithelial cells. He did not attend for his final test for cure.

CASE III.

A labourer, aged 24, single, first attended on July 17th, 1925. He had had a discharge for three days, following exposure eleven days earlier. Gonococci were present in the discharge; the first and second urines were hazy, with threads. He was shown how to irrigate and given a vaccine, but attended somewhat irregularly until August 17th, when a right epididymitis developed. He improved under treatment, but on September 10th gonococci were still present in the urine obtained after massage of the prostate. On September 28th the urine was clear, and there was some non-tender thickening of the epididymis only. On October 22nd he attended with a single small discharging sinus from the adherent lower pole of the epididymis. The cord was definitely thickened without beading; the prostate was not enlarged, nor were the vesicles thickened. A smear of the pus showed gonococci and no other organisms. He was admitted and the sinus scraped. It was soundly healed by November 17th. On November 23rd he was examined by the tuberculosis physician, who reported no signs in his chest and that a test reaction of tuberculin failed to elicit any reaction at all. On November 24th the urine was clear, and a specimen after prostatic massage showed no gonococci or pus cells. On December 28th there was a similar result after passage of an acorn bougie as well, there being only a very slight thickening of the epididymis.

As Kenneth Walker⁵ points out, it is by no means always an easy matter to distinguish between the various forms of epididymitis. It is, of course, important that a gonococcal epididymitis should not be labelled tuberculous, or vice versa. The history may be misleading, and it is known

that an attack of gonorrhoea may predispose to a tuberculous infection in the organ. In most textbooks the liability of the latter infection to break down is given as one of the points in its favour in making a differential diagnosis.

REFERENCES.

- ¹ D. Thompson: *Gonorrhoea*, London, 1923. ² Luys: *Text-book on Gonorrhoea*, Foerster's translation. ³ Reith Fraser: *Gonorrhoea*, 1923. ⁴ Harrison: *Diagnosis and Treatment of Venereal Diseases*, London, 1919. ⁵ Kenneth Walker: *British Journal of Venereal Diseases*, Vol. 1, No. 2.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

AN UNUSUAL CASE OF CARBON MONOXIDE
POISONING.

A MAN and wife, aged respectively 49 and 63 years, were recently found dead in bed, the woman lying in a natural position and the man lying across the bed, face downwards. There were no marks of violence on the bodies and no evidence that anything of a poisonous nature had been taken; the woman had been under treatment for diabetes. On *post-mortem* examination death was found to be due to asphyxiation by carbon monoxide poisoning, there being a 50 per cent. saturation of the blood with the gas in each case. The organs of the man were quite healthy. The woman, who was the elder, had cirrhosis of the liver, degeneration of the pancreas, and enlarged heart and spleen.

Interest in the case lies in the fact that there was no closed or anthracite or coke stove in the room; no gas was laid on, and there were no gas pipes in the vicinity. There was a small open fire grate, and when the couple retired to bed for the night the fire was left to die out as was the usual custom. Coal only was burnt, and some unconsumed remains were found in the grate. Carbon monoxide must have been produced by the fire and escaped into the room in sufficient quantity to cause death. The room was of about 1,000 cubic feet capacity and the window and the door were shut.

Another point of interest in the case is that the man was employed in a large steel works as a gasman, and was thus exposed to gas. At midday on the day before he died he had complained that the place in which he was working was full of gas and that he did not feel well. However, he walked home from work that evening about 5 o'clock and did not complain of being unwell then or afterwards. The couple were last seen alive about 10 p.m. The question whether the man had not died from inhalation of gas in the works was raised by the solicitor representing the man's relations with a view to compensation. The coroner's verdict was that death was due to asphyxiation by carbon monoxide, the source of the gas being the fire in the room.

Fairfield, Llanelly.

J. A. HUNTER, L.R.C.P. Ed.

ACUTE HAEMORRHAGIC PANCREATITIS WITH
EPIGASTRIC HERNIA.

THE following case appears to me to be of sufficient medical interest to merit publication.

A married woman, aged 49, was admitted to the Blackburn Royal Infirmary at 5 a.m. on February 16th, 1926. She was taken ill fairly suddenly at 9 a.m. on February 15th with violent pain across the middle of the abdomen—below the umbilicus and in the flanks. She vomited twice a little later, but had a constant desire to "belch." She had no pain in the shoulders or back, and the bowels were moved on the evening before admission with an enema, which gave a fairly good result.

She gave a history of having been troubled with her heart and with oedema of feet, etc., for a few years. She had two children, aged respectively 17 and 13, and had had an epigastric hernia ever since her last child was born.

The patient was a very fat woman, and obviously dyspnoeic and cyanosed. She was very tender all over the abdomen, but the maximum tenderness was in the flanks and lower umbilical region. There was definite rigidity, but its degree was masked by fat. There was no marked hyperaesthesia. She had an