Clinical and other Notes.

A CASE OF AURICULAR FIBRILLATION WITH RECOVERY.

By Major P. J. S. O'GRADY,
Royal Army Medical Corps.

Sergeant R. C. W., aged 38. Eighteen years' service.

A. Previous History.—Joined the Army in 1916 from school, at age of 17.

His first admission to hospital was for dysentery (amœbic) at Meerut, in 1920. Had malaria in Jamaica, 1928.

No history of rheumatism, chorea, or previous cardiac valvular disease.

His symptoms began at Rawalpindi in the spring of 1934. He complained of fluttering sensations in the precordium and vertigo, especially on stooping, and on one occasion lost consciousness. In May of that year he went to Gharial, where his symptoms became intensified. There he developed dyspnœa, which was experienced when at rest and markedly increased at exercise. There was a complete absence of pain at first, but later he had anginal pain which woke him up at night, and was accompanied by marked dyspnœa. He had to sit up in bed for hours.

He reported sick with these symptoms and was admitted to hospital. The marked irregularity of the pulse was noted, but no organic lesions were discovered. He was treated with digitalis which appears to have benefited him, in that the irregularity improved considerably. He was discharged to "Light Duty."

At a medical examination in October, 1934, for fitness for a machine gun course, the medical officer concerned suspected his condition and admitted him to hospital.

Radiograms were taken. A diagnosis was made. He was invalided home. Admitted to Royal Victoria Hospital, Netley, March 16, 1935.

B. Condition on Admission.—A man of small stature, healthy looking, and not a bit worried about his condition. There is a complete absence of subjective symptoms. There is no hyperthyroidism. No tremors. He has not been losing weight. Sweats rather easily. No bony changes indicative of rheumatism. His oral hygiene is good, and tonsils and fauces look healthy. The right pupil is larger than the left, but reacts to light and accommodation.

Cardio-vascular system: Apex beat difficult to locate, but probably in fifth interspace just inside the nipple line. No thrills palpable or murmurs audible. No clinical cardiac enlargement.

The ventricular rate as counted at the apex by auscultation is 62. The rate of the radial pulse is 50.

J R Army Med Corps: first published as 10.1136/jramc-68-06-07 on 1 June 1937. Downloaded from http://militaryhealth.bmj.com/ on August 19, 2022 by guest. Protected by copyright.

Pulse: Thready. Is irregular, and the irregularity is accentuated by increasing the pulse-rate. Jugular pulsation is present, one wave being visible during ventricular systole. The blood-pressure varies with each heart beat.

Radiologically, the heart is within normal limits of size. Heart—lung coefficient 2:1. Red blood-corpuscles 3,890,000. Hæmoglobin 80 per cent. Urine contains no albumin or sugar. Knee-jerks and ankle-jerks sluggish. Wassermann-Kahn reaction negative.

Fig. 1 is a cardiogram taken on March 15, before any treatment, beyond rest in bed, was carried out.

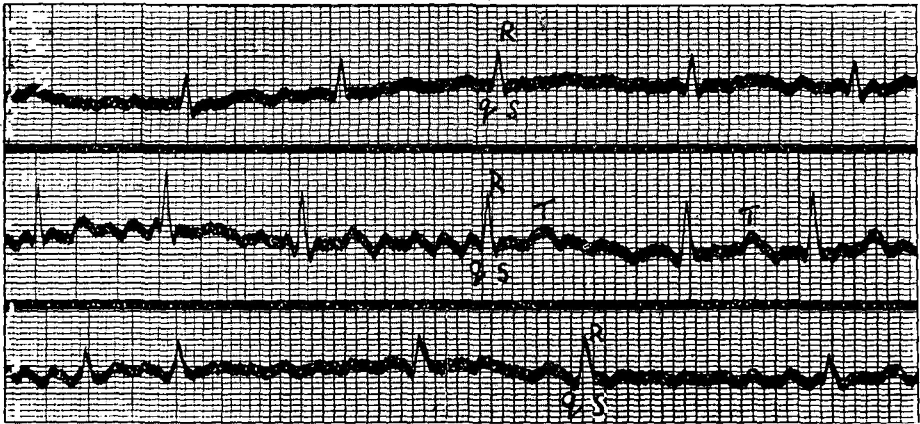

FIG. 1.

