Clinical and other Notes

for about half an hour after injection and for a short time again the same night, when a slight but uncomfortable dragging pain, radiating towards the loin of the affected side, was experienced, suffered no inconvenience following the injection. For about a week the testicle was a little tender, but this tenderness was of such slight consequence that the patient was able to go out on horse-back on the day following the injection without undue discomfort or any ill-effect.

On the evening of the day after the injection a “crepitation” similar to that felt in a case of teno-synovitis was detected on gentle massage of the injected tunica.

On March 19, 1932, I again tapped the effusion (which had returned to some extent). The fluid was now cloudy, and contained a trace of blood; on standing, a thin clot formed at the bottom of the test-tube. The amount of fluid removed (as far as possible the complete contents) was thirty cubic centimetres.

Since that date there has been no return of fluid, and the hydrocele would appear, at the time of writing (six weeks after treatment), to be completely cured.

I was assisted in carrying out this treatment by Assistant Surgeon J. F. Freeman, I.M.D., to whom I am indebted for his help, rendered necessary by the fact that the patient was myself.

REFERENCES.


A FATAL PERISPLENIC ABSCESS COMPLICATED BY MALARIA.

By Major W. W. S. Sharpe,

and

The Late Lieutenernt E. G. C. Darke

Royal Army Medical Corps.

The following notes will, it is hoped, be of interest, on account of the difficulty of differential diagnosis. Private J., aged 28, had spent five years in India—in Calcutta, Nasirabad and for a short time in Ahmedabad, where he first contracted benign tertian malaria. There was no history of dysentery, and he stated that he had never suffered from diarrhoea, except very occasional slight attacks. His medical history sheet contains no relevant entries except those for malaria, viz.:

Fresh infection in October, 1928, mild benign tertian, four days in hospital. First relapse (?) in September, 1930, eight days in hospital. A second relapse in June, 1931, the precursor of his fatal illness. The spleen
was much enlarged, three fingers' breadths below the costal margin and gametocytes were at once found in the blood.

The attack was mild, was not unusual in any way except for the splenic enlargement, and after three days fever, 101° to 102° F., and four days convalescence, during which he was treated with quinine hydrochloride with small increasing doses of liq. arsenicalis, he was discharged to barrack treatment. The spleen was then two fingers' breadths below the costal margin. The stools, which were a trifle loose, showed no cysts or ova.

Three days later, on July 2, the patient was "detained" in hospital, complaining of pain in the left side of the abdomen. The temperature was 100° F.; pulse 100. There was obvious fulness in the left flank. From under the left costal margin, extending downwards into the flank and backwards into the loin, was an elongated tumour with a sharp inner edge reaching a point midway between the umbilicus and the anterior superior spine and with its apex just below the level of the umbilicus. The tumour was tender and moved with respiration. The abdominal respiratory movement was normal and there was no rigidity. There were no physical signs in the chest. Blood-films showed no parasites. The condition suggested thrombosis of the splenic vessels. He was unfit to be sent fourteen miles for X-ray examination.

The following morning, July 3, the temperature had fallen to 99° F.; pulse 88. The patient felt "quite well in himself" and his condition was unchanged. Examination of the urine showed that quinine was not being absorbed. The urine was normal. The crenated edge of the spleen was distinctly felt, and there was no sign of rigidity. Evening temperature 102° F.; pulse 100.

On July 4 pain had subsided; temperature was 100° to 101° F., pulse 76 to 84. The condition was unchanged. Blood-films were repeatedly negative. Blood was taken for culture and agglutination, and the counts were as follows: White blood-cells 12,000, polymorphs 75 per cent, red blood-cells 2,800,000, small lymphocytes 20 per cent.

On July 5 the condition seemed definitely improved. He did not complain of abdominal pain; temperature and pulse remained the same. Quinine was present in the urine and no parasites were found in the the blood. Russo's test was negative. Agglutination (TAB) gave T 71, A 116, B 126, standard agglutinin units. He was last inoculated in December, 1930.

The patient's condition did not change until 3 a.m. on July 7, 1931, when he complained of a return of the pain and feeling of weakness; a "rub" was heard above the spleen and there was some cyanosis. This was followed by more marked cyanosis, acute abdominal pain, with tenderness and general rigidity, working of the alæ nasi and facies Hippocratica. The patient's condition was critical, and it was decided to give a blood transfusion in the hope that sufficient improvement would
take place to permit of laparotomy. No group sera being available, his
serum was tested for agglutination against the blood of several donors, and
one was selected. A pint of blood was obtained and transfused on the table
by the citrate method with an improvised apparatus. Calcium chloride
was also administered, but his condition did not improve and laparotomy
could not be proceeded with. Death occurred two hours later.

