INTERESTING CASES OF PRIMARY TUBERCLE IN ORGANS OTHER THAN THE LUNG.

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These cases occurred in negroes at Sierra Leone, and are published in illustration of some of the difficulties of diagnosis in countries where malaria, liver abscess, and other tropical disorders prevail.

The notes are taken from the official records. Case 1 was in hospital under my charge, but was in the immediate care of the medical officer named. I examined the cases in consultation, and assisted at the operations. I was present at the first post-mortem and made the second alone.

Case 1. Tubercle of the Pericardium, with Hydro-pericardium which was Mistaken for Pleural Effusion.—Private ——, West India Regiment, aged 24. (Case in immediate care of Civil-Surgeon A. T. Latchmore.)

The patient was admitted for bronchitis on June 28th, 1901; died on July 29th, 1901. Dr. Latchmore notes that on the third day the bases of both lungs were dull on percussion, especially the left, and that “on the sixth day the dull area on the left side extended forwards and merged with the cardiac dulness. Up to this point the breathing had not been interfered with to any remarkable extent, but during the next few days it became gradually impeded, and on July 14th an aspirating needle was inserted into the 9th intercostal space on the left side internal to the angle of the scapula, and 64 ounces of blood-stained fluid removed. The cardiac impulse was seen to be a little to the right of the sternum, but the cardiac sounds were very faint. The pulse improved considerably after the operation and patient’s general condition became distinctly better, although pneumothorax was evidenced on the left side in place of fluid. It was thought that the condition was due to rupture of a portion of lung tissue by violent coughing. The patient, however, never rallied completely, gradually got worse, and died on July 29th. The sputa were frequently examined for tubercle, but with negative results.”

The case lasted exactly one month. Temperature was above normal for the first week; highest point, 103⁰ F. Afterwards it became lower, irregular, and frequently subnormal.

Post-mortem Examination. “Lungs: Right acutely congested; small scattered tubercles over pleura at margin of lung; exudes frothy, semi-purulent fluid on section. No consolidation. Pleura bound down with recent adhesions; about 8 ounces of bloody serum in pleural cavity. Left lung completely collapsed, size of spleen, alike in appearance and colour. Pleura healthy in relation to lung, but firmly adherent, and greatly thickened over pericardium, from which it is impossible to separate it. Tubercular nodules were observed in the collapsed lung.
Heart and pericardium: The pericardium filled the whole of the left cavity of the chest, compressing the lung into a small space behind; about 20 ounces of sanguineous fluid distended the sac, which was thickened to nearly \( \frac{1}{4} \) of an inch. Heart muscle pale, surface of heart covered by thickened granulations and tubercles, valves healthy. The sac of the pericardium was only moderately distended by the 20 ounces of fluid, and evidently had contained much more before being aspirated. The condition exactly simulated left pleural effusion, and evidently the fluid had been drawn from the greatly distended pericardium and not from the pleural cavity. The other organs were quite healthy with the exception of the left kidney, which had two old puckered scars under the capsule on the posterior surface. A thrombus occupied the left femoral vein. The disease was evidently an acute tubercular pericarditis."

I am indebted to Captain J. B. Forrest, R.A.M.C., Officer Commanding Station Hospital, Mount Aureol, for permission to publish the following case:-

Case 2. Tubercle of the Liver, Spleen, Pancreas and Pericardium, probably Synchronous with Tubercle of the Lung; Case gave Rise to a Suspicion of Liver Abscess.—Private——, West India Regiment. (Case latterly in immediate care of Captain F. E. L’Estrange, R.A.M.C.)

Patient was admitted to hospital for fever on September 3rd, 1904. On one occasion, the fourth examination of the blood, malarial parasites are said to have been found by Captain L. F. Smith, R.A.M.C., who was then in charge of the case. Temperature fell to 98.6°F on the fifth day. Patient then complained of pain in the region below the right axilla, where there was slight dulness, diminished movement, and loss of vocal resonance; expectoration of mucus only. There seemed to be slight bulging or puffiness of the right side of the lower part of the chest. A fortnight after admission attention was directed to the liver, which was enlarged and tender. Liver and pleura were explored by Captain Smith with the aspirating needle; neither pus nor fluid was obtained. Temperature in the meantime had risen and continued irregular. Examination of sputum on September 30th is said to have given a negative result. On October 15th crepitations were audible at the base of the right lung. On November 5th Captain Smith diagnosed tubercle of lung on the clinical evidence.

Towards the end, which came on December 5th, Captain L’Estrange notes that the patient had attacks of dyspnoea and diarrhoea.

Post mortem.—Body not much emaciated. Abdomen: Clear serous fluid in peritoneal cavity. Heart and pericardium: Adherent, except where separated by pus; pericardium \( \frac{1}{4} \) of an inch thick. Lungs: Right pleura adherent in whole extent; no pus. Lung a consolidated mass of greyish friable material about to break down, dots of pus here and there, no cavities. Left pleura not adherent; lung sparsely but generally scattered with tubercles. Liver: Enlarged, adherent to dia-
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phragm posteriorly, infiltrated throughout with tubercle, here and there small abscesses up to \( \frac{1}{2} \) of an inch in diameter. *Spleen*: Enlarged and studded with tubercles. *Pancreas*: Full of miliary tubercle; an abscess \( \frac{1}{2} \) an inch in diameter. Some glands enormously enlarged, especially those adjacent to pancreas. Intestines not examined. Stained smears of the lung, liver, pancreas, and pericardial pus showed many tubercle bacilli.

A SUGGESTION FOR THE EXAMINATION OF CERTAIN PROPOSED RECRUITS BY A MEDICAL BOARD AT COMMAND HEADQUARTERS.

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To most medical officers who have much experience in examining recruits it must at times occur to reject a man because of his failure to attain to some particular standard, though in their independent judgment he is capable of making a useful soldier. I would not advocate a greater discretion being left to the individual medical examiners, as that policy has been tried in the past and with unsatisfactory results, but I think the present system might be rendered more elastic by allowing recruits who, in the opinion of an examining medical officer, are likely to make good soldiers, but whom he is debarred from passing owing to deficiency of teeth, a stiff finger-joint, &c., to be brought before a medical board at headquarters of the command. To render this course as expeditious as possible, such a man would be sent at once to the headquarter station, notification to the Principal Medical Officer and regimental authorities being made by telegram, and a board there assembled not later than the day following his arrival. In this way expense, loss of time, and correspondence would be reduced to a minimum. To a medical board presided over by a senior officer might safely be entrusted a discretion in the application of certain arbitrary standards of physical fitness, and as a result I think that a certain number of men who under the present rules must be rejected, would be found fit for service, and the loss of them to the Army thereby prevented.

CLINICAL NOTE OF THE VALUE OF HYOSCINE IN THE TREATMENT OF CONVULSIONS FOLLOWING HEAT-STROKE.

By Captain S. O. Hall.

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Sergeant — was admitted on the night of May 18th, 1905, suffering from heat-stroke. On admission he was unconscious, pulse 130, respirations shallow and stertorous, and temperature in axilla 110° F.