

Prognosis.—Without complications and in an otherwise healthy individual the prognosis is good.

Treatment.—During the rise, antipyretics and if necessary cold applications and aperients; during the remission, quinine and some saline diaphoretic mixture; and after the attack, tonics. If the temperature is over 104° 10 grains of phenacetin with or without five grains of calomel and a hot lime drink are commonly given. Cold applications are necessary if the temperature refuses to react to drugs; as ice is difficult to obtain on the Gold Coast it is usual to resort to a brine bath—i.e., salt, vinegar, lime-juice, and Florida water are mixed with the water and the patient is either sponged with this, packed, or placed in the bath. The latter is at times dangerous owing to the shock which it produces. The saline diaphoretic mixture generally used is liquor ammoniæ acetatis in one-drachm doses, together with spiritus ammoniæ aromaticus, spiritus ætheris nitrosus, and a little syrup of orange. Quinine is often given in 10-grain or 15-grain doses twice a day, in the morning and in the afternoon. This, of course, is only given in the remission of the fever, and as soon as convalescence is established it is cut down to 10 grains once a day; then five grains once a day, next five grains every other day, and lastly, it is stopped after a little time. In the convalescence stage quinine is only given in the morning. In convalescence, in order to treat the anæmia and to improve the general system of the patient some tonic is necessary. A common prescription here is 10 grains of the citrate of iron and quinine with three minims of the liquor of strychnine hydrochlorate and a little syrup of orange for a dose. After repeated attacks of fever and the consequent anæmia a patient is invalided to either (1) the Government Sanatorium at Aburi, situate on the hills 26 miles from Accra at an elevation of 1440 feet and surrounded by beautiful gardens; or (2) a sea trip to Sierra Leone, Canary, or England according to his condition.

Prevention.—This is important and much can be done by using common-sense and obeying the ordinary rules of life and hygiene. Chills must be avoided and clothes should be changed if they get wet (this, however, is often impossible). Constipation and excesses can be avoided. Proper and sufficient food should be taken if it can be procured. Recreation and certain kinds of amusement can easily be obtained on the coast and often help to counteract mental worry. Possibly some alcohol should be taken to counterbalance the deleterious effects of a hot moist climate. If possible, Europeans should live in the good airy bungalows which are common on the coast and which have been built by the Government for officials, and should also be provided with mosquito nets, which I am glad to say are in general use. A little quinine in the damp cold weather or when wet or before a long trying march has been found useful. In my opinion persons have many times been prevented from having an attack of fever by being given a purgative and a few grains of quinine. As the country gets opened and as the forests are cut down and the swamps are drained by the gold-mining and other industries now beginning, the malarial fevers will, in my opinion, diminish, even as they have in the Fens and in Kent.

Accra.

ON THE DIAGNOSIS OF THORACIC ANEURYSM BY THE ROENTGEN RAYS.

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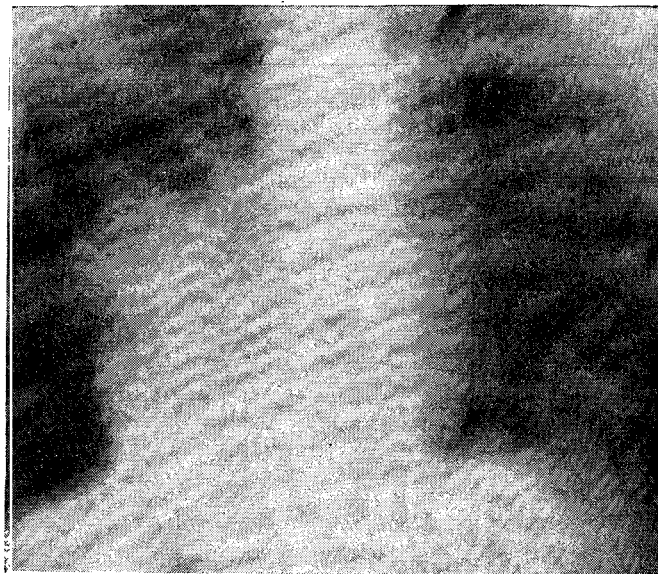
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MANY aneurysms of the aortic arch can, of course, be readily diagnosed without any help from skiagraphy, but there are others, and they are not a few, in which the physical signs leave us in doubt between an aneurysm of the aorta and a mediastinal new growth, or the aneurysm may be unsuspected. In cases such as these the x rays come to our aid and I would emphasise the importance of examining such a case with the screen, because the pulsation of an aneurysmal sac can only be discovered in this way in an aneurysm buried deeply in the thorax. The following two

cases, both of which came under my observation in the out-patient room at the City of London Hospital for Diseases of the Chest, are, I think, worthy of record.