It shows the Q, R, S complexes to be normal in all three leads. P waves (auricular) are absent, proving the case to be one of auricular fibrillation. T waves are satisfactory in lead 2, but are not very prominent in lead 1.

Treatment and Disposal.—The patient was kept at rest and stopped smoking. As digitalis had formerly been exhibited it was decided to try quinidine. Accordingly on May 6, six grains, as an experimental dose were given. No ill-effects resulted.

On May 7 he was given quinine, six grains three-hourly (four doses). At 11 p.m. that night the patient who was asleep states that he suddenly woke up with a sensation of a "highly tensed wire suddenly breaking inside his head, and at the same time he was conscious of his heart "changing gear-like."

On May 11 his heart rhythm had become normal, and remained so until he was discharged May 28.

His Wassermann-Kahn reaction was re-tested and was again negative.

Fig. 2 is a cardiogram, taken May 20, nine days after his metamorphosis. It shows normal rhythm and normal P, Q, R, S, T complexes.

He was seen by the Consulting Physician to the Army about this

J R Army Med Corps: first published as 10.1136/jramc-68-06-07 on 1 June 1937. Downloaded from http://militaryhealth.bmj.com/ on August 19, 2022 by guest. Protected by copyright.

period, who considered there was no reason why the man should not be returned to duty. Accordingly, after advice as to his mode of living for some time, he was given a month's sick leave, and thereafter to return to duty. He had about two and a half years of unexpired service.

The case was being kept in touch with through annotation in his medical history sheet.

I had a letter from this patient on September 18, in which he informed me that he was quite well. He was on manœuvres this year.

On March 1, 1937, the patient was stated to suffer from a little dyspnœa on exertion, but otherwise was quite well. He was still serving.

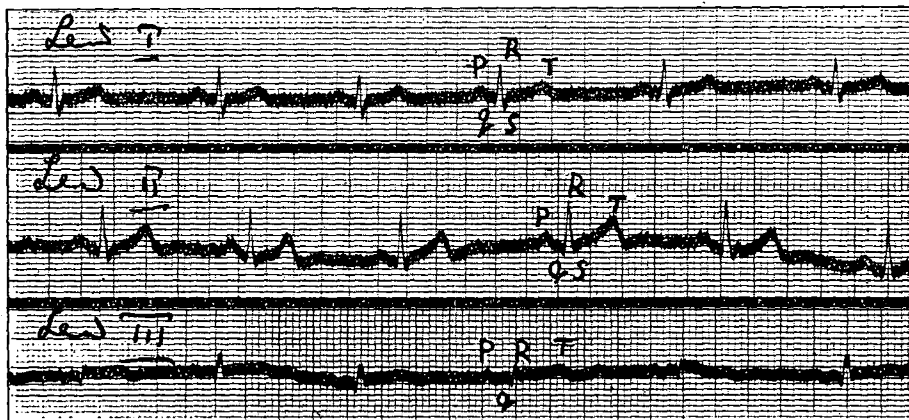

FIG. 2.

I am indebted to Dr. Harold Bower and to the staff at the Royal South Hants Hospital, Southampton, for their kindness in taking the necessary electrocardiograms; to Colonel A. D. Fraser, D.S.O., M.C., Officer Commanding R.V. Hospital, Netley, for permission to forward these notes, and to Major W. R. Spicer, R.A.M.C., for his valuable help in treatment.

The case has been followed up, and when seen in February, 1937, was perfectly well with no recurrence of symptoms.

A CASE OF GLANDULAR FEVER OR INFECTIVE MONONUCLEOSIS.

BY CAPTAIN R. ST. J. LYBURN,
Royal Army Medical Corps.

ON October 1, 1936, the patient, a girl, aged 13, was admitted to the Families Hospital, Moascar, complaining of slight sore throat and being off her food. She had been ill for ten days before admission, and during this period had been running a remittent temperature varying between 99°F. and

J R Army Med Corps: first published as 10.1136/jramc-68-06-07 on 1 June 1937. Downloaded from http://militaryhealth.bmj.com/ on August 19, 2022 by guest. Protected by copyright.