

A CASE OF MALTA FEVER FROM NORTHERN NIGERIA.

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MALTA fever has long been known to exist in other parts of the world than the Mediterranean, cases recently having been reported from India, South Africa, the Sudan, and elsewhere, so there is nothing remarkable in the fact that it should also occur in Northern Nigeria. Whether or not it should prove to be common there remains to be seen, but certainly since I saw the gentleman (in 1906) whose case I am about to read to you to-night, I have not heard of any others till the one Sir Patrick Manson had under his care at the end of last year. This case of Dr. Foy's in Northern Nigeria is also to be read to you to-night, and perhaps when some prominence has been given to the subject other cases of obscure and prolonged fever from these parts may turn out to be the same disease. The notes of my case are as follows:—

Case of Mr. G.—A former patient of Dr. Blair's in Northern Nigeria was under the care of Dr. Cardell at Tonbridge, and I saw him in consultation with the latter on July 18, 1906. Dr. Blair had before this seen Mr. G., who was suffering from fever, and had ordered intramuscular injections of quinine on the assumption that the illness was malarial fever, but this treatment had absolutely no effect on the temperature.

History of Case.—Patient had served in the South African War in 1898, and after that had done three tours on the West Coast of Africa—the first to Sierra Leone, the second and third to Northern Nigeria. In the last of these he was chiefly stationed at Kano, but had been on an expedition to Sokoto in March, 1906, and after that

on another one to Hadeija in April of the same year. After this he proceeded down country to go home on leave. During his stay on the coast he had enjoyed fairly good health all the time with the exception of one or two slight attacks of fever, which responded to quinine. He had been in the habit of taking 10 grains of quinine every second day as a prophylactic during his first two tours, but latterly took it irregularly. He was always careful about sleeping under a mosquito net, and was never conscious of having been specially bitten by tsetse or other biting flies.

Previous Illnesses.—Slight touches of fever as above. Slight dysentery in South Africa in 1898. No blackwater fever. No syphilis.

Present Illness.—This began indefinitely. Fever was apparently contracted on coming down to the coast from the interior in April, 1906, and this resisted quinine. On account of this he was kept in hospital for a week at Zunguru, but the temperature still persisted. Afterwards he reached the coast and took ship for England, the sea air reviving him considerably and causing his fever to disappear after a week on board. When he landed in England he felt well. On July 7, 1906, he was at a cricket match, the day being very warm, and in the course of the afternoon he began to feel chilly and seedy, so he went home to Tonbridge that night. Since that day continuous fever set in, five intramuscular injections of quinine and plenty of quinine by the mouth having no effect on the temperature.

State on Examination (July 18, 1906).—The patient looked somewhat sallow, was not in the least apathetic or dull, conversed sensibly, and did not strike one as being specially ill. His temperature was 102·5° F., Dr. Cardell stating that it usually ran up to 103° or so at

nights, falling to 100° or 99° in the mornings. The pulse was slow in comparison, 82 during examination. There was nothing specially abnormal in any part of his system. The tongue was small, heavily furred and dry. The liver was perhaps slightly enlarged, its upper border being at the fifth and sixth ribs, its lower border at the costal margin, edge not palpable. The spleen was also slightly enlarged, especially upwards, its upper border being at the seventh rib, its lower at the eleventh; it could not be felt. An examination of his blood gave the following count:—

Reds	4,060,000	} No parasites of any kind found.
Whites.. ..	7,500	
Hb.	75 per cent.	
Differential: Polymorphonuclear	40 per cent.	
Large mononuclear	11 ..	
Lymphocytes	45 ..	
Eosinophile	1 ..	
Transitional	2 ..	
Mast cells	1 ..	
		100

What might have been three spots were noted on his abdominal wall, but they were doubtful and uncertain. From the blood count the case was evidently not an abscess of the liver; malaria was negated by the failure of intramuscular quinine to influence the temperature; trypanosomiasis, typhoid, tuberculosis, and Malta fever remained. Of the first of these there were no confirmatory signs such as enlarged glands or erythematous eruption on body; it looked more likely, then, that the patient was suffering from a very mild attack of typhoid fever, though several things were against this, especially the previous fever in Africa and the cheerful condition, as if there was little the matter with him. Blood was taken back to London for the Widal reactions; these were done on July 19, dilutions of 1 in 25 and 1 in 50 being abso-

lutely negative for typhoid, while for Malta fever there was a suspicion of clumping, but as this was not altogether satisfactory I gave it as negative. More blood was sent the following week, and on July 25 the Widal for typhoid was again negative; that for Malta fever was positive in dilutions of 1 in 25, 1 in 50, and 1 in 100. Dr. Cardell also reported on this date that the temperature continued the same, but the patient had had an unexplained pain in the left maxillary joint (supposed to be rheumatism). The blood was sent again the following week, and it reacted very strongly for Malta fever in dilutions of 1 in 50 and 1 in 100. Dr. Blair again saw the patient on August 10 and found the temperature still remaining the same and no fresh developments. It was clear, then, that the case was one of Malta fever, and I directed that the case should be treated as such. I did not see the patient again nor hear of him until I saw Dr. Blair in January, 1908, when he told me that the patient had remained ill till the late autumn of 1907, *e.g.*, well over a year, when he slowly regained his health, and was then (January, 1908) in perfect health. The long duration of the disease was of course a strong point in favour of the original diagnosis, if that were required. No cultures were made from the blood for the micrococcus, and one or two other minor points are wanting in the clinical history, but there is no doubt that the case was one of Malta fever, and it shows that this disease is present in Northern Nigeria, as well as in other parts of Africa.