Clinical and other Notes.

AN UNCOMMON TYPE OF CHRONIC NEPHRITIS.

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Lance-Sergeant S. C., aged 27, was admitted to Queen Alexandra Military Hospital, Millbank, on November 7, 1933, from Bedford, where he had complained of lassitude, headache and dyspnœa. There was a history of a mild attack of tonsillitis eight days before. Some œdema of renal type was present, and the urine contained albumin. There was no history of any renal disease.

Details of urine analysis were: Acid reaction; sp. gr. 1008; albumin present (0·125 per cent.); no deposit; no casts; no sugar.

The blood showed 650 milligrammes of urea per 100 cubic centimetres.

Blood-pressure 160/100/60.

The clinical condition was typical of acute uræmic poisoning and need not be further described.

Death occurred on the seventh day after admission.

The post-mortem findings showed:—

A small left kidney weighing $2\frac{3}{4}$ ounces, with marked areas of fibrosis unevenly distributed. A right kidney nearly normal in size, weighing $4\frac{3}{4}$ ounces, with similar findings in a less advanced condition.

There were also present the common terminal complications of a pleural effusion, patchy bronchopneumonia, and recent pericarditis.

The case is one of interest in that such conditions are occasionally met with in serving soldiers. One of the writers had charge of an exactly similar case in Aldershot four years ago.

The diagnostic data which are usually definite and distinctive are as follows: (i) Complete absence of any history of renal disease. (ii) A very high blood urea. (iii) Moderate albumin with usually a few casts, no blood. (iv) Moderate hyperpiesis ranging between 140-180 millimetres mercury, systolic. Œdema. (v) No marked cardiac enlargement. (vi) Absence of albuminuric retinitis.

The cases may be summarized by stating that the *first clinical features* consist of the terminal uræmia, death occurring within a week or so of their coming under observation.

There is no effective treatment beyond temporary palliative measures such as venesection and the intravenous injection of sodium chloride, or magnesium sulphate solution.

The classification of these cases is difficult. They were originally described by Rose Bradford as a special type of contracted kidney.

Sometimes there is evidence of a degree of renal dwarfism upon which is engrafted a progressive fibrosis of the kidney without (as has been stated) the occurrence of any periodic exacerbations recognizable by clinical means.

The consensus of opinion is that they form a small separate group of chronic nephritis (small white kidney) causing early death, and distinct from chronic interstitial nephritis. In the type of case under discussion fibrosis is less evenly distributed throughout the kidney while there is considerable atrophy of the glomeruli.

In this case there were none of the recognizable symptoms of acute infective nephritis, although the patient had suffered from tonsillitis shortly before the first and final phase of his illness.

Histological report on kidneys. Both kidneys showed a chronic nephritis with marked scarring and contracture of the cortex. There was some evidence of an acute inflammatory condition supervening on this.

The lungs showed a patchy bronchopneumonia together with a pleural exudate which contained as the predominating organism a long chained streptococcus.

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A CASE OF CYSTICERCOSIS (*T. SOLIUM*) WITH WELL-MARKED OPTIC NEURITIS.

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This case appears to be worthy of record, as it illustrates many of the points brought out in Colonel W. P. Mac Arthur's [1] work which do not yet appear to be fully appreciated.

(1) That optic neuritis is not an uncommon occurrence in cysticercosis, this being the fifth case in our series of sixty-two.

(2) That every case of fits occurring in a previously healthy adult who has lived in a tropical country should be regarded as a probable case of cysticercosis until it is proved otherwise.

(3) That even when full investigation fails to reveal evidence of cysticercosis, the patient should be kept under observation for a considerable time and frequent examination made for subcutaneous nodules which may come and go without even the patient being aware of them.

(4) That a negative radiogram of the skull is of no value, for in many cases where radiograms of the skull are negative, well-marked calcification