

*Nature of fluid withdrawn.*—This was examined on several occasions and showed little variation from the analysis given. (1) Appearance: Milk-like, with no separation into a creamy layer on standing, and little or no tendency to clot. In first aspiration blood was present, but in later ones none was detected. (2) Specific gravity: 1008-1016. (3) Reaction: Alkaline. (4) Fat: Nil. (5) Albumin: Very abundant. (6) Micro-organisms: None detected either in smears of fluid or by culture. (7) Cellular content: Practically entirely composed of small lymphocytes. No filaria found. Some of the fluid was sent to Surgeon Captain Bassett-Smith, who confirmed the above findings, and kindly inoculated a guinea-pig with it. The animal was killed after a month's time and showed no signs of tubercle.

*Result of autopsy.*—Subject was thin; extreme emaciation not present. The right pleural cavity contained much chyliform fluid similar to above. The pleura itself was slightly injected; in places a little fibrinous deposit. The right lung was slightly collapsed, but floated in water; no pathological change on section. Some thickening of pleura close to spine at level of seventh, eighth, and ninth thoracic vertebrae (possibly due to original trauma); no injury to thoracic duct found. The heart, left lung, and all abdominal organs were quite healthy; no neoplasm or tumour of any sort found either in thorax or abdomen. Microscopic sections of right lung, pleura, and of patch of thickened pleura close to spine were made; no tubercular lesions found. This was confirmed by Surgeon Captain Bassett-Smith, to whom parts of these tissues were sent.

#### *Remarks on the Differential Diagnosis.*

The chief points of interest about this case are the large quantity and peculiar characteristics of the fluid removed. The exact determination of the lesion (whether pathological or traumatic, or both) presented great difficulty. With the history of trauma and milky fluid in the pleural cavity, one is inclined to attribute the condition to injury of the thoracic duct. Against this are the post-mortem findings, the nature and excessive amount of the fluid. Also there were no marked signs of the wasting or symptoms of thirst usually associated with this lesion. Tuberculosis is occasionally responsible for chyliform effusions with characteristics similar to those in the present case, but in view of the complete absence of any tubercular lesions had to be abandoned.

The blood count throws no apparent light on the condition. It was as follows: R.B.C., 3,420,000. W.B.C., 13,800. Differential count, neutrophils, 70 per cent.; large lymphocytes, 8 per cent.; small lymphocytes, 12 per cent.; and mononuclears, 9 per cent. Blood platelets increased, no filaria were found. Neoplasm is also associated with pleural exudates of this type and has been excluded.

The not very extensive literature on this subject has not been available. Simon, in "Clinical Diagnosis," states that chyloid and chylous exudates have been repeatedly observed. Out of 104, 49 occurred in the pleural cavity. The causes given were pressure on the thoracic duct, tumours, syphilitic disease of the liver, disease of lymph vessels, and Hodgkin's disease. He also mentions that some chyloid exudates contain no fat. In chylous ascites, Quincke recognises two types, one in which there is a true fatty fluid, the other in which the turbidity is due to chemical substances of a non-fatty nature: lecithins combined with globulins. Milton<sup>1</sup> has reported a case in which 15 pints of chylous fluid were withdrawn from the left pleural cavity at one sitting. This fluid contained fat, a few cocci, but no tubercle bacilli. The fluid did not recur and the patient made a good recovery. He attributed the effusion to tuberculosis of the thoracic duct.

In conclusion, we wish to thank Surgeon Captain P. W. Bassett-Smith, C.B., C.M.G., R.N., for his kindness in confirming the pathological findings and Surgeon Commander T. W. Philip, R.N., for permission to publish the case.

### CASE OF INTESTINAL OBSTRUCTION BY MECKEL'S DIVERTICULUM.

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THE following case of intestinal obstruction presents points of interest.

