

It is difficult to be sure whether No. 62 on the opposite side was responsible or whether No. 10 was himself infected before admission to the hospital. This case was a medical case admitted under similar circumstances to No. 62—namely, pressure on medical beds due to the general epidemic. This man was a slight gas case and was admitted about midnight on the 6th, afebrile on arrival, but had a sudden rise of temperature at 12 P.M. on the 8th, a period of 48 hours after admission. His ailment showed pyrexia, rhonchi, and crepitations at the left base. His recovery was rapid, the laryngitis, due to gas, remaining unaltered during the whole period. His left-hand neighbour, No. 11, suffered from fracture of the right and left humerus, and this case had a sudden rise of temperature on the 8th, shivering and coryzal symptoms, and an ear discharge. This cleared up very rapidly. The incubation period was between 35 and 40 hours.

The limitation of spread from these cases may be explained by the fact that although the beds were occupied, yet elaborate cross-pieces for splints materially increased the space between the beds, thus interposing the barrier to further spread.

Summary.

The ailment from which all these cases were suffering appears without doubt to be influenza, both from the positive bacteriological results in two cases out of nine and also from the clinical observations. As regards the latter, it is interesting to note that the following symptoms were presented by one or other case, and that the duration of the illness was either long or short: (1) septicæmia; (2) coryza; (3) bronchitis; (4) broncho-pneumonia; (5) otitis media; (6) body pains, &c. In all these cases the incubation period was about 48 hours, the cases in which possibilities of accurate observation were greatest were those which approximated most closely to a 48-hour period.

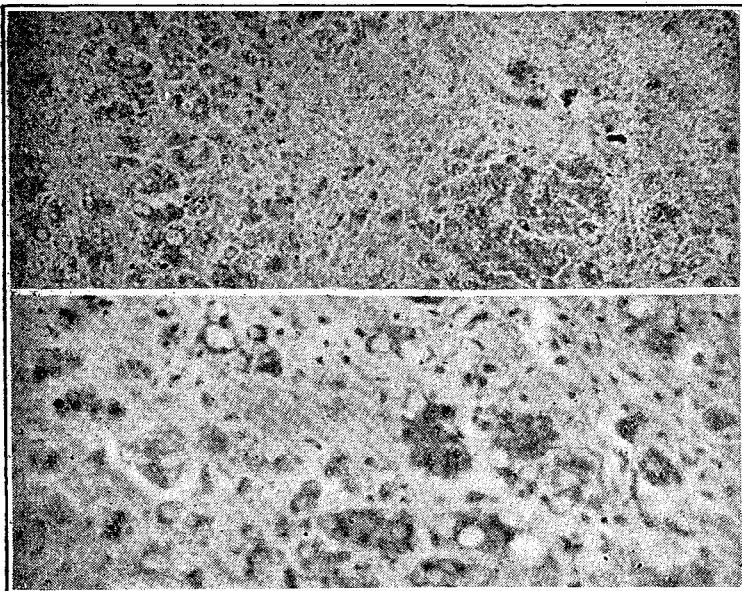
These observations illustrate two factors in the spread of influenza. Firstly, the narrow radius within which infection takes place; secondly, the shortness and apparent punctuality of the incubation period. Both these factors help to explain the rapid spread of epidemic influenza.

SUPPLEMENT TO A NOTE ON

"ACUTE YELLOW ATROPHY" (?).

BY ERNEST GLYNN, F.R.C.P. LOND.

THE following microphotographs illustrate the condition of the liver on microscopical examination in the case of the female munition worker, aged 20, who died suddenly of acute toxic jaundice (?) nine months after leaving the T.N.T. filling-room. A full note on the case appeared in THE LANCET of Oct. 26th, pp. 555-6.



Upper half.—Section of liver, $\times 150$, showing large necrotic areas and portions of persisting but fatty lobules.

Lower half.—Section of liver, $\times 400$, showing (right quarter) unusually cirrhotic area and (left bottom corner) necrotic area. Fatty liver cells are also seen.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SECTIONS OF MEDICINE, EPIDEMIOLOGY, AND PATHOLOGY.

Encephalitis Lethargica.

A COMBINED meeting of these sections was held on Oct. 22nd, Surgeon Rear-Admiral Sir HUMPHRY ROLLESTON, President of the Society, being in the chair, when a discussion took place on *Encephalitis Lethargica*, a brief note on which has already appeared in our columns.

Pathology.

Lieutenant-Colonel F. W. MOTT, R.A.M.C. (T.), gave a résumé of the results of the examination of two brains which was sent through him by M. Marinesco, professor of neurology at Bucharest, who had been working for some time past in the pathological laboratory of the Maudsley Neurological Clearing Hospital. Disseminated miliary or punctiform hæmorrhages visible to the naked eye existed in the grey matter in the neighbourhood of the floor of the fourth ventricle, the aqueduct of Sylvius, and even the third ventricle, and were also found in the posterior part of the pons and the peduncles. The cerebral cortex, except for congestion of some of the vessels of the lepto-meninges, had shown in these two cases neither macroscopic nor microscopic lesions. On the contrary, the first segment of the spinal cord, which was the portion of the cord available, had presented the same histological lesions as the pons, bulb, and peduncles. Microscopical study of the above-mentioned regions had demonstrated the existence of four kinds of lesions: 1. Infiltration of the walls of the small vessels, and especially the veins, consisting of lymphocytes and plasma cells in the adventitia, disposed in several layers. The endothelium and fibroblasts might also take part in the inflammatory process. 2. Foci of interstitial inflammation consisting of neuroglia cells of several kinds, including large cells with voluminous eccentric nucleus and many fibrillar prolongations, lymphocytes, and polynuclears. The foci of interstitial inflammation appeared sometimes to be altogether independent of vascular infiltrations, and might occur in the roots of the nerves—e.g., hypoglossal, pneumogastric, &c. 3. Lesions of the nerve cells, which did not correspond with those usually seen in infantile paralysis. There was dissolution of the *soi-disant* Nissl bodies, relative achromatosis, reduction in volume of the cellular body and of the number of prolongations and multiplications of the satellite cells, but only exceptionally was there evidence of neuronphagia, as was described by Economo. 4. The foci of hæmorrhage, the most obvious microscopic change, were seen to be much more numerous when microscopic examination was made. These hæmorrhagic foci remained circumscribed around the walls of the small vessels, and red corpuscles were mingled with the cells of inflammatory infiltration, or they constituted a kind of covering and floated about around the vessels. In spite of the very great number of hæmorrhages the vessel wall did not appear to be necrosed, but sometimes a solution of continuity of the vessel wall could be seen. From microscopic investigation of these two cases, M. Marinesco drew some conclusions upon the nature of the disease. He regards lethargic encephalitis as a disease entirely different from botulism, from the hæmorrhagic poliomyelitis of Wernicke, from the poliomyelitis of Heine-Medin, and from sleeping sickness. Like these two last diseases, it was an infectious inflammatory disease, but the nature of the infectious germs had not yet been determined. It was distinguished from botulism by its symptomatology and by the four above-mentioned histological lesions. The vascular lesions, due to the presence of an infiltration of the walls of the vessels by migratory elements, were absent in botulism, and the readily recognisable *Bacillus botulinus* had not been found in these cases. Colonel Mott then showed photomicrographs illustrating the chronic inflammatory conditions of the perivascular lymphatics in sleeping sickness and cerebro-spinal syphilis, in which there was definite infection by a specific organism, and which might be accompanied by somnolence. In