Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF MALTA FEVER ARISING IN ENGLAND.

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THE case to be described seems undoubtedly to be one of infection by *M. melitensis*, and as it would appear to have been contracted in this country it merits record for its rarity. It also points to a possible introduction of sources of infection into this country as the result of the war, for I imagine the number of goats has been increased in order to supplement the milk-supply, as these animals are more easily fed, at present, than cows.

Temperature chart of a case of Malta fever arising in England. The record covers a period of seven months, with an interval at A of two and a half months, and for the sake of clearness the morning readings are joined by an interrupted line, the evening readings by a continuous line. At R rheumatic pains were felt in the neck. The arrows indicate injections of stock *M. melitensis* vaccine, the figure denoting millions. While febrile in October, the average pulse rate was between 90 and 100, the maximum being 104 and the minimum being 74. The respiration rate never varied from normal.

The patient, a male aged 50, of independent means, and at no time serving in the Army or Navy, writes the history of his illness as follows:—

"I was never in Malta and never to my knowledge tasted goat's milk, nor have I associated with anyone suffering from Malta fever to the best of my belief.

I spent the winter of 1890-91 in Corfu and Athens, and while abroad had a very slight touch of chill or fever after duck-fighting waist deep in water—only in bed one day. I next spent two or three weeks at Ostend early in 1893, and six weeks at Biarritz in the spring of 1896. These are the only occasions on which I have been out of the United Kingdom.

The first symptoms of my present illness commenced at the end of May or the beginning of June, 1917. I took to bed with rheumatic pain in the heel on June 28th and discovered my temperature to be 102° F. My blood was subsequently tested for typhoid and my lungs examined for consumption, both with negative results. On August 3rd I was sent from London into the country for a change and got gradually better. During September perspirations stopped and my temperature became normal. I then returned to London and felt fairly fit for a few days when shiverings began again and fever returned. Each evening on going to bed about 6 P.M. I felt very hot, and after a short sleep would wake shivering violently and drenched with sweat, so that my pyjamas sometimes required changing six or seven times during the night. During my first fever-wave my temperature once reached 105°. My appetite has been fairly good throughout."

The patient came under my personal observation on Oct. 19th, 1917. He was then obviously ill and much wasted. His skin was healthy and nothing abnormal was detected in the heart or lungs. The liver and spleen were both palpable but not tender. The whole abdomen was slightly distended and tympanitic—the patient's chief complaint being of abdominal distension. Peripheral blood taken at 2 P.M. that day showed no evidence of malaria. The urine was slightly alkaline though otherwise normal. Temperature is shown on the accompanying chart. That night the patient slept fairly well, but perspired freely and the following morning complained of headache. On Oct. 22nd his blood gave no agglutinins for typhoid or paratyphoid A and B. A differential white blood count gave:—

Polymorphonuclears ... 24% | Large mononuclears ... 15%
Lymphocytes ... 61% | Eosinophils and basophils.. nil.

That day his blood agglutinated *M. melitensis* in dilutions up to 1 in 500 in 30 minutes at 32° F. A control serum gave a slight positive reaction up to 1 in 20 under similar conditions. This was approximately the patient's 144th day of disease.

Attempts to recover *M. melitensis* from the urine failed, it being impossible to pass a catheter owing to slight enlargement of the prostate.

On Oct. 23rd rheumatic pains and stiffness were complained of in the neck. At this time depression and inability to concentrate the attention were marked features of the case. As the evening rises of temperature continued, with profuse sweating, and as the patient was obviously making no progress a vaccine was prepared from stock cultures of *M. melitensis*. On Nov. 1st one million organisms were injected subcutaneously at 2 P.M. That night the patient perspired even more freely than usual, and complained of pain in the arm injected. The local reaction was severe and persisted for some days. On the 6th a second injection of five millions was given, with less local and general reaction. Thereafter the temperature remained normal for nearly a fortnight and the patient's general condition greatly improved. At this time he was taking a good mixed diet with a high vitamine content, and being massaged daily. During this afebrile interval the neighbourhood of the right hip-joint became acutely painful, though no physical signs were detected. Dowsing radiant heat procured relief and allowed the patient to sleep.

On Nov. 20th the temperature again rose to 100° at 8 P.M., so the following day a third vaccine injection of five millions was given. Further injections at intervals of four to five days were given, the dose gradually rising to 30 millions on Dec. 14th. Each dose caused both a general and local reaction, though of decreasing severity, but the fever-wave appeared to be in no way influenced and extended over a period of 27 days. The dates of the remaining seven injections are shown on the chart. The reaction became successively less and the patient's general condition steadily improved. At the end of January both knee-joints became slightly tender and contained fluid, but without

apparent thickening of the peri-articular structures. This condition rapidly subsided under local applications of collosol iodine in oil. On Feb. 11th blood serum agglutinated *M. melitensis* in dilutions up to 1 in 50 only. By the end of February the patient was resuming his normal life. The spleen was still palpable, though the patient was otherwise apparently recovered. On March 7th he reported: "General improvement continues, temperature ranging from 97.2° to 98.8°; pulse 75 to 99, the higher figure following either breakfast or lunch; sleep is good and without perspiration."

Seen again on April 2nd, the spleen was still just palpable on deep inspiration; the temperature had continued normal, and the patient expressed himself as well. Blood serum agglutinated *M. melitensis* in dilutions up to 1 in 50.

A SUCCESSFUL CASE OF HERNIA INTO THE MESO-SIGMOID FOSSA.

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IN an exhaustive article by Rendle Short upon herniæ into peritoneal fossæ¹ a short time ago several cases of this variety of hernia were included. The condition is apparently very rare, and still more rarely has been successfully treated by operation.

A man, aged 27 or 28, was admitted into Middlesex Hospital in the early hours of a morning in January, 1908. He was sent into hospital as suffering from acute intestinal obstruction of short duration. The ordinary signs of an acute abdominal crisis were present, and a couple of enemata had failed to produce any relief of the bowel. The doctor, of whose professional capability I entertained the highest opinion, had given him a large dose of morphia before sending him up to hospital, and with him came an urgent note to that effect and a request to explore the abdomen without delay.

Laparotomy was performed through a median incision, and coils of distended and collapsed small intestine were found. On tracing the latter I was led to a fossa under the meso-sigmoid in which a knuckle of small bowel had become ensnared. Bowel not very firmly engaged. After edge of opening into fossa had been cautiously "nicked," intestine was readily freed. Contents of distended intestine above were seen to empty themselves into distal collapsed portion. Owing to difficulties with anæsthetic nothing was done to obliterate fossa. Bowel acted later in day. Recovery uneventful.

I heard of the patient some four or five years later, and he was then in good health. He owes his life to the diagnostic skill of Dr. H. B. Shepherd, the medical attendant called in, to the prompt manner in which he was transferred to hospital, and to the urgent desire of this doctor for an immediate abdominal exploration.

¹ British Journal of Surgery, 1916.