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INDIAN TYPHUS; A PATIENT'S VIEWS.

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Having been a recent sufferer from the Indian variety of typhus fever, it struck me that a few remarks from the patient's point of view might prove of interest.

At the time of my infection I had been stationed at Ahmednagar, Deccan, for about ten months and had been comparatively fit throughout the period.

The first case of this disease was seen by me just after my arrival in 1932, and was handed over as a case of "tick typhus"; the making out of the case card, A.F. I.1220, fell to my lot, and as the disease was new to me I had taken more than usual interest in the symptoms, progress and treatment.

One point that impressed me was that the case was not a true, textbook, typhus; it and several other cases seen later were not very severe, the face was not congested, the typical stuporose or drunken look was absent, the breath was not more offensive than usual nor was the tongue more coated than one expects to see in febrile cases; not one case suffered from epistaxis, vomiting or delirium.

The louse, P. humanus, is not the vector nor could I get the patient to admit having been bitten by a tick. I therefore wrote on A.F. I.1220, to the following effect: "Handed over to me as a case of 'tick typhus,' does not seem to be a case of true typhus and there is no evidence to show that it is due to ticks."

The receipt of the card seemed to have caused some excitement at headquarters as a telegram was received directing that the name "tick typhus" was not to be used, future cases were to be diagnosed as "P.U.O." Later, "typhus" was allowed, but up to the time of my leaving India, in November, 1933, the word "tick" had not reappeared.

During the first season I was at Ahmednagar there were about twenty cases amongst British and Indian troops; the Civil Surgeon told me that he had some similar cases in the jail which he was treating as cases of enteric fever; there were also a few cases in the Families Hospital. The admission of one small child caused some amusement; she was rigidly isolated, a quite unnecessary procedure in my opinion, and on her mother being told that the child had typhus she replied "Is that what it is, doctor? Her little sister had the same complaint about seven months ago and the doctor said that it was chicken-pox."
All the cases show very much the same symptoms. There is an initial attack of fever; this may be diagnosed as P.U.O. or, if there is any previous history of the disease, as clinical malaria; on the third or fourth day a rash appears, which is at first roseolar but later becomes purpuric. The distribution of the rash is general all over the body, including the palms of the hands and the soles of the feet; in some cases however the scalp, axillæ and groins do not show any rash.

Congestion of the throat is common, also congestion of the eyes, with some degree of photophobia. The fever persists for about fourteen days. The staining caused by the rash persists for several months.

During the second season there had been two cases, one a British "other rank" and the other a small child, prior to my becoming infected, my admission being quickly followed by two others to the Families Hospital. We one and all denied having had any knowledge of having been bitten by ticks.

Now to come to my personal experiences. In March, 1926, I was invalided home from India on account of malaria, from which I had suffered for two years previously; my last attack after my return to England was in July, 1926.

The A.D.M.S., Deccan District, Colonel E. C. Hodgson, D.S.O., I.M.S., inspected at Ahmednagar on September 11 and 12, 1933, and as Senior Medical Officer of the station I accompanied him on his inspection.

On September 11, it rained heavily, we were caught in the B.I. Lines and were considerably "damped"; on the 12th it was fine and we had a good morning's work and arranged that in the afternoon, should all be well, my wife and I were to call for the A.D.M.S. and then go on to the Club, but at the last moment our car refused to go, so we walked down to the M.E.S. Rest House; thence we decided to walk to the ruins of an old palace, about a mile away; my wife went back to our bungalow instead of going with us. On our return I walked home feeling very fit and well, had an excellent dinner and went to bed at the usual hour.

On September 13, at about 3 a.m. I awoke feeling very ill, awoke my wife and asked her to get me a dose of quinine and aspirin as I had a bad attack of malaria. My wife got up, gave me the medicine and took my temperature, which was 103°F. I went to sleep again, awoke as usual at 6 a.m. and had my morning tea and bath. About 8.30 a.m. I walked over to the hospital, a distance of about half a mile, dealt with the office work and then went round the wards, but at about 11 a.m. I told my senior assistant surgeon that I was feeling cold and shivery and was going home; I walked home, had lunch, more quinine, and as my temperature was still 101°F., I lay down on the bed most of the afternoon; at 7 p.m. as my temperature was still 101°F., we sent for the staff surgeon. He, having been but a short time in India, was quite willing to agree with our diagnosis of malaria and told me to carry on with the quinine.

When he called next morning my temperature was still 101°F., so it
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was decided that I should continue the quinine and aspirin; as I was taking quinine the absence of malaria parasites in my blood was of no diagnostic value. My evening temperature was still 101°F. but on the morning of the 15th it had dropped to 100°F.; examination of my urine showed that I was absorbing the quinine, so as my temperature was still high I suggested that Assistant Surgeon Ray, I.M.D., might come in to see me; he came and, whilst a careful examination was being made, noticed two or three small spots on my abdomen, very suggestive of the enteric group of diseases. That evening my temperature was again 101°F.

Next morning, September 15, my temperature was 100°F., and I was practically covered with a roseolar rash which left no doubt as to the diagnosis. Specimens of my blood, urine and feces were sent to the District Laboratory and the disease continued to run a normal course.

During the first three nights my wife slept under my net and fanned me most of the time, but after that I made her move away as she could not carry on day and night duty. I also sent for a nursing orderly to help me when washing or using the bed-pan, the latter unpleasant procedure being necessary, as I was ordered to remain lying down and not to exert myself in any way.

My wife and I worked out a diet; it consisted of two-hourly feeds between 6 a.m. and 8 p.m. of milk, soup, barley water and orange juice. For the first two days I wanted nothing, and my wife told me that I did not take half a pint of nourishment on either day.

