more accurate diagnosis, to pass a bougie or even the oesophagoscope, the result might have been instructive to the onlookers, but could have been nothing but mortifying to the patient and surgeon.

A CASE OF HUMAN INFESTATION WITH BELASCARIS MYSTAX.

BY MAJOR R. F. DICKINSON,
Royal Army Medical Corps.

The following case is of interest in that infection with this parasite is very rare in man, the optimum host being one of the Felidae.

The patient was a girl aged 3 years, the daughter of British parents of good social position stationed in Mauritius. One worm was passed in a copious putty-coloured stool. The child was in good health and has remained so ever since. The faeces contained Belascaris mystax eggs with fine honeycomb markings.

Treatment with santonin and pulv. scammony co. on two occasions failed to produce any more worms.

A point of interest in the case is that there was a very thin and sickly cat in the house at the time from which the child probably got infected. The cat was destroyed by the child's father before the nature of its illness could be investigated.

My thanks are due to Dr. Clark H. Yeager, Senior State Director, International Health Board, Rockefeller Foundation, who very kindly cut sections of the worm and identified the specimen for me as Belascaris mystax.

A CASE OF TRAUMATIC PERFORATION OF THE JEJUNUM ASSOCIATED WITH COMPOUND FRACTURE OF THE LEG, NECESSITATING AMPUTATION.

BY CAPTAIN D. McKELVEY, M.C.
Royal Army Medical Corps.

LANCE-CORPORAL H. was admitted to hospital at 11 a.m. on July 22, 1924, with the diagnosis of compound fracture of the left leg. He gave the following history:—About 7.30 a.m. that morning whilst riding a horse over a jump in the riding school of his unit the animal fell and rolled on top of him.

Condition on admission.—A moderate degree of shock was present. The temperature was 97° F., and the pulse rate 94 per minute. The blood-pressure was not much below normal. There was an extensive wound in the lower third of the left leg through which the broken ends of
the tibia and fibula were protruding. The left ankle-joint was laid open. The astragalus was fractured and dislocated, and protruded through the skin wound. There was also a fracture of the os calcis. The foot was pale and cold. No pulsation could be made out in the dorsalis pedis or posterior tibial arteries. The patient also complained of severe pain in the epigastrium. There was no history of nausea or vomiting. Both rectus muscles were intensely rigid. The breathing was thoracic in character. Tenderness was generalized but was most marked just above and to the left of the umbilicus. There was no diminution in the liver dulness, and there were no external signs of bruising of the abdominal wall.

The patient was warmed with hot-water bottles and blankets and a hypodermic injection of morphia ½ gr. and atropine 1/100 gr. given. After half-an-hour there was no improvement in the abdominal condition, and it was decided to operate at once as it was felt that a rupture of the intestine had occurred. The anaesthetic was administered by Captain C. P. Chambers, R.A.M.C. Induction was carried out by chloroform and ether, and thereafter open ether was given. The abdomen was opened by a left rectus incision. On incising the peritoneum some free fluid and a small quantity of gas escaped. A rupture about the size of a sixpenny piece was found in the jejunum twelve inches from the duodeno-jejunal junction. The long axis of the perforation ran at right angles to the long axis of the gut. The edges of the rupture were ragged and contused. The opening was closed by two layers of catgut sutures. The whole gut was then systematically examined, but no further perforations were found. The abdominal cavity was mopped dry as far as possible, a suprapubic drain inserted and the operation wound closed. Attention was then directed to the foot. After a hurried examination it was apparent that it would not be possible to save it. It was decided that immediate amputation afforded him the best hope of recovery, as it was felt that the additional shock likely to supervene if the foot were left would greatly minimize his chances. Amputation was accordingly carried out through the leg. After the operation 750 cubic centimetres of 6 per cent gum acacia in normal saline were given intravenously and rectal salines were administered four-hourly. For the first three days his condition remained critical. On the second day he vomited several times. On the morning of the third day vomiting became very troublesome and persistent. A tube was passed and the stomach washed out, and thereafter his condition steadily improved and gave no further cause for anxiety.

The case would appear to be of interest from two points of view, viz.:

(1) The question of diagnosis.—The general symptoms exhibited and the condition of the pulse were no more than might have been produced by the leg lesion alone. The diagnosis of an intra-abdominal lesion was based entirely on the abdominal pain, tenderness and marked muscular rigidity which were present. These signs were considered sufficient to warrant exploratory laparotomy. Rowlands and Turner state that a certain
diagnosis in these cases is seldom possible for twelve hours or longer, but they recommend that operation should not be postponed on this account.

(2) The mode of production of the rupture.—As a result of experiment in animals, B. F. Curtis, of New York, came to the conclusion that such an injury is not of the nature of a true rupture, i.e., a bursting of the wall of the gut over its contents, but a contused and lacerated wound caused by the gut being crushed between the contusing body and the bony parts. From this it would appear that a rupture is more likely to be produced when the gut is empty. These conclusions were amply supported by the ragged and contused appearance of the edges of the perforation. As the accident occurred before breakfast the jejunum was to all intents practically empty.

I am indebted to Lieutenant-Colonel L. Wood, R.A.M.C., for his kind permission to publish these notes, and to Captain C. P. Chambers, R.A.M.C., for his skilful administration of the anaesthetic.

A CASE OF SYPHILITIC BASAL MENINGITIS.

By Captain V. J. Bonavia.
Royal Army Medical Corps.

It is well recognized that the severe headaches which sometimes occur after a primary chancre is healed, and before the secondary stage has developed, may be due to some meningitic conditions, and the following case is of clinical interest as it affords evidence that definite neuro-syphilis may appear in the secondary (and even early secondary) stage of syphilis, as well as in the late tertiary stage. It also illustrates the tendency of the syphilitic virus to settle in a previously damaged tissue.

The patient, Corporal M., gives a history of having been in perfect health up to April, 1917, when he became involved in a shell explosion by which, he states, he was "knocked unconscious" and buried in the debris, from which he was eventually "dug out." He suffered from severe concussion and its after-effects, for which he was admitted to hospital. He was under treatment in various hospitals until January, 1918, when he was invalided from the Service for "shell-shock" and awarded a full pension.

He apparently made a good recovery and re-enlisted in the Army in September, 1919. He suffered from malaria and sandfly fever in Mesopotamia in 1920, and on both occasions severe headache was a prominent symptom, which did not clear up for an unusually long period. Subsequently, except for one admission to hospital for "myalgia" in June, 1923, he was in good health, until he contracted syphilis in July, 1923. The dates of the appearance of the manifestations are significant as indicating a severe and virulent infection.

July 23: Exposure to infection. August 6: Appearance of primary