Clinical and other Notes

The right frontal lobe was found to contain a large abscess which had ruptured into the right lateral ventricle, which was full of blood-clot and pus.

Lungs and pleuræ were normal.
The heart was normal: it had stopped in diastole.
Abdominal organs were normal.
The laboratory report on specimens of pus from ethmoidal labyrinth, cranial abscesses, etc., stated: "Pure culture of hæmolytic staphylococcus."

COMMENTS.

(1) The condition was an acute one superimposed on a chronic fronto-ethmoiditis. Spread into the left orbit took place by septic thrombosis of the communicating veins: spread into the left frontal lobe by carionecrotic erosion of the postero-inferior bony wall of the left frontal sinus, infiltration through the dura and also septic thrombosis of the dural veins, and so along the communicating veins into the meningeal vessels and brain substance: spread into the right frontal lobe by septic thrombosis of the diploic veins, and so by communicating veins and the dural veins into the meningeal vessels and brain substance. The longitudinal and cavernous sinuses apparently became infected and thrombosed by extension.

(2) The fulminating development of the intracranial infection is well shown.

(3) The well-known marked resistance offered by the orbital periosteum to the passage of infection is clearly demonstrated in the case of the left orbit.

(4) The organism responsible for intracranial spread is almost invariably the hæmolytic streptococcus, but would appear in this case to have been a staphylococcus.

I am indebted to Colonel A. W. M. Harvey, K.H.S., D.D.M.S., Northern Command, and to Lieutenant-Colonel C. D. K. Seaver, R.A.M.C., O.C., B.M.H., Murree, for permission to forward these notes for publication.

A CASE OF HÆMOPHILIA.

BY MAJOR K. M. NELSON, M.C.,

AND

MAJOR H. A. BOYLE,

Royal Army Medical Corps.

LANCE-CORPORAL J., 1st Battalion, the Manchester Regiment, stationed at Jamaica, was detained at midday, June 26, 1935, after a general anaesthetic and extraction of twenty teeth at the surgery of a civilian dental surgeon in Kingston.

On arrival there obviously had been a great deal of hæmorrhage but when seen it was not alarming. Patient was put to bed and given mouth
washes. Apparently the operation had to be curtailed on account of the haemorrhage at the time.

Family History.—A brother (also in this battalion) states he had two teeth out some time ago and that he bled profusely for a week, the gums having to be plugged, and injections into his arm being also given. Lance-Corporal J. stated voluntarily that he himself had a very severe epistaxis on one occasion when boxing, and that he always bled profusely and for fairly long periods when boxing.

June 27: Patient passed a fair night. Gums oozing a great deal all night; early this morning the oozing became more profuse. At 10 a.m. sockets (two upper and two lower molars on the right side) were plugged with adrenalin gauze and four minims of adrenalin given subcutaneously. Slight improvement. At noon the bleeding was profuse, and patient was seen by the civilian dental surgeon, who again plugged the sockets and advised subcutaneous injection of thromboplastin. After some time this was obtained and five cubic centimetres were given at 6 p.m., intravenously.

June 28: Patient passed a fair night. Gums still oozing. Haemoplatin, five cubic centimetres, given intravenously. At 11 a.m. profuse haemorrhage from right upper and lower gums commenced. These were again well plugged with adrenalin and another five cubic centimetres of haemoplatin were injected intramuscularly. At 12.30 p.m., in spite of the efforts of Major Boyle, R.A.M.C., and myself, the haemorrhage could not be controlled. The civilian dental surgeon was called in at 1 p.m. He plugged the sockets and applied a splint. In spite of this, haemorrhage was again very profuse at 6 p.m., and the dental surgeon re-plugged and reapplied the splint. At 9.30 p.m. bleeding appeared to be stopping and the patient was dozing.

June 29: At 3 a.m. Major Nelson was called up to see the patient, who was bleeding severely. Patient was very weak and unable to spit out the blood, which he appeared to be swallowing. The mouth was cleared out, the splint removed, and digital pressure applied. Pulse was very poor. Major Boyle was sent for to assist. The sockets were rapidly re-plugged and an intravenous injection of five cubic centimetres of calcium-gluconate was given. During the injection patient became very cyanosed, and his pulse was barely perceptible. He rallied, however, after a short time. On looking at the gums about three minutes after the injection, the bleeding was found to have practically ceased. At 4.30 a.m., as bleeding appeared to be re-commencing, a further five cubic centimetres of calcium-gluconate was given intravenously. At 6.30 a.m. there was only very slight oozing from the gums on the right side, and patient was dozing. General condition very fair. Pulse regular (80 to 84). At 9.45 a.m. the plugs were changed, no definite bleeding was seen. Three cubic centimetres of calcium-gluconate were given intravenously. This was repeated intramuscularly at 1 p.m. At 2 p.m. one pint of saline with glucose was given. General condition of patient much improved. Five cubic centimetres of calcium-gluconate given at 5.30 p.m.
Clinical and other Notes

June 30: Patient had a fair night, slight haeorrhage twice during the night, which was soon controlled. No further bleeding. Taking fluid nourishment well. Enema simplex given with very good results. Five cubic centimetres of calcium-gluconate given intramuscularly. Slight haeorrhage from left upper molar sockets at 2.15 p.m.; controlled, but needed re-plugging with adrenalin at 4.30 p.m. Five cubic centimetres of calcium-gluconate given intramuscularly at 6.30 p.m. Rather profuse haeorrhage occurred from the left lower molar sockets at 11 p.m. Plugged with adrenalin and five cubic centimetres of calcium-gluconate given intravenously. Bleeding ceased almost immediately. Slight haeorrhage recurred about 5 a.m., but ceased after re-packing.

July 1: Doing well. Five cubic centimetres of calcium-gluconate given as a precautionary step at 10 a.m. No actual haeorrhage seen. Taking feeds well. Appears brighter. At 7 p.m. slight bleeding from left upper and lower gums. Plugs changed and five cubic centimetres of calcium-gluconate given intramuscularly. At 9.30 p.m. bled profusely for a short time. Checked by plugging and intravenous injection of five cubic centimetres of calcium-gluconate.

July 2: General condition improved. Five cubic centimetres of calcium-gluconate given at 9 a.m. as routine treatment. No haeorrhage. Plugs removed at 6.30 p.m. No haeorrhage seen. Five cubic centimetres of calcium-gluconate given.

July 3: Passed a very good night. Slight bleeding only from the left upper gums at 5.45 a.m. Easily controlled. Five cubic centimetres of calcium-gluconate given intramuscularly at 9.30 a.m. Enema simplex given; good result. No haeorrhage during the afternoon, but five cubic centimetres of calcium-gluconate were given intramuscularly at 6.30 p.m. From this time onward there was no more haeorrhage and patient made an uninterrupted recovery.

Conclusions.

(1) Taking into consideration patient's history and that of his family, so far as it is known, and the long duration of the haeorrhage, this is a case of true hemophilia.

(2) The local application of adrenalin by injection and intravenous and intramuscular injection of thromboplastin were of no avail; the intravenous and intramuscular injection of calcium-gluconate was the only drug of any use, suggesting that the disease in this case, at any rate, was due to calcium deficiency.