Regarding my personal feelings; I was, for most of the time, quite indifferent to everything that was going on. If anyone spoke to me I answered, but had no desire to make conversation myself. If food was offered to me I took it, but had it not been offered I would have willingly left it on the plate.

I slept well, usually waking about midnight for a drink, after which I went to sleep again.

On the eighth day of my illness a telegram was received from the office of the A.D.M.S., ordering my admission to hospital at once and stating that two members of Q.A.I.M.N.S. were being sent to look after me. My trip in the ambulance was one of the most unpleasant periods of the illness.

Morning and evening temperatures remained between 100°F. and 101°F., until the thirteenth day, September 24. On the morning of the fourteenth day the temperature fell to normal, and remained so until my discharge from hospital on the twenty-ninth day of the disease.

My pulse reached 96 on the first day and was as low as 60 on the fifteenth day, usually it was between 80 and 84. Respirations averaged about 20. Bowels were open once daily. There were no serious complications; I developed a slight cough due to chronic bronchitis and an attack of dorsal myalgia in an old football injury which prevented my turning in bed without help, but this soon wore off.

On my admission to hospital I remained on two-hourly feeds until I
was able to take solid food, when I gradually returned to normal meal hours.

When I came back to solid food one or two rather amusing things occurred which seemed to suggest that a course of invalid dieting might be of use if taught at the Royal Army Medical College. The medical officer is responsible for the ordering of the diet, the nurse being only responsible for seeing that it is properly served.

As Ahmednagar is a small station, not blessed with a Government dairy, it is possible to have cows brought to the hospital so that they may be milked before some responsible person; the milk was therefore of very good quality and rich in cream. One evening, at 6 o'clock, I was given half a pint of this milk, and an hour later was offered dinner, consisting of soup, fish, chicken and sweet, which I was unable to face. On another occasion I was ordered a "mixed grill" for my evening meal; such a course may be suitable for lunch, but I found that a mixture of sausage, liver and bacon was rather nauseating when served for dinner. Again the sister suggested giving me two poached eggs at 6 a.m., but after a few remarks from her patient she changed her mind. Generally the food was well served and well cooked.

A typical diet was as follows: 6 a.m. tea. 8 a.m. breakfast, eggs in some form, toast, butter and coffee. 10 a.m. orange juice with glucose. 12 noon, beetroot, fowl, duck or meat, pudding. 2 p.m. orange juice with glucose. 4 p.m. tea with scones or bread and butter or toast. 7 p.m. dinner, soup, fish, chicken or meat, sweet. This diet was ample for anyone lying in bed, and I found on my discharge from hospital that I had lost only one stone in weight.

Generally the diet should be varied, given in small amounts at frequent intervals and well served; a most important point is that the food must be offered to the patient and not simply dumped by his bedside to become covered with flies. It should be realized that he is suffering from an intense toxæmia, is inclined to be lethargic, and unless pressed will not trouble about food or anything else.

Throughout my illness, both out of and in hospital, my wife gave me all my meals, except my chota hazri and orange juice at 2 p.m.; had she not done so it is very doubtful whether my recovery would have been as rapid as it was.

The question of regular dieting is of the greatest importance where "Other Ranks" are concerned; in stations where there are no sisters they should be asked for, so that the patients are not left to the tender mercies of well-meaning but not fully trained regimental nursing orderlies.

Treatment appears to be symptomatic, no general course can be given, but I would strongly recommend a small daily dose of some effervescent saline each morning.

Thanks to the careful attention of my wife I was able to return to duty
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on the twenty-ninth day of the disease and so escaped any penalties as regards loss of leave or pay, but was not fit to take any form of exercise for some time after my discharge. I tried to go out shooting, but after a mile or so fell behind and returned to my car. Even when we embarked for England, about the end of November, I was still feeling far from well, but not too ill to embark!

The rash was still visible, or rather the staining of the skin due to the rash was still visible six months after the onset.

The vector is still uncertain; elsewhere ticks have in two cases been proved to be the culprits, but it was not possible in any of the local cases to get anyone to admit any knowledge of having come in contact with ticks. Of course ticks abound, but so do many species of insects. It is not considered that bugs, lice or fleas are responsible for the disease; mosquitoes were under suspicion, as everyone in the station was bitten by these, but there was nothing to prove that they had anything to do with the matter.

I have not gone into the results of blood examinations and laboratory reports, as judging from the voluminous notes on my case and others a full technical report will in due course appear, and it is well to encourage junior officers in the way they should go. One point which I have omitted is that it is quite unnecessary to isolate patients or contacts. The disease is in no way contagious, so that cases can be safely treated in the general wards of the hospital.

Before ending I should like to express my deepest gratitude to Colonel E. C. Hodgson, D.S.O., I.M.S., for the interest he took in my case and for sending the two members of Q.A.I.M.N.S. to look after me in hospital; to Lieutenant, now Captain, B. Blewitt, R.A.M.C., and Assistant Surgeon Ray, I.M.D., for all the trouble they took over my well-being and for procuring the necessary laboratory specimens; to the nursing orderlies of the Royal Fusiliers who were untiring in their endeavours to make me comfortable; members of the I.H.C. also added their quota of assistance. To all I convey my very best thanks.

NOTES ON TWO INTERESTING CASES OF INFECTIOUS DISEASE.

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The following notes on two cases of infectious disease which were in Tidworth Isolation Hospital last year may prove of interest:—

Case I.—Cerebrospinal Meningitis.

Recruit J. S., aged 18. Service one month. Previous history: Treated in a reception station for influenza (which was then mildly epidemic), January 24 to 31. Proceeded to his home on sick leave February 1 and returned therefrom on the 7th, on which evening he reported sick and was