CASE 1.—A man, aged 33 years, came to the out-patient room on April 19th, 1899. He gave the following history. He had had syphilis 16 or 17 years ago. 12 years ago his right elbow-joint was excised by Lord Lister in King's College Hospital. Five or six weeks before coming to the hospital he noticed a "cramp-like feeling" in the region of his heart which extended down his left arm. This sensation only lasted for a few minutes at a time but was severe. This lasted for two or three days and then disappeared. About the same time he noticed that he was getting short of breath on exertion. For a few weeks he had had a slight cough with frothy expectoration. He had never had rheumatism. On examination the heart's impulse was found to be in the fifth interspace in the left nipple line. In the third and fourth interspaces on the left side, three and a half inches from the mid-sternal line, there was a diffuse area of expansile pulsation over which a systolic murmur was audible. The aortic and pulmonary second sounds were clear. At the apex there was a systolic murmur following the first sound. The expansion of the left side of the chest was a little less than the right. The breath sounds all over the left side of the chest were a little weak. There were numerous crepitations to be heard over the left base behind. The pupils were equal and reacted to light. Both vocal cords moved well. The pulse was 72, regular and equal on each side. On May 3rd, 1899, he was admitted to the hospital under the care of Dr. Eustace Smith. The first skiagram (Fig. 1) was taken the day before his admission.

FIG. 1.



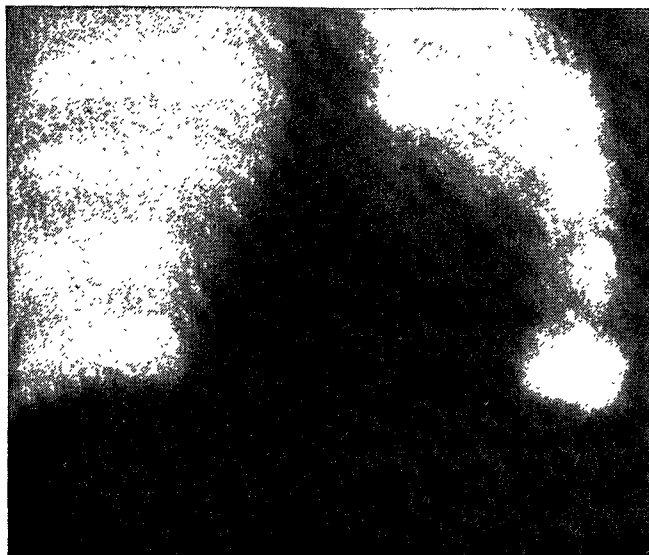
Showing the shadow of the aneurysm at the left base of the heart.

The chest is viewed from the back. The first point noticed is the very peculiar shape of the heart. The projecting shadow to the left of the base of the organ corresponded exactly to the pulsation felt on the chest wall. The shadow occupies the position of the left auricle. On a screen examination well-marked pulsation was visible in this projecting shadow. The diagnosis arrived at was that the patient had an aneurysm, and if aneurysms of the left auricle were not so extremely rare, there being, according to Dr. Wickham Legg,¹ only three or four cases on record, it might have been thought from the skiagram that the patient had an aneurysm of this chamber of the heart. The patient left the hospital of his own accord on June 1st, 1899, the physical signs remaining practically the same. A fortnight after, owing to palpitation of the heart, he went to the Middlesex Hospital and was admitted, remaining there for three weeks. After his discharge from the hospital he kept fairly well for five or six weeks. He attended again at the Middlesex Hospital for examination and was again admitted for six weeks. His condition remained much the same until the last week in November, 1899, when he fainted in the street.

¹ Dr. Wickham Legg: Some Account of Cardiac Aneurysms, Bradshawe Lecture, delivered before the Royal College of Physicians of London, 1833.

After this he came again to the City of London Hospital for Diseases of the Chest on Dec. 5th, 1899, and was re-admitted to the hospital under the care of Dr. Eustace Smith. On examination the physical signs were apparently the same as before but with the addition of a friction rub at the base of the heart. He informed me that the diagnosis of the physician under whose care he was placed when in the Middlesex Hospital was that he had an adherent pericardium. He was discharged on Jan. 18th, 1900. On April 7th, 1900, he came again to the out-patient room complaining that for the last few weeks his shortness of breath had increased. On April 12th, 1900, the second skiagram (Fig. 2) was taken, the interval between the two skiagrams being almost exactly 12 months. The chest is viewed from the front. It will

FIG. 2.



Showing the great increase in the aneurysmal shadow.

