Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A NOTE ON

DORMANT FILARIAL INFECTION.

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THE case of filaria here recorded presents several unusual features.

The patient, a clerk, was admitted to hospital on Feb. 20th, 1922, complaining of shortness of breath following influenza four weeks previously.

Condition on Examination.—He was pale but well-nourished, and any exertion caused distress. There was some cardiac dilatation with a hæmic bruit at the apex. The lungs presented no signs other than a somewhat impaired percussion note at the bases, where a few crepitations were also audible. The abdomen was normal except for a marked ptosis of the liver. The urine was normal, and the bowels regular.

History.—While on service in 1917 in West Africa he contracted malaria and had since had several recurrent attacks of ague. About the same time swellings appeared in both wrists, arms, and above the left eye, which had never received treatment and disappeared spontaneously. A medical officer in casual conversation informed him that these swellings were due to filaria.

Blood Count.—In view of the obvious anæmia a blood count was done, and was as follows: Red blood cells, 2,256,000 per c.cm.; white blood cells, 4800 per c.cm. Differential percentages: Polymorphonuclear 38, eosinophils 45, lymphocytes 10, large mononuclear 6, basophils 1.

The anæmia with the remarkable degree of eosinophilia suggested a possible infection with ankylostoma duodenale or other helminths, but neither worms nor ova were ever discovered in the stools. A search was also made for malarial parasites, but these were never demonstrated at any time. In view of the history of a possible filarial infection the blood was carefully examined, and micro-filariae were seen in specimens taken from the peripheral circulation both during the evening and in the morning. *Micro-filaria bancrofti* was identified in the evening samples and *Micro-filaria diurna* in the morning, showing the presence of a double infection, which was not heavy as the micro-filariae were never numerous.

On March 11th the patient awoke totally blind except for perception of bright light when flashed on to the retina. Both eyes were equally affected. The pupils reacted normally and examination of the fundi revealed an acute retro-bulbar neuritis. The vision began to return after 48 hours and rapidly improved until it became normal again at the end of two weeks. While in hospital the patient was treated with iron and arsenic without any appreciable benefit to his anæmia, but the respirations were reduced from 26 to 20 per minute, and all signs in the lungs cleared up. The cardiac condition remained stationary. He was afebrile except for two separate evening rises of temperature to 99.4° and 100° F., during which times the micro-filariae in the peripheral circulation were not increased, and the presence of malarial parasites was not demonstrated.

Remarks.

The history of influenza during the winter epidemic together with the known fact of the predilection of the micro-filaria for the lung tissue suggests a hypothesis in this case: that the micro-filariae had lain dormant in the lungs until an attack of influenza affecting the respiratory tract had again released the parasites into the general circulation with the resulting symptoms.

(Continued from preceding page.)

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It is not easy to discover any detailed description of the hæmatology in filariasis. In numerous published works of investigators scant attention is paid to the blood picture, and no constant changes have been noted except that an eosinophilia generally exists. Bahr and Low have shown that the parasite leads to a glandular fibrosis associated with an excessive number of eosinophile cells. Castellani and Chalmers state that filariasis does not exhibit anæmia unless associated with hæmatochyluria or diarrhoea, neither of which was present in this case. Grall and Clarac, who give the best account of the hæmatology, report that Ricot found 5 to 15 per cent. and Bescançon and Labbé 4 to 8 per cent. eosinophilia in filaria, and that Remlinger found a 70 per cent. eosinophilia in one case with chyluria. The double infection, retro-bulbar neuritis, marked secondary anæmia with high eosinophilia without any other usual complications of filarial infection impart considerable interest to this case.

The patient was under the care of Dr. Norman Dalton, to whom I am indebted for permission to publish these details.

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A CASE OF

RUPTURE OF THE CORD DURING FORCEPS DELIVERY.

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AND

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THE case here recorded is sufficiently unusual to deserve mention.

History.—The patient, aged 26, was married in October, 1919. Her last period began on Dec. 12th, 1921, and ended on the 18th. The early part of her pregnancy was marked by much vomiting, which subsided, and she pursued a normal course until the beginning of June, 1922, when her abdomen swelled very rapidly.

