

Clinical Notes

SPIROCHETES IN ACUTE LYMPHATIC LEUKEMIA AND IN CHRONIC BENIGN LYMPHOMATOSIS (HODGKIN'S DISEASE).

SECOND COMMUNICATION.

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In connection with a former communication¹ on spirochetes in Hodgkin's disease, we wish to report two further cases in which spirochetes were found during life.

CASE 1.—History.—The first case presented the picture of acute lymphatic leukemia. The patient had been sick about six weeks. He entered the hospital Wednesday, August 28, and was seen by Dr. Pröschner in the hospital on the morning of this day.

Examination.—On examination he appeared very anemic and cachectic. The lymph glands over the whole body were swollen, soft and discrete. The lymph glands in the inguinal and crural region were the most enlarged, but those in the cervical and axillary regions were also very large and easily palpable. Glands behind the ear and in the cubital region were enlarged also and distinctly felt. The patient had had profuse hemorrhages from the mouth for five weeks. He had been always healthy up to six weeks before admission. There was absolutely no trace of luetic infection to be found and no history of such infection could be elicited.

The blood examination showed: Red blood corpuscles, 900,000; leucocytes, 32,000; hemoglobin, 14 per cent. The blood smears showed only large and small lymphocytes, very few polymorphonuclear leucocytes, a few poikilocytes and normoblasts.

Dr. Pröschner found in the smears made from the fluid obtained by aspiration of the lymph glands large numbers of spirochetes. These organisms averaged about 20 microns long, the curves of their body were shallow and few in number. The body was slender, and both ends of the organism pointed.

A gland was extirpated and: First. In the exudation from this gland spirochetes with very poor motility were seen with great difficulty. Second. In frozen sections stained by Levaditi's last pyridin silver method, innumerable spirochetes were found. Third. In smears made from the exudation from this gland stained by a special method (Pröschner), which we will describe later, very great numbers of spirochetes were found.

CASE 2. History.—The second case presented the picture of chronic lymphomatosis (Hodgkin's disease). The patient had been sick about three years.

Examination.—The blood picture was normal. One year previously the red blood corpuscles numbered 5,000,000; leucocytes, 6,600; hemoglobin, 80 per cent.

The glands in cervical axillary and inguinal regions were considerably enlarged and readily palpable. One gland, extirpated one year ago by Dr. Pröschner, showed only the lesions of chronic lymphatic hyperplasia. In this patient three different glands were aspirated. In the smears from the fluid obtained in this way we found in each instance large numbers of spirochetes, which corresponded with the organism described in the former case. On aspiration, two of the glands furnished small particles of cheesy-looking material. Smears from this were made and stained for tubercle bacilli and spirochetes. No tubercle bacilli were found. The cheesy material was a solid mass of spirochetes.

In a later communication we will furnish a complete record of our findings in these cases, with six additional cases which we have now under examination, together

with our conclusions concerning this class of blood diseases.

NOTE.—Since the writing of this paper the patient in Case 1 (the acute case) has died. It was absolutely impossible to obtain an autopsy, which would have helped us to determine: First, whether this was a pure lymphatic infection or whether the bone marrow was also involved; secondly, something of the port of entry of the organism.

AN INTERESTING CASE OF INCONTINENCE OF FECES IN AN UNDERSIZED BOY OF SIX YEARS.*

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When, two years ago, three boys with incontinence of both urine and feces were brought to the Children's Dispensary, University Hospital, inside of three months, I reviewed the literature¹ on incontinence of feces in childhood and could find altogether only twelve cases in children over three years of age. Another recent review of the literature from 1904 to the present time failed to reveal any more cases of this condition.

Patient.—In February, 1907, a very small, rather stout, ruddy-cheeked boy of six years was brought to me with this history:

History.—His parents, who are well, are both short and stout. The father is a motorman. John is the fourth child, born after a protracted labor, without instruments, however. He was a large, well-developed baby at birth and had never been seriously ill. He was breast-fed until nine months of age, was then weaned, and given table food soon afterward. His teeth appeared regularly and he grew normally until four years old.