Patient, a girl of 13, was admitted on Nov. 21st, 1918, under the care of Dr. A. Spong, with the history that

four days earlier she was taken, after a hearty meal, with sudden pain in the abdomen—not intense pain and not localised, though "perhaps worse at first in the right flank." Soon after the pain started she vomited and had been more or less sick ever since; the last vomit was copious, black, and evil-smelling. Since the attack began the bowels had not acted, nor had any flatus passed up or down.

On admission patient was dull and heavy, but did not look like an acute abdominal case; T. 98.6° F., P. 128, R. 24. The tongue was furred. The whole abdomen was rigid, but not excessively so; tender, but not acutely. Pain was felt most on the left side, just above the umbilicus, but when asked to point to the worst place she passed her hand impartially over the whole abdominal wall. There was just a suspicion of visible peristalsis once in the left hypochondrium; the rectum was empty.

A diagnosis of intestinal obstruction was made and the abdomen was opened at once. Distended and acutely congested small bowel presented, and, when pushed aside, revealed collapsed small intestine and colon. During the manipulation the collapsed bowel slowly filled with flatus, and it was evident that, whatever the cause of the obstruction, the handling had relieved it. After some searching a Meckel's diverticulum was found. The proximal portion was a thin fibrous cord twisted many times on its axis; the distal part was a dilated pouch, inflamed and full of blood clot, and adherent to a tag from the great omentum, also inflamed and twisted. This connexion had formed an arch or band under which the lower 4 feet of the ileum had become partially strangulated.

The band was divided close to the bowel and again just above the dilated pouch. The proximal end was buried by a purse-string suture; the distal end was tied off in the usual way. The wound was not drained.

Nov. 29th: Patient had done very well; the bowels acted freely with a simple enema on the third day; no temperature or bad symptoms of any kind.

### NOTES ON A CASE OF CENTIPEDE BITE.

By STEPHEN W. COFFIN, M.R.C.S., L.R.C.P.,

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THE following case of the results of a centipede bite seems worthy of record:—

The patient, a native Christian, aged 22, reported sick on Dec. 30th, 1918, with a history of having been bitten on the scrotum about midnight by a centipede. He said he actually saw the insect biting him and knocked it off; considerable pain immediately; an hour or so later vomited twice. When first seen (about 7.30 A.M.) the left cremaster was contracted and the scrotum very wrinkled, but neither swollen nor markedly tender. He said it felt hot. Patient was put to bed, purged, and the scrotum fomented. Later in the day the following condition, stated to have commenced in the morning soon after first examination, was found. There were several large bullæ on the scrotum containing serum, which showed no cells or other structure microscopically, and proved sterile on cultivation. Over the chest, neck, and arms was a papular and vesicular eruption, at each hair follicle, giving an appearance of cutis anserina. Temperature 99° F., pulse 80; he felt fairly well. Trace of albumin in the urine.

On the second day pulse and temperature were as before, some pain over area of rash, and aching in scrotum. The bullæ on scrotum had broken; almost whole scrotum raw and denuded of skin. No testicular tenderness. The skin eruption was composed of a few papules and a large number of vesicles about 1 mm. in diameter, each surrounded by a real areola. Each lesion coincided with a hair follicle, the hair growing from the centre of each vesicle.

*Distribution:* Very marked on both sides of the chest, over shoulders and arms, and on neck and face. In the last two places the vesicles were very small and numerous. The ears were thickly covered; vesicles confluent over pinnæ, forming bullæ. The anterior and inner surfaces of the thighs, especially over Scarpa's triangle, were well covered. The rash was less marked over front of chest and abdomen, in popliteal spaces, on forehead, between scapulae, and on forearms and legs. No eruption over pressure points (e.g., buttocks, back—except between scapulae—and back of legs and thighs). The feet and palms of hands were free; a few vesicles on dorsum of hands. No spots in the mouth. A vesicle on an ear and one on a shoulder were opened, and yielded a muco-purulent fluid containing a few leucocytes and mucus. It was sterile on cultivation.

