Medical Matters.

TONSILLAR TUBERCULOSIS.

Dr. C. S. Means, in the *Columbus Medical Journal*, says there are more cases of localised tuberculosis in the tonsils than generally discovered, and that if this primary lesion of tuberculosis in the throat could be discovered, many cases could be cured before the lungs became affected. He reports a case of a man, twenty-nine years of age, who gave history of hæmorrhages, fever, sweats, loss of appetite, rapid loss of flesh, great languor, and general depression. Upon examination nothing was to be found in his lungs. Bacteriological examination negative. Throat normal, except a large Luschka's or third tonsil with small clots of blood at several points over its surface, no breaking down or ulcerations. The tonsil was just about the same in general appearance as found in many throats, yet on account of hæmorrhages a portion of tonsil was removed, which upon examination was found to contain numerous bacilli. None had been found in the sputum before. The remainder of the diseased tissue was removed. Patient regained health.

MALARIAL FEVER IN BRITISH CENTRAL AFRICA.

Dr. H. Hearsey, principal medical officer, British Central Africa, contributed a paper in the Section of Tropical Medicine at the meeting of the British Medical Association on Malarial Fever in British Central Africa. He stated that in British Central Africa the forms of malarial infection were the tertian and the æstivo-autumnal. The tertian type was the commoner and was of either the single or double tertian variety. The tertian forms were amenable to quinine, whereas the "multiple" infection forms and æstivo-autumnal fever were generally resistant to quinine. Dr. Hearsey was inclined to regard hæmoglobinuric fever as a pernicious form of the æstivo-autumnal variety and was inclined to attribute the disease to (1) anæmia due to long-standing malaria, rendering the hæmoglobin more unstable and permitting of its liberation on slight provocation; (2) a sluggish condition of the liver; and (3) the presence of nephritis. In the treatment of hæmoglobinuric fever quinine must not be given. A mixture of bicarbonate of sodium (ten grains) and perchloride of mercury (thirty minims) every two or three hours served to prevent suppression of urine; an injection of half a grain of morphine helped to control vomiting; nourishment was maintained by the ordinary invalid food and drink, and brandy was used to the exclusion of other stimulants.

There is still a diversity of medical opinion as to the treatment of hæmoglobinuric fever. Some medical practitioners believe that quinine should be pushed, others that the cause of the disease is over dosage with quinine.

DISTRIBUTION OF STREPTOCOCCI THROUGH INVISIBLE SPUTUM.

Dr. Alice Hamilton, of Chicago, has been conducting investigations in this subject, and presents the result in a paper in the *Journal of the American Medical Association*. She found that an increased severity of infection might be conveyed from one scarlet-fever patient to another in this way, and that the operating surgeon or nurses in attendance might thus infect a wound by coughing, speaking, or whispering. She thus summarises her conclusions:—

"Streptococci are expelled from the mouth in the invisible droplets of sputum by coughing, speaking, whispering, crying, or breathing forcibly through the mouth. They are expelled to a distance of at least 36 centimetres. Thirty-three out of fifty scarlet-fever patients, most of them children, were found to expel streptococci in coughing, crying, or breathing; forty-two out of fifty normal adults were found to expel streptococci in coughing or in speaking. The streptococci thus disseminated may be inhaled by others, and may set up streptococcal complications or may fall on the tissues exposed at an operation and cause suppuration. Just as the virulence of an individual strain of streptococcus may be raised by planting on certain nutrient media or by passing through susceptible animals, so, in all probability, it may be raised by passage from one human being to another. In this way may be explained the conversion of a case of simple scarlet fever into one of scarlatinal sepsis, and in the same way may be explained the cases of surgical sepsis which occur after all usual precautions have been taken. In cases of scarlet fever, the streptococcal complications should be isolated from cases without such complications. Surgeons and nurses should have their mouths protected during the time of an operation."

previous page next page