part of the congested stomach or duodenum; all the lymphatic tissue in the abdomen was hypertrophied; brain, etc.: normal.

Cause of death: status lymphaticus. Cause of stimulation: (?) toxæmia from tinned food.

N.B.—There was no evidence as to whether there had been any vomiting before the patient went to his hammock.

CASE 3.

An English lady of 75, non-inoculated, was ill three weeks in her home with slight diarrhoea. A Greek doctor saw her, diagnosed acute T.B. lung and eventually sent her into a women's and children's hospital. Just before she died I saw her with the medical officer, and we both thought of typhoid. I took a blood culture on chance and got a very good growth of Bacillus typhosus in thirty-six hours. Faeces also positive; Widal negative. Temperature subnormal until just before she died.

TWO CASES OF LEUKÆMIA.

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Case 1.—Sapper X, aged 22, was admitted to Fort Pitt Military Hospital on February 2, 1922.

Family History.—Nine brothers and sisters. Two brothers killed in the war. All other members of the family alive and healthy, including father and mother.

Condition on Admission.—Stated he had been on full duty previous to admission but lately felt a bit "off colour." Complained of headache and sore throat of twenty-four hours duration. Temperature 100° F., pulse 76. Pain in left side and slight cough. Slight friction rub could be heard. Lymphatic glands in anterior triangle of neck were moderately enlarged and tender.

Stated that he had noted a similar "lump" some weeks before but it had gone away of its own accord. On third day of admission moderate epistaxis occurred. Pain in the left side continued, and the painful site was painted with iodine. Temperature continued at 100° F., and pulse rate 80.

The counter-irritation of the iodine relieved the pain but produced a purpuric rash exactly coinciding with the area painted: a similar rash, but very much milder in type, appeared on the forehead.

Blood examination at once cleared up the diagnosis, showing: red blood corpuscles, 1,375,000; leucocytes, 268,000; hemoglobin, twenty-six per cent.

Laboratory Report.—Blood picture was typical of an acute lymphatic leukemia. Lymphocytes exceed ninety-nine per cent and are very irregular in size and shape of nuclei. No myelocytes or eosinophils were seen, and no nucleated red cells.

The progress of the case was rapidly down hill. The epistaxis continued and was more severe. Other lymphatic glands in the neck, axilla and groins became enlarged. Temperature varied from 100° to 104°, rising towards the termination of the illness. Pulse rate from 104 to 136.
Clinical and other Notes

Patient died on February 12, 1922. Anæmia, not at all marked on admission, rapidly increased as the case progressed.

Autopsy.—Spleen much enlarged, friable and adherent to the diaphragm, weight eighteen ounces. General enlargement of lymphatic glands all over the body with haemorrhages into the gland substance. The stomach showed numerous sub-peritoneal haemorrhages. Bone marrow of the tibia was grey in colour and small in amount.

The outstanding feature of the case was the apparently sudden onset and rapidity of further symptoms.

Case 2.—Sapper V., aged 18, was admitted to the Military Hospital, Fort Pitt, on March 18, 1922. Diagnosis, tonsillitis.

Family History was unimportant.

Condition on Admission.—Both tonsils enlarged and injected. No folliculitis. Temperature 99·2° F. General condition was that of a poorly developed and rather anæmic youth. The throat condition cleared up in three days. It was noticed that the gums were swollen and spongy. The dental officer saw the case and the teeth were scaled and mouth washes prescribed. Bacteriological examination of mouth showed a heavy infection of staphylococci and streptococci. No fusiform bacilli were seen. The cervical glands in the anterior triangle of the neck were enlarged. The mouth condition improved but the gums remained swollen and slight haemorrhages occurred. The temperature and pulse were normal. The patient ate and slept well, complained of no pain, but showed an increasing anæmic appearance.

A blood examination showed an enormous increase of leucocytes, ninety-eight per cent large lymphocytes. Total count was: red blood corpuscles, 1,000,000; leucocytes, 120,000.

As the case progressed, the cervical, axillary, and inguinal glands became enlarged and palpable. The leucocyte count rose to 180,000 and the anæmia became so marked that the patient became of a "bled white" aspect.

The long bones of the leg and the pelvic bones were radiographed but no change was noticeable in the medullary canals. The gums continued to be spongy, in fact the condition was more marked, but it was merely a clean swelling without sepsis.

The patient gradually sank and death took place on April 20, 1922.

The case differed from the previous case in: (1) Gradual in onset and more prolonged. (2) Haemorrhage negligible. (3) No purpuric rashes. (4) Temperature remained normal and sub-normal. (5) The marked spongy gum condition. Both young soldiers belonged to the same Battalion and had not served out of England.

No autopsy was possible in Case 2.

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