On the third morning the temperature was normal; 99° in evening; the surface of the scrotum was as before, but the vesicles on the face, neck, chest, and arms had reverted to a papular condition without any encrusting. By the evening of the third day vesicles remained only in the axillæ and on upper portions of anterior and inner surfaces of both thighs.

<sup>1</sup> Brit. Med. Jour., November, 1907.

By the fourth day vesicles were marked only on upper portion of inner surfaces of thighs. Considerable punctate desquamation was present over the areas where the papules were finally disappearing, especially on the chest. The urine was now free from albumin.

On the evening of the fifth day the last remaining vesicles (on the thighs) had become papular and had begun to desquamate.

*Treatment.*—No treatment beyond fomentations and, later, hydrogen peroxide dressings to the scrotum and purgation was attempted. The rash received no local treatment.

#### *Differential Diagnosis.*

On first seeing the case the following suggested themselves as possibilities :—

1. *Small-pox.*—Pro : Sporadic cases are constantly occurring in the neighbourhood. Contra : Distribution and type of rash by no means typical ; rash not shotty ; body pains, especially loins, absent ; general reaction almost nil ; pyrexia and rash synchronous.

2. *Chicken-pox.*—Pro : Rash appeared early, and was at first somewhat suggestive. Contra : No cases occurring in neighbourhood ; no successive crops of vesicles appeared ; no encrusting ; quickness of disappearance of rash ; no spots in the mouth.

The bullæ and almost complete loss of epithelium, as a result of the bullæ bursting on the scrotum, gave support to the story of the centipede bite, which at first had been treated with some suspicion. Taking into consideration the above points, the case was diagnosed as the results of the bite of a centipede.

I am indebted to Lieutenant-Colonel H. O'Reilly, R.A.M.C., for permission to publish this case.

Malappuram, Southern India.

### INTOLERANCE OF ASPIRIN.

BY E. J. TYRRELL, M.B., B.S. DURH., M.R.C.S.,  
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IN view of the modern craze for aspirin and other drugs the following case may prove of interest as illustrating the danger that sometimes accompanies the indiscriminate taking of these drugs.

A clerk, J. D., aged 33, ate a fairly hearty meal of beef, potatoes, cabbage, bread, and marmalade roll, washed down with ale and followed by a liqueur, about 1 P.M. At 3 P.M. tea was handed round in the office. A brother clerk, suffering from headache, produced a box of aspirin cachets and proceeded to swallow one with his tea. He handed the box to J. D., who also took one, out of sheer curiosity. An hour later he felt a peculiar itching on face, chin, and lips. His arms began to swell and in a short time wheals appeared on the skin. At the same time, his tongue became swollen and his whole face commenced to swell and assume a bloated appearance. His eyes felt heavy and the skin on his forehead felt as if it was being stretched. The swelling increased. He felt giddy and sleepy. He found a difficulty in speaking owing to swelling of tongue, lips, and cheeks. He became alarmed and two colleagues almost carried him to my rooms.

I saw him at 5 P.M., when he presented rather an alarming appearance. There was a general dusky swelling of the whole face ; the eyes were partly closed and lips greatly swollen. He could speak only with great difficulty. His face exhibited a bloated and bruised appearance. He could open his mouth only a little, when the tongue appeared almost to fill the buccal cavity. His hands and arms were swollen to nearly twice their usual size. His pulse was quick and feeble.

He was given an emetic of sulphate of zinc, which acted promptly, then a hypodermic injection of strychnine, followed by sal volatile. Improvement was perceptible within a few minutes ; the swelling and bluish tint commenced to disappear. He began to shiver and complained of feeling very cold. He was well wrapped up, placed in front of a big fire, and given brandy. Within an hour of taking the emetic he was well enough to proceed home, his pulse having greatly improved and the swelling subsiding rapidly. He was given hot milk and brandy and sent to bed. He slept for 11 hours, and woke feeling a little tired but otherwise quite normal and showing no trace of swelling anywhere.

