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A special stereoscopic picture has been prepared. Opposite the right eye there is a picture of a boy, and opposite the left that of a man. These viewed through the stereoscope are seen separately if the eyes are closed alternately, but if looked at with both eyes the boy is seen on the man's back. The opportunity of catching out a malingerer with this device is obvious.

(13) Tests for binocular vision in alleged monocular blindness:—

(a) Place a lighted candle in front of the subject; hold an 8° prism base outwards before one eye. If both eyes see, the one behind the prism will move inwards, and on removing the prism will move outwards; the other eye remains fixed. (Welz.)

(b) A lighted candle is placed twenty feet from the subject; an 8° prism is put before the sound eye. If the superimposed double images are admitted, the fraud is apparent. In obtaining the admission it should not be asked if he sees two images, which gives an opportunity for a negative reply, but he should be requested to state at once if the two images are placed one above the other or side by side, and which is the brighter.

In neither (a) nor (b) need the room be darkened, although artificial light is being used.

Apparatus Required for the Tests.

Trial spectacle frame with: A plain glass; a red glass; a green glass; two convex lenses, one 5° and the other 8°; two prisms, one 4° and the other 8°. Snellen's test-types reversed. Soft red crayon. Bishop Harman's diaphragm test. Mirror. Haselberg's parti-coloured test-card.

CASE OF ACUTE YELLOW ATROPHY OF THE LIVER TREATED BY INJECTIONS OF SODIUM BICARBONATE; RECOVERY.

By Temporary Captain C. NEPEAN LONGRIDGE.

Royal Army Medical Corps.

E. P., aged 25, reported sick on October 1, his symptoms at that time being headache, pains in the legs, occasional slight attacks of diarrhoea, and a pain described as neuralgic in character in the gums. These symptoms were accompanied by fever. He was sent from Gallipoli and admitted to the Giza Hospital, Egypt, on October 10, 1915. Inquiry into his previous history revealed nothing of any interest except an attack of synovitis of the knee some years previously. On admission he complained of feeling sick, loss of appetite and feeling weak, the pains in his legs being much better. He was a healthy-looking, fresh-complexioned young man and well nourished. The tongue was
clean, teeth good, and there was a slight tinge of jaundice in both conjunctiva. The bowels were acting normally, temperature 99.6° F., and pulse normal.

The case was regarded and treated as one of epidemic catarrhal jaundice which was common at the time.

On October 13 marked icterus had developed, the water was mahogany-coloured and the stools like clay; temperature normal, liver dullness normal. The following morning he had a severe fainting attack for no ascertainable cause, and complained of pain in the epigastrium. He vomited occasionally and was obviously ill; the jaundice had increased and the liver dullness was found to extend from fifth space in nipple line to just below the costal arch. He was ordered a drachm of glucose in five ounces of water every four hours by the rectum, and a drachm of sodium bicarbonate in two ounces of water every two hours by the mouth. A specimen of water was examined and found to contain large quantities of leucin and tyrosin. The temperature was subnormal and the pulse 70, of good quality.

On October 15 the patient was no better. He had continued to vomit bilious fluid, the bowels had acted and the motions contained a small quantity of blood; the tongue was clean, but the man was violently delirious, and the liver dullness had descended to the sixth space in the nipple line. The injections of glucose into the rectum were continued with difficulty and could not be given regularly. The sodium bicarbonate was now administered hypodermically, 100 cubic centimetres of a two per cent solution being injected morning and evening.

The delirium continued throughout the night and the next day; there was incontinence of urine and faces, some blood was noticed in the vomit, which was now less frequent. The jaundice was no deeper, the pulse 60, of fair quality, the liver dullness had descended a further half an inch. No petechiae were visible on the skin. Only a few ounces of very dark urine were passed. The injections of sodium bicarbonate were continued to the exclusion of everything else. He could only be persuaded to take a few mouthfuls of milk or lemonade occasionally. At this period, Colonel William Hunter came over from Alexandria to see the man, and agreed that it was a case of acute yellow atrophy of the liver in all probability, and recommended continuation of the same treatment. On the following morning (October 17) the patient was conscious and had slept a few hours, the pulse improved and the liver dullness had gone up half an inch to the sixth space. Over 200 cubic centimetres of alkaline urine were passed, still containing leucin and tyrosin, but neither albumin nor sugar. The improvement continued on the 18th, the liver now reaching the fifth space, and within a few more days the patient was convalescent and the liver was found at the upper border of the fifth rib. On October 21, with the exception of occasional attacks of nausea, the patient made an
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uninterrupted recovery and left the hospital for the Luxor Convalescent Home on November 18.

I record this case because, in the opinion of Colonel Hunter and Major Llewellyn Phillips, who also saw the case, it was one of acute yellow atrophy, and the injections of sodium bicarbonate were the probable cause of the favourable termination.

The atrophy is an acute autolytic degeneration of the liver, a process which is much more rapid in an acid than in an alkaline medium, and therefore demands a free administration of alkali to bring about its arrest. It is closely akin to what occurs in certain cases of eclampsia, in which I believe I was the first to point out a marked diminution of the alkalinity of the blood (estimated by Wright's method). In these cases of eclampsia I have learnt to regard as an ominous symptom complaint of pain in the epigastrium, such as this patient had.

A SANITARY LAUNDRY ON THE LINES OF COMMUNICATION.

By SERJEANT-MAJOR E. B. DEWBERRY.

Royal Army Medical Corps.

DURING the early period of the War when reinforcements were being rapidly sent up from the base camps in France to the front, it was found that a quantity of dirty though serviceable clothing, underclothing, socks and other articles were thrown away by the troops waiting in camps and under orders to entrain. This wastage was practically unavoidable in the earlier stages of the campaign owing to the unusual conditions obtaining at the time. The various articles were generally left scattered in the neighbourhood of the tents, and being collected by the men on sanitary duties were mixed with the other camp refuse, and ultimately found their way to the incinerators. The clothing was very dirty and probably infested with lice, and as the troops had neither the time nor the convenience for washing it, the only course which appeared open to them was to throw it away. Various attempts were made on a small scale to stop the wastage, but they did not meet with any great measure of success.

In the month of June, 1915, it was definitely decided to try and remedy this state of affairs, by arranging for each camp to collect the discarded articles, to sort out those which could be re-issued if washed, and to send the remainder, after having been torn into rags and disinfected, to the Ordnance stores. Orders were issued accordingly to the effect that on no account was any clothing or rags to be burned, but that they were to be dealt with as described.

Arrangements were then proceeded with for the erection of a small laundry to deal with the serviceable articles. Some difficulty was at