has been found to work efficiently and a large number of disinfestations have been carried out with it.

The construction of the disinfestor was entirely carried out by men of a Field Hygiene Section. I am particularly indebted to Serjeant Austin, R.A.M.C., for designing and supervising the construction, and to Private Leitch, R.A.M.C., for drawing the scale plan.

A CASE OF INFECTION WITH FASCIOLA HEPATICA.

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And

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Human infection with Fasciola hepatica, the common liver fluke of the sheep, is a rare condition. Stitt¹ quotes some fifty cases as having been recorded. In the circumstances, the following case is of interest:—

Mrs. R. W., aged 30, the wife of a soldier, reported at the British Military Families Hospital, Poona, on May 6, 1940, complaining of an acute stabbing pain of the right upper abdomen, in the region of the liver, for the past week.

She had been in India for ten years, previous to which she had lived in Switzerland.

Nine months before admission she was in hospital with "bacilluria," and three months later for appendicectomy (diagnosed "chronic appendicitis"). On both occasions the main symptom had been vague abdominal pain, chiefly right sided. Two months ago, she was again in hospital with "pain in the abdomen and back," this time diagnosed "myalgia" after X-ray examination had excluded renal calculus. She had been married six years, with one child, aged 5, and had had no abortions or miscarriages.

When admitted, the patient had a temperature of 99·4°F. and pulse 92. She had a small hard painful nodule over the seventh rib in the right anterior axillary line. This nodule was freely movable with apparently no attachment to the rib. X-ray examination of the spine, ribs, lungs and liver region revealed nothing abnormal. The blood examination was as follows:—

Total W.B.C., 10,800 per c.mm.; total R.B.C., 5,480,000 per c.mm.; Hb., 90 per cent; differential, polymorphs, 76 per cent; lymphocytes, 20 per cent; large monocytes, 2 per cent; eosinophils, 2 per cent.

Stool examination showed nothing abnormal. There were no cysts or ova

¹ Stitt, Clough and Clough "Practical Bacteriology, Haematology and Animal Parasitology," also Faust in "Human Helminthology" quotes a similar number of cases.
visible. The blood Wassermann was returned W.R. positive + and Kahn negative. This was twice repeated, with the same result.

Because of the Wassermann reaction, the patient was put on a course of potassium iodide and sulphostab injections and the lump on her chest was regarded as possibly a gumma. It however showed no response whatever to the antisyphilitic treatment and three weeks after her admission it was decided to explore the tumour. During this time she had had repeated attacks of pain on the right side of the chest and the lump was very tender. On several occasions she had low evening fever.

An incision over the tumour revealed a mass of inflamed subcutaneous tissue, in the centre of which was a live flat worm. The inflamed mass of tissue was excised and no evidence of any track leading to deeper structures could be found. The operative diagnosis was "an inflammatory swelling due to the presence of a flat worm resembling a liver fluke." Subsequently the fluke was identified at the Southern Command Laboratory as *Fasciola hepatica*.

The patient was kept in hospital a further three weeks during which time two courses of emetine were given. Careful questioning failed to disclose any possible source of infection. Repeated stool examination failed to reveal any ova of *Fasciola hepatica*. She had no further pain and another X-ray of the liver region showed nothing abnormal. She was discharged, to report periodically for observation.

The interesting features of the case were:

1. What was the extent of her infection with liver fluke?
2. The migration from the liver through the diaphragm and chest wall to the subcutaneous tissues.
3. The positive Wassermann reaction which, in the absence of any history or clinical signs suggesting syphilis, appeared to be due to the fluke infection. The negative Kahn supports this view.

We are indebted to Lieutenant-Colonel A. C. Craighead, I.M.S., for the laboratory examinations, and to Colonel W. L. E. Fretz, the Officer Commanding, Connaught Military Hospital, Poona, for his permission to forward these notes for publication.

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THE DOCTOR'S BAG.

BY MAJOR E. A. SMYTH,

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During my experience for short periods as locum tenens in ten different general practices in various parts of the British Isles, and as medical officer in charge of families in the Army, I came to the conclusion that few doctors pay much attention to the design and equipment of their "doctor's bag."

A good bag should be: (1) Simple and strong; (2) of reasonable size and weight, enabling it to be easily carried; (3) divided into convenient