It is to be noted that the aspirin was taken within two hours of a rather good lunch, and the dose was only 10 gr.

Cornhill, E.C.

## Reviews and Notices of Books.

*Dr. John Fothergill and His Friends.* By R. HINGSTON FOX, M.D. London : Macmillan and Co. 1919. Pp. 434. 21s.

THE subtitle of Dr. Hingston Fox's book is "Chapters in Eighteenth Century Life." These chapters centre round Fothergill, who was not only a prominent London physician but also a natural philosopher, a Quaker, an active philanthropist, and one who had special relations with the American colonies both before and after the War of Separation. Among his friends were such men as Lettism, Dimsdale, William Hunter, Priestley, Collinson the botanist, the Bartrams of Philadelphia, David Barclay, John Howard, Benjamin Franklin, and Benjamin Rush. Out of such materials Dr. Fox has compiled a most interesting book. Perhaps its most noticeable feature is the ability which its characters possess of occupying themselves in pursuits outside or accessory to their several callings. Fothergill was born in 1712 and died in 1780, so that he just missed the upheaval of the French Revolution, but during nearly the whole of his life England was at war with France. Political upheavals, however, seem to have affected him no more than they did his predecessor, Sir Thomas Browne. Possibly this was owing to his being a Quaker. Fothergill came of a Westmorland dalesman family, one of whom, John Fothergill, migrated to Wensleydale in or about 1600, and to Wensleydale also came George Fox, founder of the Quakers in 1652. Several of the Westmorland Fothergills rose to eminence, among whom Dr. Fox mentions Thomas Fothergill, Master of St. John's College, Cambridge, who founded a free school in Ravenstonedale in 1668 ; George Fothergill, 1705-1760, Principal of St. Edmund Hall, Oxford ; and Thomas, his brother, born 1715, Provost of Queen's College, Oxford, from 1767 until his death in 1796, popularly called Old Customary, and of whom it was said that, like Keate in later times, "he would not have been seen abroad minus his wig and gown for a dukedom" ; also Elizabeth Gaunt, *née* Fothergill, the last woman to be burned at the stake in England ; and John Milner Fothergill, 1841-1888.

John Fothergill, junior, was the second surviving son of his father, also John, who was born in 1675, and who, like his son later on, travelled in the American colonies, where at Mattocks in Virginia he stayed in 1721 with Lawrence Washington, grandfather of George Washington. His son, the future physician, was educated at Sedbergh and later apprenticed to a well-known Friend apothecary, Benjamin Bartlett, at Bradford. Thence he went to study at Edinburgh under the first Monro, took his degree in 1736, came to London for a two years' hospital course at St. Thomas's, and in 1740 visited the Low Countries. In the same year he returned to London and set up as a physician in White Hart Court, between Gracechurch-street and Lombard-street. In his first year his fees amounted to 105 guineas. In 1744 he received the Licence of the Royal College of Physicians of London, and in 1748 published his best-known essay, "An Account of the Sore-Throat Attended with Ulcers," drawn from his experiences during an epidemic of what was apparently a form of malignant scarlet fever combined with diphtheria. In opposition to the practice of the day he treated these conditions by a cordial and supporting regimen instead of bleeding and purging. His treatment was very successful, and the publication of the essay brought his views into prominence, which greatly increased his reputation. As his practice increased so did his charities ; "he declined many fees, and where need seemed to exist would often offer a gift of his own to meet the cost of medicines, or on some other plea which his delicacy suggested." As years went on he contrived to find time for various occupations ancillary to his profession. He wrote papers upon the origin of amber and manna ; he collected corals, shells, and insects, and, beyond all, established a botanic garden at Upton in Essex, stocked with products that should be useful as sources of food, of medicine, or in the arts, and in forming his collection he was greatly aided by his friend Peter Collinson, also a Friend. About the year 1765 he took a country house near Crewe, whither he used to retire for two months every year, and where also he gave advice to the