Two years ago, however, without any general or local cause which the parents could discover then or can think of now, the boy began to lose control of his bowel movements. He did not appear to be nervous; his appetite seemed normal; he ran about like other boys of four years. He had had no illness, nor had he been kept housed up during the winter. His diet had been that of the other older children, including many fried things, much tea and coffee. He was not constipated, but had a tendency to diarrhea at times. Nor had he ever had enuresis. The three older children, though uniformly small, all kept well, and John alone developed incontinence of feces.

The incontinence recurred with constantly increasing frequency until a day rarely passed without its happening once at least, and sometimes he would soil his clothing as often as six times in twenty-four hours. He has been and still is bright mentally and physically active, though his mother has not sent him to school yet on account of the incontinence. Like his sisters, who also are small for their ages, John has a slight defect in his speech, which, his mother says, all of her children have had, but they outgrow it as they grow older.

Examination.—John is 41 inches high and has been just that high for the past eighteen months. His physical development otherwise is excellent. There are no adenoids, though his tonsils are slightly hypertrophied. The circumference of his head is 19½ inches; that of his chest is 22 inches. He weighs 41 pounds. His thoracic and abdominal viscera show nothing abnormal. Rectal examination revealed a sphincter which was apparently securely closed, and this could be palpated well by introducing the finger into the rectum.

* Read in the Section on Diseases of Children of the American Medical Association, at the Fifty-eighth Annual Session, held at Atlantic City, June, 1907.

1. Maurice Ostheimer, "Incontinence of Feces in Children," University of Pennsylvania Medical Bulletin, February, 1905.

Treatment.—His mother tried many drugs and electricity without any good result. She assured me that she would co-operate to the best of her ability in any treatment I should suggest. With her I went over his diet very carefully, excluding tea and coffee, all fried food, fresh bread, cake and pastry, and all eating between meals. A cold sponge-bath was advised daily on rising in the morning, to last two or three minutes, followed by a good rubbing with a rough towel. The child was to be kept out in the air as much as was possible, and pills of stychnin, 1/60 of a grain each, were ordered three times a day after meals.

In spite of his mother's assurances, John objected to the cold sponge-baths, and his mother began to omit them inside of a week. Incontinence of feces was noted once on the day after treatment was begun, and then not again for five weeks, during which time his pills were taken somewhat irregularly, and he got about one sponge-bath a week. Then his mother was unable to return to the hospital, so that two weeks passed without any medicine at all, during which time the incontinence recurred three times. At her next visit I insisted on a more rigid treatment, which was at once begun, with such good effect that the incontinence has not reappeared since, a period of eight weeks now. John is still under treatment, taking the pills regularly, though only getting two cold sponge-baths each week.

The following table of statistics shows that the above patient is both below the normal height and weight for his age, six years. He shows no deformities or malformations, omitting his slight speech defect.

	Height. Inches.	Weight. Pounds.	Circumference of chest. Inches.	Circumference of head. Inches.
John	41	41	22	19½
Normal—Roth ²	43.75	45.07	21.75	20.50
Normal—MacDonald ³	44.64	45.01	20.51
Normal—Holt ⁴	44.10	45.10	23.20
Normal—Griffith ⁵	43	44

There seems little doubt that incontinence of feces, in such cases, will recur soon after treatment is stopped, unless the treatment, rigidly carried out, extends over three months or longer. In this connection I might refer to the first case which I reported¹ in 1904, also in a boy of six years, in whom treatment was continued irregularly for several months, with apparent recovery. But five months later, after an attack of diarrhea following the ingestion of unripe fruit, the incontinence of feces recurred. The boy was left without treatment for the past two years, until I looked him up three months ago. I persuaded his mother to begin treatment again, and the child, now a big boy of nine years, is trying hard to overcome the condition, of which he is thoroughly ashamed. He is taking stychnin, cold sponge-baths daily and practically lives out of doors. Besides, he will soon begin to take swimming lessons daily.

