Clinical and other Notes

October 6th, 1910.—A diffuse macular rash developed. The pain, fever and leucocytosis continuing, an exploratory operation was decided on.

In the absence of localising signs and with such evidence as was available a diagnosis of retro-peritoneal suppuration seemed the most feasible.

Operation October 8th, 1910, by Major Pilcher. An aspirating needle entered perpendicularly in the tenth right intercostal space in the mid-axillary line encountered pus at a depth of 3½ inches.

Three inches of the tenth right rib were resected, the parietal and phrenic pleura sewn to the diaphragm and this incised. The needle was followed through the liver and 12 ounces of pus evacuated from a cavity of no recognisable anatomical boundaries but extending inwards to the middle line and downwards to the right. The pus provided a pure culture of \textit{Staphylococcus pyogenes aureus}.

Temporary improvement followed, but persistence of fever and leucocytosis indicated further surgical interference.

November 11th, 1910.—A counter incision was made in the right loin to meet a probe passed into the sac from above.

The upper wound healed rapidly, but despite several operations a sinus still persists in the loin.

As to the origin of the condition it seems probable that a duodenal ulcer had leaked through and infected the retro-peritoneal tissues of that region.

The pain and hyperesthesia would then be explicable by the anatomical distribution of the lumbar nerves.

I am indebted to Lieutenant-Colonel Maher, R.A.M.C., for permission to publish the notes of this case.

A CASE OF BILATERAL PERIPHERAL FACIAL PALSY.

By Lieutenant G. H. Dive.
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The following brief account illustrates this rare condition.

The patient, aged 23, was admitted to the Queen Alexandra Military Hospital on August 18th, 1910, with right-sided facial palsy of fourteen days' duration. This was peripheral in type, and probably consequent on exposure. Seven weeks after the onset, and whilst still undergoing treatment, facial palsy of the left side appeared; this was also peripheral in type. Both palsies were severe, and the reaction of degeneration was obtained on both sides. There was no evidence of central disease.

Treatment consisted of rest and sedatives, followed by galvanism, faradism and massage.
As regards the final condition the right side recovered first and completely (November 9th, 1910), and the left side almost so. I am indebted to Lieutenant-Colonel Mahor, R.A.M.C., for permission to publish this case.

FEVER OF MALARIAL ORIGIN.

By Captain R. G. H. Tate.
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Working in a laboratory in India during the fever season of the year, one cannot help being struck by the number of blood-films sent in which fail to show the parasites of malaria, even after repeated and careful examination. Many films are sent in simply as a routine matter, to eliminate the possibility of malaria being overlooked, but, setting these aside, there are many from cases in which malaria is genuinely suspected but in which no parasites are to be found. Among these are many possessing the characters which, according to Daniels, Da Costa, Manson, and Christophers, are typical of malarial blood, viz., a normal, or nearly normal, leucocyte count, a relative increase of the large mononuclear elements and pigment granules in the polymorphonuclear cells. On looking back through the medical history sheets of such cases one often finds a history of malaria, sometimes of recent date, but generally within the last year. As a rule the course of an attack of fever in such cases is short, lasting from one to four or five days, and not showing any periodicity; the case is, in most instances, returned as one of pyrexia of uncertain origin, whereas the fever is really due to old malaria. Again, if one takes films of blood from any hundred men who have had malaria at one time or another, it is surprising how many will show, in a greater or less degree, the changes noted above, and yet how very few show symptoms of active malaria. When dealing with native troops, time after time men come up complaining of "bukhar" (fever), in whose blood no parasites can be found, but whose blood shows the same relative increase of mononuclear elements as is seen in Europeans. The lack of true malarial symptoms in many of these native cases may be due to the immunity acquired in infancy and described by Koch. Now there must be some determining factor which will light up an attack of fever in these cases, although such an attack may have none of the characteristics of malaria, and two years work in the inspection room of a battalion which had suffered heavily in a malarious district, has pointed very clearly to there being at least four such agents: Over-exercise, chill, sun and digestive disturbance. Enquiry has nearly always brought one or other of these causes to light in natives and Europeans, and it would also point to the fact that sun alone, without over-exercise, may produce an attack of fever in such cases, although no other symptoms of in-