

AN INTERESTING CONTACT CASE OF DIPHTHERIA.

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AN interesting and instructive case was officially called to the attention of the Boston Health Department, recently. It emphasized the well known fact that care should always be exercised in determining the diagnosis where there is a possibility of a venereal infection or otherwise.

Katherine —, age 7 years, was taken by her mother to the family physician on account of the discovery by the mother of a discharge from the vulva. The physician, with apparently undue haste, made the diagnosis of gonorrhoeal infection and stated that in his opinion the child had recently been raped. No smear was taken and the diagnosis was evidently made solely on the presence of the discharge from the vulva. The statement made by the physician naturally disturbed the mother and father of the little patient and they consulted the Boston Health Department. Upon being assigned to the case, I found that the child had a sero-sanguineous discharge from the vulva. There was a decided exudate on the lower part of the vulva and it extended on to the perineum in the form of an incrustation. There was a noticeable quantity of blood exuding from this exudate. There was a marked odor which was the first indication to the mother that there was anything unusual. I found no clinical evidence of rape.

On questioning the child, I learned that there had been a discharge for at least one week. Eight smears were taken for the purpose of determining the presence of gonococci. They were all reported negative by the laboratory. These smears were taken from various parts of the vulva, from the urethra and from different areas of the exudative process.

The next morning I was called by the mother to treat another daughter, age 14 years, and found her with a clinical case of faucial diphtheria, which diagnosis was confirmed by a positive K.L. from the laboratory. This development naturally suggested an investigation for the probable carrier in the household, and a routine examination disclosed another sister, aged 5 years, with a distinct membrane in each nostril from which a positive culture was reported from the laboratory. This last sister slept with the child who had the exudative process in the vulva, and the former, on further questioning, was found to have had a bloody discharge from the nose for two weeks previously.

Katherine was given 3,000 units of anti-toxin as soon as I made a clinical diagnosis of diphtheria in her other two sisters. Three thousand units were subsequently administered to her eight hours later. No other treatment was instituted in her case.

Marie, the child with clinical faucial diphtheria, received 15,000 units of anti-toxin in forty-eight hours. Margaret, who had clinical nasal diphtheria, was given the same quantity in the same interval.

Two other children in the same family, who were clinically negative, naturally received an immuniz-

ing dose of 1,500 units. Marie, with faucial diphtheria, made an uneventful convalescence, showing two negative cultures on the eighth day. Margaret, with nasal diphtheria, had a protracted convalescence, two successive negative cultures for release not being obtainable until the twenty-fourth day from the date of the first treatment.

In this (Katharine's) case, the discharge from the vulva cleaned up in forty-eight hours after the first injection of anti-toxin. The exudate disappeared in the same length of time.

It may be remarked in her case that she showed no positive cultures, but it is a well recognized fact among bacteriologists and epidemiologists, that not infrequently such is the case in diphtheritic vulvitis, on account of the presence of other micro-organisms common in the vaginal secretions which prevent the growth of K.L. bacillus.

Diphtheria of the vulva is not a very common disease, but it would seem to me that we have here a well defined case of this type. The presence of the other two cases of diphtheria in the same family, the fact that the child with nasal diphtheria slept with Katherine (vulva type) showing the probability of contact, and the very rapid recovery after the administration of anti-toxin, certainly seems to bear out my contention and emphasizes the fact that one should be ready to recognize the probability of contact cases, and that it is possible to have diphtheria invade unusual channels.

Reports of Societies.

NEW ENGLAND SOCIETY OF DERMATOLOGY AND SYPHILIS.

THE second meeting of the Society was held at the Boston City Hospital on November 18, 1915, with the President, Dr. Abner Post, in the chair.

The following cases were presented and discussed:

1. RODENT ULCER (TEREBRANT VARIETY). PRESENTED BY DR. T. W. THORNDIKE.

The man was 49 years of age, with no venereal history. Fifteen years ago two or three hard lumps appeared on the forehead. Six years ago the disease became pronouncedly ulcerative, the erosion beginning at the inner canthus of the eye and progressing steadily, without any tendency toward cicatrization, until the whole upper half of the left side of the face had been destroyed down to, and including, in places, the bone.

The man has had x-ray treatment, with much resulting benefit.

2. CASE FOR DIAGNOSIS. PRESENTED BY DR. W. P. BOARDMAN.

The condition appeared about one year ago, just after the birth of a child. At first the appearances were those of an acute eczema,—deep pigmentation, scaling, sharp borders and marked rosacea. Since then the eruption has changed very little. Many forms of treatment have been tried, and the most