Condition on Examination.—On June 21st she was seen by one of us (J. S. L.), who found the uterus very large with an excess of liquor amnii. On the 22nd the uterus reached to the ensiform cartilage; there was difficulty in making out the presentation; her pulse was 100; respiration 26; she complained of difficulty in lying down and in moving. On the 23rd, under anæsthesia, the general condition was the same, but her pulse had risen to 110, and her temperature to 99.2° F.; the external os was easily dilated with the finger, and the cervical canal was found dilated, the membranes were separated and then punctured. About 1½ gallons of liquor amnii escaped, fresh, unstained.

Labour and Delivery.—After a fairly comfortable day labour began about 7 P.M., and continued with regular pains until 6.30 A.M. on the 24th, when, as she was getting exhausted, an anæsthetic was given. The os was then a little smaller than a crown piece, and rather rigid; after manual dilatation the forceps were applied to the head, which was a curious rounded shape, feeling like a large tennis ball. Delivery was difficult for a time, with great resistance to the pull; this resistance gave way suddenly, and delivery was accomplished at 7.20 A.M., when the cord was found to be completely torn across at 2 inches from the foetal navel. There was no hæmorrhage at the time of the sudden giving way of resistance, and clear unstained liquor amnii escaped after the shoulders were delivered. The placenta was large but otherwise normal, and was delivered very easily directly after the child was born. The child, born dead, was generally dropsical, and the head contained a large amount of fluid between the skull vault and the skin, and in the cranial cavity. The mother did well, but still has a little albumin in her urine.

I can find in the literature no exact parallel with this case. De Lee in his book records one case where the cord was ruptured 8 inches from the umbilicus, and another where the cord was caught between the forceps and the head, and cut as if with a knife. Sequeira¹ records a case of rupture of the umbilical

¹ Brit. Med. Jour., 1895, i., 866.

cord at its placental insertion during normal delivery, the child being born alive. Werder² has discussed the whole question, recording a forceps case of his own where the cord was torn at the umbilicus, together with part of the abdominal wall, the child also having spina bifida. He found from the literature of the subject that a velamentous insertion of the cord is the common cause (it was not so in his case), and that cases of detachment of the placenta are uncommon, this being due to moulding on the foetus internally, and compression from the outside by uterine contraction.

A large part of the literature has been written in the Spanish language; these, and many other references on the subject, we have been unable to obtain.

A NOTE ON A CASE OF CARCINOMA MAMMÆ.

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THE records at the Aberdeen Royal Infirmary show that on August 30th, 1890, a female patient, aged 35, was operated upon by the late Dr. Mackenzie Booth for carcinoma mammae. There is no further record of the case and no record of a microscopical examination. In 1915 the patient remembered that this tumour of the *right* breast had been noticed for a year before her third child was born, that the child was 11 months old at the time of the operation, and that she had suckled it from both breasts until a week before. The swelling was "a good big one." In August, 1915, the patient noticed a painless nodule in the *left* breast.

Condition on Examination.—Patient was a thin woman in good general health, and had a tumour about 1½ inches across in the upper and inner quadrant of the left breast, with a hard mass of glands in the left axilla. The supraclavicular glands on the left side were palpable, being discrete and shotty. There was a sound scar, supple and healthy, extending from the middle of the right axilla downwards and forwards for a distance of 7 inches, and there was no sign of the nipple or of mammary tissue in this region. The pectoralis major was present. There was no axillary or supraclavicular enlargement on the right side and no evidence of visceral disease.

Course of Case.—In October, 1915, I removed the left breast and axillary contents with a wide area of skin and a wider one of deep fascia, together with both pectoral muscles. The supraclavicular glands were not removed. The pathological report was "spheroidal-celled carcinoma with extensive infiltration of the axillary glands." In July, 1919, a colleague removed a recurrence from over the left fifth rib. In January, 1920, the left supraclavicular glands were apparently in the same condition as originally noted in 1915. X ray treatment was carried out in August and September, 1920, and repeated in January, February, and March, 1921.

