Japanese river fever (Tsutsugamushi), a closely related disease also common in Malaya. The etiology of this case is therefore rather puzzling. The patient was undoubtedly infected in Calcutta, as prior to his arrival in Rangoon he had not been away from there during the incubation period. It is difficult for one unacquainted with Calcutta to discuss this question, but the vicinity of Fort William would not appear to be the sort of place one would associate with scrub typhus. During his last month in the station the patient, who is a machine-gunner, did mule-loading drill with his platoon one morning on the maidan outside the Fort (normally out of bounds for troops); it is conceivable that at this time he may have been infected, but he did not lie down or otherwise come into unduly close contact with the vegetation. The only insects other than mosquitoes by which he remembers recently having been bitten are bed-bugs.

I am indebted to Lieutenant-Colonel A. G. Wells, D.S.O., R.A.M.C., Officer Commanding, and to Major F. A. R. Hacker, R.A.M.C., Officer in Charge of the Medical Ward, British Military Hospital, Mingaladon, for permission to forward this report for publication.

REFERENCES.


'AN UNUSUAL COMBINATION OF COMPLICATIONS."

By Lieutenant-Colonel C. M. Finny, O.B.E.,
Royal Army Medical Corps.

On November 15, 1934, I operated upon an Indian, aged 40, for renal calculus. He had never had an attack of renal colic, but had suffered for a long time from a constant ache in the left loin, with intermittent pain beneath the sternum.

At the operation I removed an oxalate calculus the size of a hazel nut from the pelvis of the left kidney. Apart from an unusually small loss of blood, the operation was uneventful, and his subsequent progress was at first very successful. There was no infection of the wound, no abdominal distension, and a slight pyrexia the next day soon subsided, although his pulse-rate remained over 100.

On November 17, he vomited ordinary gastric contents, and on the 18th he had a hematemesis. The following day his medical attendant became alarmed at the appearance of a large tarry stool and sent for me at 3 p.m. The patient looked as though he had lost a good deal of blood. His mucous membranes were pale and his pulse-rate was 120 but of good tension. He complained of a dull pain beneath the lower end of his sternum. The operation wound was clean and his abdomen soft and not tender.

I ordered complete rest for the stomach, with glucose salines per rectum,
and should it be necessary, a hypodermic injection of morphia. Fortunately this was not given, for at 9.30 p.m. I was again called to see him. At 8 p.m. he had been seized with severe abdominal pain, which caused him to throw himself about and cry out. He did not vomit. The abdomen moved on respiration, though the breathing was mainly thoracic. There was tenderness over the epigastrium and the right side of the abdomen and all the muscles were resistant on palpation. He complained of pain all over the front of the abdomen and chest and in both supra-scapular regions. The pulse-rate had risen to 136, and the temperature was 96° F.

After an hour with the aid of blankets and hot water bottles, his general condition had improved. The temperature had risen to 100° F. and the pulse improved. The pain was still intense and he gladly agreed to an operation.

On opening the abdomen there was an escape of gas, and a small perforation was found from which was escaping yellow gastric contents, but no blood. It was situated on the lesser curvature and nearer the cardiac end than the pylorus. This made it difficult to reach, but there appeared to be little surrounding induration, and it was readily sutured and an adjacent piece of omental fat stitched over it.

He stood the operation remarkably well and the next morning looked and felt much better—his pulse was of good volume and had fallen to 120, and he had not vomited. He was given nothing by the mouth, and rectal glucose salines continued. At 3.30 p.m., however, he suddenly collapsed and died in twenty minutes. No post mortem was allowed.

The unusual features of this case are:—

1. The occurrence of a severe gastric haemorrhage and perforation on the same day. It is reasonable to assume that they were both complications of the same ulcer. In that case it seems strange that the bleeding should cease completely while the ulcerative process went on to perforation. There was no suggestion of blood in the contents escaping from the perforation.

2. The patient must have had a gastric ulcer for some time. He had been walking about and only suffered from these two alarming complications when he was at rest in bed consuming only milk.

3. His sudden death was also strange. It did not seem sufficiently rapid to be due to a pulmonary embolism, though such a possibility cannot be excluded. It appears more likely that it was due to a sudden severe haemorrhage, which in his weakened condition overwhelmed him. The ulcer was on the lesser curvature and may have eroded the coronary artery.

4. Possibly this might have been prevented if I had ligatured the artery on each side of the ulcer at the time of the operation, but exposure was difficult and his condition was so critical at the time that I considered his interests were best served by performing the simplest operation possible.