Fresh air, cold water and stychnin all seem to act by raising the lowered tone of the rectal muscles. I wish to lay stress on the fact that the treatment of this condition, which fortunately is rare, should be instituted early, carried out regularly and continued as long as possible, in order to prevent recurrence of the incontinence.

Since reading this report two cases of incontinence of the feces have been reported by C. G. Kerley in his new book on the "Treatment of Diseases of Children." An interesting review of the treatment of the conditions, by G. F. Still, appeared in the *London Clinical Journal*, April 24, 1907.

The incontinence has not recurred in either of these cases since June, 1907.

DISCUSSION.

DR. A. W. FAIRBANKS, Boston, thought that most of the cases of incontinence developing after control has once been established are really due to lack of mental control. In many of these cases the child has some anatomic or physiologic defect in other respects, or the other children in the family, or parents, may be defective in some way. Some of the children show no visible mental defect, but it is nearly always a matter of mental control. The earlier in the life of the child the incontinence occurs, after control has already attained, the less, as a rule, will be the outward evidence of slightly defective mental stamina. The later its onset in childhood, the more noticeable is likely to be some evidence in other ways of deficient cerebral capacity. In other words, the longer control has been established, the greater must be the temporary lapse of cerebral power, causing the incontinence. Incontinence, therefore, is not likely, in the absence of disease, to occur in later childhood, except in those children who show in other ways well-marked defective cerebral function.

CONCRETION IN LUSCHKA'S TONSIL.

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The following case is of interest from its rarity. I have been unable to find a report of a similar case in the available literature. It is further of interest from the symptoms, which resembled those of hay fever:

Patient.—A. B., male, aged 28, has always had trouble with his throat and nose, but otherwise presents no clinical history of importance. He at first appeared to be a victim of hay fever, although there was no sneezing at the moment. The face presented a vacuous expression; nose was long and narrow, giving a pinched expression. The alæ moved feebly, and considerable thin discharge flowed from the nostrils. The mouth was open to aid breathing, and there were fetor of the breath and painful deglutition. Deafness was also present.

Examination.—Anterior rhinoscopy showed the picture of trophic rhinitis: crusts and scabs, showing shallow ulcerations underneath when they were lifted by the probe. Inspection of the mouth revealed a high palatine vault, moderate hypertrophy of the faucial tonsils and pharyngitis. Posterior rhinoscopy showed a few adenoid plicæ surrounding a centrally located, greatly hypertrophied single growth, presumably the pharyngeal tonsil of Luschka's gland. The latter was onion-shaped, with a few crypts showing inspissated yellowish secretion and one rather large crypt at the most dependent portion. Uniform redness was everywhere seen.

Diagnosis.—A cystic degeneration or abscess of the third tonsil.

Treatment.—As the patient refused curettage, he was given iodine as an alterative. Appreciable relief as to ability to swallow was experienced in twelve hours. The patient was beginning to show signs of iodism and commenced to hawk and spit, when an object was felt to drop into the throat. This seemed to be a rhinolith. Inspection showed that the concretion came from the center of the enlarged tonsil, which now had a shrunk, baggy appearance and was discharging blood and pus. Improvement soon became manifest and has continued under the use of douches, etc.

The concretion had a somewhat cretaceous character, but was much harder.

The patient lives in what was evidently the bed of an ancient river, and the drinking water of the region is hard. I removed some renal calculi from a woman living half a mile south of him, and half a mile from her lived a patient on whose parotid gland I operated for calculus. These facts seem to lend some support to the theory that the calcium in the drinking water has something to do with the etiology of such calcareous deposits.

2. T. M. Roth, "Pediatrics," 1901, pages 45 and 81.

3. MacDonald, quoted by H. Koplik, "Diseases of Infancy and Childhood," 1902, page 56.

4. L. E. Holt, "Diseases of Infancy and Childhood," 1897, page 20.

5. J. P. Crozer Griffith, "Care of the Baby," 1903, page 53.