Major J. J. McGrath, R.A.M.C., demonstrated a case of Korsakoff’s syndrome and Lt.-Col. J. D. F. Murphy, R.A.M.C., Adviser in Psychiatry, discussed the features of the case with special reference to the modern views on aetiology, treatment and prognosis. Other cases presented were:

Unilateral optic atrophy with a history of old head injury (Lt.-Col. J. B. George, R.A.M.C., Ophthalmologist).

Aneurysm at the bifurcation of the left common carotid artery in a man aged 41 years with B.P. 115/70 and evidence of generalized arteriosclerosis (Major G. B. L. Laird, R.A.M.C., Medical Specialist).

Right submandibular lymphadenopathy for diagnosis (Captain W. Cunningham, R.A.M.C., Venereologist, and Captain John Butler, R.A.M.C.).

Sphenopalatine neuralgia (Lieutenant G. Freeman, R.A.M.C., Otologist).


ACHOLURIC FAMILY JAUNDICE

BY

Lieutenant-Colonel J. A. M. CAMERON

ACHOLURIC JAUNDICE is sufficiently rare in infancy to make the following case worth recording.

CASE REPORT

In July 1940 the 3-year-old child of a Warrant-Officer came under my care. This little boy was a deaf-mute, mentally retarded, and with a patent anterior fontanelle. Whenever the child caught a cold it became mildly jaundiced. The morning after seeing him I had occasion to have the father before me for medical board proceedings, and the remainder of this report concerns the latter. All previous records were to hand.

Born in Lancashire 1906. Passed fit for the Army October 17, 1926.

British Military Hospital Gharial, July 15 to 23, 1929. Tonsillitis with jaundice.


York, July 20, 1933, to August 12, 1933. Acholuric jaundice. Diagnosis confirmed. Red cell fragility definitely increased. No other cause was found for the enlarged spleen and jaundice. Operation was considered but not advised at present.

Preston, October 11, 1935, to October 21, 1935. Fairly well-marked icterus dating from childhood and increasing recently. No history of gastric disturbance. Spleen much enlarged and slightly tender. Urine shows no bile. Blood: Slight increase in polymorphs and increase in red cell fragility (range unstated).

Transferred to Catterick Hospital, October 21, 1935. Spirochetal jaundice. Source of infection not ascertained, but considered to be a very mild attack of spirochetal jaundice superimposed upon acholuric jaundice. No rash, hæmorrhages, or nerve symptoms. Spleen enlarged to 2 in. below navel. Traces of bile in urine on admission.
Clinical and Other Notes

but later disappeared. Spirochaetes present in the peripheral blood in large numbers, later disappearing. Increased blood clotting time (twelve and a half minutes) with normoblasts and megaloblasts, with anisocytosis (chiefly microcytes) and poikilocytosis and chromatophilia. W.R. and Kahn tests negative. Evening rises of temperature to 100° F. Subcutaneous injections of Sulphostab 0-22 gramme, 0-35 gramme one week later, and 0-45 gramme ten days later. Temperature became normal on the fifth day. No spirochaetes found in the blood after the fifteenth day from the commencement of treatment. No spirochaetes found in the centrifuged urine. Agglutination test negative. Discharged to duty.


B.M.H. Karachi. Admitted July 12, 1940.

This Warrant Officer has never had malaria.

Family History.—Married, youngest child aged 3 years, who also suffers from intermittent attacks of acholuric jaundice. This child is truly "a chip off the old block" in so far as clinical findings and facial features are concerned.

Past.—Patient is now 34 years old. Has never had a haemolytic crisis and general health has always been good despite repeated minor episodes of jaundice, usually during an infective fever. In "normal health" the icterus never completely leaves the sclera. At one time his spleen was enlarged down to the iliac crest. There is no history of jaundice in this man's relatives.

Condition on Admission.—This man is a good specimen and has no symptoms apart from a feeling of weight in the left side of the abdomen. The sclera show mild icterus and the spleen is hard and enlarged as far as the level of the navel, being smooth and notched anteriorly. The stools are normal in colour and the urine shows no bile.

Laboratory Report.—Red cell sedimentation rate, 19 mm. in one hour.

Blood.—R.B.C. 3,600,000; Hb 80 per cent; Sahli (14·5 grammes per 100 c.c.); W.B.C. 14,200, differential count normal.

Blood smear: no malaria parasites nor Leishman-Donovan bodies, microcytosis marked. Van den Bergh test: indirect positive, direct test is delayed. Reticulocytes 8 per cent. W.R. negative (24.7.40). Red cell fragility test: commencing haemolysis in 0·5 and complete in 0·40 per cent saline (control tests were used).

Blood Group IV/o.

Operation.—Splenectomy on July 23, 1940. Chloroform and ether anaesthesia, with concurrent whole blood transfusion 700 c.c. (drip). There were no splenic adhesions, no gall-stones, and the appendix was normal. The greatly enlarged spleen was removed by the classical method. About 8 oz. of blood remaining in the splenic bed was returned via the drip to the vein. Pulse remained below 100/min. throughout.

On September 20, 1940, I had a swim with the patient, and did not see him until 1944 when we met in a bar while on leave from the Burma Campaign. He was then a robust Captain, in Category A, and had had no further symptoms.

I have great pleasure in acknowledging the help given me by my late C.O. and medical colleague Major-General Sir Alexander Biggam, sometime O.C. the B.M.H. Karachi, India.

REFERENCE

ASHBY, H. T. (1940) B.M.J., April 27.