It is further of interest to note that for about thirty-six hours after the injury had been sustained the victim was able to carry out his ordinary work, while no serious symptoms arose until a further eighty-four hours had elapsed.

The probability is, therefore, that the blow caused a rupture of a small vessel only in the spleen, with consequently but little hæmosorrage during the earlier period while the man was at work. The hæmosorrage gradually increased, and at the end of thirty-six hours sufficient pressure was exerted by it to cause pain and distress. On the other hand, a further three and a half days elapsed before sufficient pressure was exerted to cause a rupture of the capsule.

In this case the violence applied appears to have been by no means considerable, and under other circumstances the history of this injury might not have been elicited, and in consequence the case recorded as one of spontaneous rupture. The authors feel that, in a great many of the recorded cases of so-called spontaneous rupture of the spleen, the initial cause has been the application of external violence, and that spontaneous rupture of a spleen, whether healthy or enlarged, does not occur.

A point of clinical importance in this case is the fact that acute pain or other localizing features were entirely absent, this no doubt being due to the fact that the primary rupture took place within the substance of the organ.

A CASE OF GASTRIC SYPHILIS.

By MAJOR J. H. M. FROBISHER.
Royal Army Medical Corps.

AND

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Royal Army Medical Corps.

The patient, aged 39, a warrant officer, was admitted to the Military Hospital, Gibraltar, complaining of chronic constipation and of anorexia, associated with a sense of fullness in the epigastrium after meals, of six months duration. He also complained of occasional attacks of nausea, rarely associated with vomiting. There was no history of hæmatemesis, and no history of alcoholism or venereal disease was admitted. He had not been losing weight.

His appearance was that of a chronic dyspeptic, and on admission to hospital his tongue was heavily furred, his breath offensive and there was some degree of ptyalism. Patient had an imperfectly fitting denture but his oral hygiene was fair. There was slight tenderness over the whole epigastrium on deep palpation but epigastric pain had apparently never been a feature of his illness. At first nothing abnormal could be discovered in chest or abdomen and his condition was considered to be one of chronic
gastitis. However, as the patient did not improve under treatment, and as his ptyalism became markedly worse, investigations were carried out to exclude the possibility of ulcer or neoplasm.

*Test Meal* gave the following result:—

<table>
<thead>
<tr>
<th></th>
<th>Free HCl</th>
<th>Combined HCl</th>
<th>Organic acids</th>
<th>Total acids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Result</td>
<td>0·124 per cent.</td>
<td>0·127 &quot;</td>
<td>Trace</td>
<td>0·251 &quot;</td>
</tr>
</tbody>
</table>

A mere trace only of lactic acid was detected in the test meal and blood was not present. It is suggested that the patient's marked ptyalism lowered the percentage reading of the total acids.

*Faces.*—No blood or occult blood detected in the faces.

*Barium Meal.*—The result of this examination showed great delay in emptying of the stomach, and an apparent "filling defect" on the greater curvature near the cardiac orifice.

In addition the radiogram showed a peculiar appearance in the splenic flexure (*vide* radiogram) about which we are unable to express an opinion. The apparent "filling defect" made us consider the possibility of new-growth, ulcer, or gumma.

Patient's blood was then sent for a Wassermann test and the result was strongly positive. In view of this and the radiological appearances, a provisional diagnosis of "Syphilis" of the stomach was made, and patient was put on antisyphilitic treatment.

A total of 3·62 grammes sulfarsenol with large doses of potassium iodide, and a short course of mercury by the mouth was given.

As was anticipated, the specific treatment increased the ptyalism and this was controlled to a great extent by the administration of tinct. belladonna fifteen m. t.d.s. and an astringent mouth wash.

His ptyalism is difficult to explain and no local cause could be found to account for it, but it was a marked feature of the case and was not an hysterical manifestation. The antisyphilitic course was given over a period of three months. At the end of this his Wassermann reaction and Sigma test were both negative. Equally important, the patient had lost all his dyspeptic symptoms and a further radiological examination showed that a great change had apparently taken place in the stomach.

Prior to the antisyphilitic course the patient was very sluggish mentally. His pupils reacted to light and accommodation and his fundi were normal. Romberg's sign was not present. Knee-jerks were a little exaggerated, gait normal, but patient had a little inco-ordination, well shown when he tried to button or unbutton his jacket. In addition he had throughout his illness difficulty in opening his mouth widely, and had more control over the left side of his face than the right. At all times there was an almost mask-like immobility of his face. At the end of his specific course patient was distinctly more alert mentally, but his face remained immobile, a
slight degree of ptyalism was present, and there was still difficulty in carrying out fine movements with his hands. According to one of his officers who had known patient for five months, this facial expression had not altered, but the patient's wife informed us that about six months prior to his admission to hospital he gradually began to take no obvious interest in his family or affairs, and that he gradually cultivated the habit of sitting in a chair staring somewhat vacantly into space. It is of interest to note that patient has five children; the three older children are healthy but the two youngest, who are twins, closely resemble congenital syphilics. It is considered that the patient had probably a very slight degree of cerebral syphilis prior to his admission to hospital. He had now been transferred to England for further treatment.

Finally, we should like to call attention to the article by L. T. Le Wald (Radiology, Feb., 1926, p. 138) in which he maintains that a radiological examination affords the best means of recognizing the existence of syphilis of the stomach, and that antisyphilitic treatment under radiological supervision should always be employed in cases where there is any doubt as to the diagnosis, or where malignancy is believed to be present and so advanced as to render operation impracticable.

In regard to the interpretation of this case both clinically and radiologically, we are open to correction, but if our deductions are correct the case is one of considerable interest.

[Note.—At the request of the authors we have referred this paper to Major McGrigor, X-ray Department, Q.A.M. Hospital, Millbank, for his opinion. Major McGrigor states that from his experience of cases of syphilis of the stomach he thinks the clinical and radiological deductions of the authors are correct.—Ed.]

NOTES ON THE SCHICK TEST AS CARRIED OUT AT THE DUKE OF YORK'S ROYAL MILITARY SCHOOL, DOVER.

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AND

MAJOR F. CASEMENT, D.S.O.
Royal Army Medical Corps.

Owing to a small outbreak of diphtheria at the Duke of York's Royal Military School early in 1926 it was decided to carry out the Schick test on the boys of the Junior School, and it is thought that the technique and results may be of interest.

The Junior School consisted of ninety-one boys, of whom six were absent in hospital when the test was performed.