In July, 1921, there was a hard mass about half an inch across, situated in the middle of the original scar of the operation on the right breast, nearly 31 years before. Another small, hard mass was felt in the right axilla. The right supraclavicular glands were not enlarged, but the left glands were larger and softer than before. There was no local recurrence on the left side. Thereafter there was little change externally, but signs of right pleural effusion developed and the patient died in October, 1921, aged 66, more than 31 years after the operation on the right breast, and six years after the operation for carcinoma of the left breast. There was no post-mortem examination.

In the absence of definite information as to the nature of the original tumour in the right breast and in view of the appearance of the nodules in the original scar (right) late in the course of the disease of the left breast, it seems to me that these nodules were embolic in origin, the emboli having been arrested where the lymphatic tissue was interrupted by the old scar. It is my practice to examine every case of malignant disease after operation at least four times a year, and I think the dates may be accepted as approximately correct.

² American Jour. of Obstetrics, 1899.

BRITISH MEDICAL ASSOCIATION.

ANNUAL MEETING AT GLASGOW.

(Concluded from p. 672.)

SECTION OF OBSTETRICS AND GYNÆCOLOGY.

WEDNESDAY, JULY 26TH.

STILLBIRTHS AND NEONATAL DEATHS.

At this session Prof. EWEN J. MACLEAN (Cardiff) presided. The opening paper of the discussion was read by Dr. J. W. BALLANTYNE (Edinburgh), who dealt with

Antenatal, Intranatal, and Neonatal Death; Causes, Pathology, and Prevention,

with special reference to antenatal death. He referred to the great advances which had been made in our knowledge of these subjects since the preceding meeting of the Association in Glasgow in 1888, when the causes of intra-uterine death were discussed by the leading obstetricians of that time. Dr. Ballantyne proceeded to deal most minutely with the physiological changes which characterised the various stages in the development of the product of human conception—the pre-germinal, the germinal, the embryonic, the foetal, the intranatal, and the neonatal stages. He classified precisely the factors which operated at each of these stages to cause disease or death of this product, and indicated how imperfect was our knowledge of the pathology of these conditions, particularly of the antenatal stages. The maceration of the ovum or foetus must no longer be allowed to prevent minute investigation of the tissues of such casualties. The action of the germs and toxins which reach the ovum from the maternal blood-stream must be studied further, and the protective action of the placenta towards the foetus more definitely investigated. The result of such study should enable us to reduce very greatly the enormous losses now occurring in this stage of development. At present syphilis was practically the only condition which we could treat with precision at this stage. Dr. Ballantyne then outlined the methods by which the casualties occurring in the antenatal and neonatal stages might be prevented.

1. Every morbid condition of the mother which may be detected during her pregnancy should be watched for and treated. Such conditions include albuminuria, syphilis, and the exanthemata.
2. Every anomaly in the relation of the foetus to the mother in the obstetric sense should be diagnosed and corrected before the onset of labour. By such obstetric prevision it is possible to prevent the arrival in labour of an occipito-posterior or a breech presentation, to make an early diagnosis and so prevent the extreme exsanguination which may result from a placenta prævia, and also to eliminate craniotomies resulting from an undiagnosed disproportion between the foetal head and the maternal pelvis.
3. All the existing methods of delivery should be revised completely in the interests of the foetus. Should a healthy foetus with a good foetal heart be used as the plug to arrest placental hæmorrhage in an early diagnosed case of central placenta prævia? Should such a case not be treated by Cæsarean section?
4. The various lesions which occur in the new-born child should be more accurately diagnosed, and suitable treatment adopted for each individual case. Schultze's method of artificial respiration is surely not correct for an infant when blood is oozing into the lateral ventricles of its brain. Dr. Ballantyne went on to describe the results which had attended the exercise of these principles in the Royal Maternity Hospital in Edinburgh. Over the whole city of Edinburgh birth notifications showed a stillbirth incidence of 47·8 per 1000. The Maternity Hospital showed a stillbirth rate of 56·3 per 1000, made up of 68·8 per 1000 in the indoor department and 41·2 per 1000 in the outdoor department, the large proportion in the former department being due to the large percentage of abnormal cases found in institutions of this type. In the venereal department the figures were specially interesting. Among such patients who had been supervised