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some experience in these matters, and who had formerly been under my care in the Surgical Division for radical cure of hydrocele, insisted on being supplied with a similar appliance when his other testicle became inflamed from a different cause.

RECURRANCE OF MALTA FEVER.

By Lieutenant-Colonel G. Cree.
Royal Army Medical Corps.

This case is illustrative of the length of time that Malta fever may lie dormant in the system and then make itself felt.

Private M., 2nd Suffolk Regiment, was admitted to the Station Hospital, Bellary, under the care of Lieutenant R. R. Lewis, R.A.M.C., on January 16th, 1906, and developed what was, clinically, Mediterranean fever. He remained in hospital, and suffered from three distinct waves of fever, till March 20th, 1906, when he was transferred to Wellington as a convalescent. His blood was sent for Widal’s reaction on January 26th, 1906, and gave no reaction to enteric, nor were there any malarial parasites found in his blood. A few days after his arrival here the blood was again taken and sent to Kasauli, the result being “a distinct reaction to Micrococcus melitensis in a dilution of 1 in 20.”

His medical history sheet shows as follows: an admission for Mediterranean fever on October 14th, 1897, whilst at Malta, which lasted forty-four days. This was preceded by an admission for simple continued fever, lasting eight days, from June 30th, 1897, to July 7th, 1897, and followed by another admission for the same disease, also lasting eight days, from January 14th, 1898, to January 21st, 1898. From this date he was free from fever till September 27th, 1902, when he is shown as admitted for ague, whilst at Karachi, also lasting eight days, and a second attack of ague on June 11th, 1903, when in Hyderabad, Seind, which lasted five days. There is no record of the malarial parasite having been found in either of these instances. From the date of this last admission for ague till the admission in Bellary for the illness under consideration, he had no admissions for any form of fever, and presumably was in very good health.

POST-ENTERIC THROMBOSIS, AND ITS TREATMENT BY CITRIC ACID TO DISSOLVE THE CLOT.

By Lieutenant-Colonel E. J. E. Risk.
Royal Army Medical Corps.

Remarks.—Post-enteric thrombosis is almost always produced by the local effects of micro-organisms. Thrombosis is generally attributed to one or more of four causes: (1) Feeble circulation; (2) some injury or
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alteration to the intima of blood-vessels; (3) intrusion of foreign matter into their lumen; (4) some alteration in the blood itself, leading to hyperinosis, or a marked tendency of the blood to form clots.

Hyperinosis is increased by carbolic acid, ether, chloral hydrate, lime salts, diet rich in proteids; potable waters rich in lime salts; diet of milk. Milk contains \( \frac{1}{4} \) gr. to the ounce of lime salts, i.e., more than the liquor calcis of the British Pharmacopoeia.

Hyperinosis is decreased by a rise of temperature, use of citric acid, sodium citrate, whey and cream, fresh lemonade; free use of \( \text{H}_2\text{O} \) in enteric (Osier); well-prepared green food, and a diminution of proteids, or a purin-free diet.

Last year, out of fifteen cases of enteric fever at Bloemfontein, one alone suffered from thrombosis. All cases were treated by 5 minim doses of ol. terebinth, t.d.s., and a diet of milk freely diluted with barley water. Most of the patients also had one or two pints of lemonade daily during the pyrexial stage, supplemented in the third and fourth weeks by Benger's food and beef tea when necessary. They had, therefore, plenty of fluids, although not the quantity used by Osler in the Johns Hopkins Hospital, where water to the extent of six to seven litres is pressed upon the patients daily, with a minimum of three litres.

I am inclined to think the general freedom from thrombosis is due to the use of lemonade and free dilution of milk. I gather that in the Military Hospital, Pretoria, lemonade is given as a routine to all enteric cases, with the result that very few cases of post-enteric thrombosis occurred during 1906, and these not of a severe type.

Our patient, then, on the twenty-ninth day, and after an apyrexial period of ten days, first felt pain in the calf of his right leg and the popliteal region, this phlebitis being followed by extension up to the groin, the foot, leg and thigh becoming immensely swollen by the third day after the initial pain. The internal saphenous vein was hard and painful to touch from foot to groin. On the fourth day the circumflex iliac vein became affected, hardness and oedema extending three or four inches above Poupart's ligament. The leg and thigh were placed at once in a boracic acid poultice, and bandaged lightly up to the limit of the oedema. On the third day after the pain commenced, I ordered citric acid in solution, grains three, six times a day; on the eighth day the pain ceased, and by the fourteenth day the leg was equal in size to the other. This appears to be a small dose to have this effect, and I should like to learn from brother officers their experience in this matter.

Sir A. E. Wright and Sir Dyce Duckworth, to whom I am indebted for this idea of treatment, the former in the Lancet of October 14th, 1905, and the latter in the St. Bartholomew's Hospital Reports for 1905, state that half a drachm dose of citric acid, well diluted, several times a day (as Wright states), decalcifies the blood.

This idea opens up a wide scope for treatment of gouty phlebitis, thrombosis, and the phlegmasia dolens of parturient women, and if it
acts as it appeared to do in this case, it is a most valuable and striking remedy. It would appear also that as long as there is danger of intestinal haemorrhage in enteric fever, milk, containing, as it does, half a grain to the ounce of lime salts, should be given up to the limit of digestion, to produce a state of comparative hypercinosis, and promote the viscosity of the blood, say up to the third or fourth week, when haemorrhage may occur, after which period it is the duty of the physician to prevent a tendency to thrombosis by either administering citric acid, freely diluted, or by some other measure, as before suggested, to diminish the tendency of the blood to clot, in other words to decalcify the blood in convalescence, and to calcify or increase the viscosity in the haemorrhage danger period.

A COMBINED DIET- AND CASE-SHEET.

By Captain A. H. SaFFoRD.
Royal Army Medical Corps.

The only alteration in the present form of diet-sheet I would propose is that the space at present allotted for change of diets be curtailed, and a blank space be left at the bottom for notes of the case. This form would only be used for minor cases, and is not intended to take the place of the case-sheet for the most serious ones. The junction of the diet-sheet and the blank space would be perforated, so that the latter could be easily torn off and filed, and on the reverse of this slip the name, rank, age, &c., of the patient would be noted. The space for diets on the present form of diet-sheets is not required, as the diet never requires changing daily.

[The diet-sheet is an Army Service Corps and not a medical document. There are obvious objections to the course proposed.—Ed.].