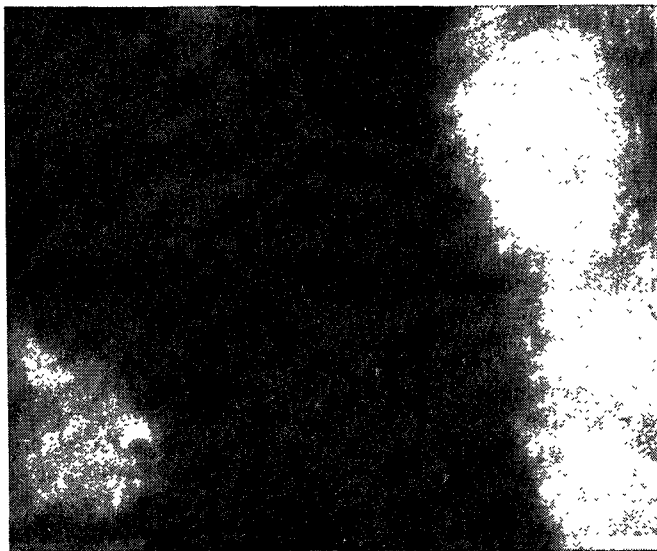
be at once seen that the shadow of the tumour at the left base of the heart has increased to more than double its original size. It also shows evidence of commencing dilatation of the right side of the heart. On a screen examination the pulsation in the sac was very distinct. I think the second skiagram leaves no doubt about the aneurysmal nature of the tumour. The patient is still under observation.

The second case is also of very great interest from a diagnostic and perhaps a prognostic point of view.

CASE 2.—A man, aged 42 years, came to the out-patient room on Nov. 29th, 1899. He gave the following history. He had never had any previous illness, being quite well up to 18 months ago when he began to suffer with shortness of breath on exertion which had gradually increased. He had had pain extending down the right arm. He also noticed that the veins on the right side of his neck were swollen. He had had a cough with slight expectoration but no hæmoptysis for 12 months. For the last two months he had been wasting rapidly, having lost nearly two stones in weight. Nine months ago he said that his face and neck were swollen but this swelling had now disappeared. On examination the superficial veins over the upper part of the right side of the chest and in the epigastric region were full and tortuous. There was no pulsation anywhere to be discovered. There was dulness to percussion with tracheal breathing all over the right side of the chest in front—the dulness extending a little to the left side at the level of the second costal cartilage. The dulness was also marked at the back of the chest on the right side but not so absolute. The breath sounds over the left chest were normal. The heart's impulse was displaced downwards and outwards in the sixth interspace just outside the left nipple line. There was a soft systolic murmur following the first sound. The murmur was conducted towards the axilla. The pulse was weak, soft, and regular, and appeared a little weaker in the right radial artery. I was in doubt between an aneurysm and a new growth. The patient was admitted to the hospital on Dec. 13th, 1899, under the care of Dr. Eustace Smith. The first skiagram (Fig. 3) was taken on Dec. 7th, 1899. The chest is viewed from the front. It is at once seen that there is a large tumour occupying the right side of the chest and extending upwards nearly to the right clavicle and downwards to where it meets the shadow of the liver. It also extends a little to

the left of the sternum at the level of the second costal cartilage on the left side. It seemed hardly possible that an aneurysmal sac could reach such enormous dimensions. I was therefore—taking into consideration the rapid wasting—in favour of a mediastinal new growth. The patient remained in the hospital until March 15th, 1900, and was discharged decidedly improved. He returned to the hospital

FIG. 3.



Showing the shadow nearly filling the right side of the chest.

the following month saying that although his breath was less short his cough had increased. On examination the physical signs were the same with the addition of rhonchi over both bases. The bronchial catarrh soon cleared up under treatment. Until June, 1900, the patient attended at the hospital once a month to report himself. The second skiagram was taken on April 26th, 1900, the interval between the two being very nearly five months. On comparing skiagram 4 (see Fig. 4) with skiagram 3 it will be seen

FIG. 4.



The shadow has now much contracted.

that the mass on the right side of the chest has undergone a certain amount of contraction, its shape being quite altered. This contraction of the tumour leaves now, I think, no doubt about its aneurysmal nature.

Since the above was written I have discovered an aneurysm of the descending thoracic aorta in a patient, by means of the Roentgen rays, which was unsuspected, the patient having been under treatment for intercostal neuralgia.

Harley-street, W.

UNIVERSITY COLLEGE OF NORTH WALES.—The half-yearly meeting of the court of governors of the University College of North Wales was held at Rhyl on Oct. 24th. Lord Kenyon was elected President in succession to Mr. W. Rathbone, who retired after 15 years' service. The financial report showed a deficit of £1604.