POST-MORTEM EXAMINATION.

The body was well nourished.

Abdomen.—The peritoneal cavity contained turbid, free fluid
and a small amount of gas. The intestines were very injected and
somewhat dilated. In the left hypochondrium was a large mass which
extended forward to the mid-line and downward to the iliac crest. This
proved to be a large peritoneal abscess containing foul-smelling pus and
bounded above by the left portion of the transverse meso-colon, anteriorly
by an enlarged spleen and by matted, indurated and oedematous omentum,
to the left by the splenic flexure and upper part of the descending colon,
to the right and below by coils of dilated, adherent small intestine and
posteriorly by the peritoneum of the posterior abdominal wall. These
structures were separated and revealed an indurated mass three inches long
on the descending colon extending downwards from the splenic flexure.
The intestine was opened at this point and the lumen admitted the
little finger only. The transverse colon above the tumour was slightly
dilated and the descending colon below somewhat collapsed.

The descending colon on being opened revealed, two inches below the
splenic flexure, a large ulcer 1 ½ inches wide completely encircling the gut.
The edges were slightly raised and everted but not indurated. The base
of the ulcer was rough and necrotic and, at the right side of the colon in
two places, extended deeply into the colon wall and thickened surrounding
tissues. One of these deep excavations communicated by a small opening
with the abscess cavity. The whole wall of the colon at this point was
thickened. No other ulcers were found throughout the large or small
intestine.

The spleen (weight 15 ounces) was enlarged, congested and indurated,
and a part of the capsule was involved in the wall of the abscess and
covered with lymph. A smear from the spleen pulp revealed no malaria
parasites. The kidneys (weight 5 ounces) were normal.

The liver (weight 64 ounces) was normal and did not reveal the fatty
change expected. The gall-bladder was normal.

The stomach contained much bile-stained fluid and the mucous
membrane was healthy.

The pelvic organs were healthy. The heart and lungs were palpated
by opening the diaphragm. The lungs were congested but no pleural
adhesions or patches of pneumonia were present. The heart appeared
normal on palpation. No organism was found in the pus from the abscess cavity.

The descending colon was preserved and examined microscopically by Major L. Dunbar, D.A.D.P., Mhow District, who reported: “I have examined many sections of the wall of this abscess and, though I am of opinion that it was originally due to amoebiasis of the intestine, I have failed to find microscopic evidence of Entamoeba histolytica infestation.”

The sharp edge of the spleen anterior to the abscess and its apparent increase in size after the patient’s discharge for malaria gave rise to an initial diagnosis of splenic thrombosis.

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Echoes of the Past.

THE REMINISCENCES OF AN ARMY SURGEON.

BY LIEUTENANT-COLONEL W. A. MORRIS.

Royal Army Medical Corps (Ret.).

(Continued from Vol. lviii, page 149).

[In the last section of Colonel Morris’s Reminiscences which we published he described his journey home in the “Syria.” Later Colonel Morris again proceeded to India. In the following section the author resumes his story when he is again about to leave India.—Ed.]

I handed over charge of the hospitals at Murree at the end of October, and took leave pending embarkation, and proceeded to Lahore. I had served in the Pindi Division for fourteen years and left it with genuine regret. It is the finest station in India, and I had the fortune to serve some of the best officers of my Corps there—Sir T. Mansel, Sir C. Cuffe, Colonel Blennerhassett, and S.M.Os. like Colonels Pollock, Ring and Bourke.

We sailed home in the “Plassey,” and arrived in London in the middle of a very cold snap, when I received orders appointing me to the charge at Edinburgh and S.M.O. Scottish Defences. It was a good charge which I was glad to get, but I rather wished it had been nearer my home in Wales. I began to think of the future, for I was an interminable time a Lieutenant-Colonel, and as a matter of fact became 55 years of age before my turn came, but I was on the selected list for promotion. I had been ten years a Lieutenant-Colonel, a rank the majority pass through in three to five years. This was due to three very heavy batches which entered the Army before me and blocked promotion.

I knew Edinburgh well, the good-natured Scotsmen were always very kind to me, and I had many friends among them. We took a house near the Pentlands, where I used to play golf and also at Morton Hall and Barnton.