On the next morning the temperature fell to 98°, only reaching 99.4° in the evening, and on the following and subsequent days it remained absolutely normal. All traces of erysipelas had disappeared from the face, the leucocyte count dropped to 7,000, and the patient looked and felt completely convalescent. Suppuration rapidly diminished, and completely disappeared in a fortnight.

The improvement in the patient's condition was remarkably dramatic, and I think undoubtedly due to the specific action of the erysipelas antitoxin on the streptococcal infection.

REFERENCE.
[1] *Journ. Amer. Med. Assoc.*, December 7th, 1929.

## PSITTACOSIS WITH ENCEPHALITIC SYMPTOMS.

BY

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DR. A. P. THOMPSON (*Lancet*, February 22nd, 1930, p. 396) describes a case (No. 8) of psittacosis in which the nervous symptoms were marked enough to suggest a diagnosis of encephalitis. Below is a description of a similar case occurring in Port Said. This is the first recorded case of the disease in Egypt.

The patient, Mrs. H., aged 32, a British resident of Port Said, had begun to feel ill on the evening of February 10th, 1930, with headache, cough, and vomiting. She was seen by a local practitioner, and as her condition became steadily worse during the next few days and no definite diagnosis could be arrived at, she was admitted to the British Hospital on February 15th.

On admission the patient looked ill, being flushed and bathed in perspiration. She complained of severe headache, especially at the back of the head, and difficulty in speaking and swallowing. She was also slightly delirious. Her temperature was 102.8° F., pulse rate 114, and respiration rate 28. On examination a few moist sounds were heard at the left apex. The right lung was clear and the heart normal. The abdomen was distended, but not tender on palpation, and the tip of the spleen could just be felt. A trace of albumin was present in the urine. A bilateral Babinski response was elicited, and also Kernig's and Brudzinski's signs. Both knee-jerks were absent, and the fundi were normal. There was no cough or dyspnoea, and no sputum could be obtained.

On February 16th the patient's condition was worse, the temperature being 104° F. and the pulse rate 98. She was still complaining of severe headache. Lumbar puncture was performed; the fluid was clear and not under pressure, and it disclosed no abnormalities on examination. On February 17th she was much worse; the abdominal distension had increased, the temperature was 102.6° F., and the pulse rate 88. The left apex was now solid, and air entry was practically absent. Coarse crepitations were present over the whole of the left chest. The patient was more delirious, very weak, and unable to speak.

Agglutination tests for "O" and "H" agglutinins against *B. typhosus* and *B. paratyphosus* A and B were negative, and it was not possible to demonstrate the presence of specific agglutinins for any member of the biphasic group of salmonella organisms. Blood culture in a variety of media and inoculation experiments were negative. Culture of the faeces and urine resulted in the isolation of *B. faecalis alkaligenes*. It was present in pure culture in the urine. Thompson notes a similar finding in one or two cases. There was a leucocytosis, the number of white blood corpuscles being 15,000 per c.mm.

During the evening of February 17th the patient was seen by another medical man in consultation, and a diagnosis of psittacosis was made. The patient had twenty-three birds at home, including three parrots and two love-birds recently acquired. The husband stated that some of the birds had been fighting furiously. Two had died after this disturbance; probably they had been sick and were killed by the others. All the birds were gassed, and post-mortem examination and a fairly extensive cultural investigation yielded negative results. This does not discount the possibility of the dead birds having been infected with the virus.

During the next three days coma supervened; the abdomen became more distended and the temperature remained between 103° and 104° F., the pulse being relatively slow. Examination of the fundi showed blurring of the edges of the discs, suggesting a rise of intracranial pressure. The condition of the patient was critical. On the evening of February 21st lumbar puncture was again performed; the fluid was clear, but this time it came out under great pressure, and on examination small numbers of diplococci were seen. The same evening an injection of 30 c.cm. of polyvalent antipneumococcal serum was given intrathecally. After a rather severe reaction the temperature fell the next day to 100.2° F. A further 20 c.cm. of the same serum were then given, intrathecally as before. A mild reaction occurred, during which the temperature rose to 102° F. and then fell to 99° F. The coma now began to diminish, and the patient seemed much better. The fundi were now normal.

On February 23rd 20 c.cm. of polyvalent antimeningococcal serum were given intravenously, and the temperature fell to 98.2° F. in the next few hours. During the following two weeks the patient slowly gained ground and made an uninterrupted recovery. On March 4th she was able to sit up in bed and take solid nourishment. At the moment of writing she still has some slight difficulty in articulation, and the features are rather inexpressive, resembling the mask-like facies seen after encephalitis lethargica. However, both these conditions are improving rapidly, so that in all probability no permanent disability will result.

I have never seen any reference to a case of psittacosis in which the meningeal symptoms and the general nervous symptoms were so pronounced. Although an apical lobar pneumonia is always associated with active delirium and some nervous symptoms, I incline to the clinical diagnosis of psittacosis, for these reasons:

1. After a week's illness the patient appeared to be as ill as if she were in the third week of enteric fever—she had a brown, furred tongue, sordes on lips, etc.

2. The left lung was solid; there was no tubular breathing and hardly any air entry; the patient had no dyspnoea, no cough, and no expectoration; coarse crepitations were present; in fact, the chest condition was more acute than in any condition I know.

3. A meningitis can develop in any acute condition.

4. The specific serum treatment was hardly sufficient to have worked so remarkable a cure.

5. The nervous symptoms were more those of an encephalitis than of a pure meningitis—for example, the mask-like expression of the face, the early loss of knee-jerks, the double Babinski response, and bulbar paralytic symptoms (speech and swallowing) before the cerebro-spinal fluid was even cloudy or contained abnormal cells or organisms.

6. The impression I gained from this case was that it was a clinical syndrome that I had never met before.

I am indebted to Dr. Dolbey and Major Bensted of Cairo for their kind and valuable assistance in enabling me to prepare this case for publication, and to Dr. R. P. Stewart for permitting me to publish this report.

## TREATMENT OF MEASLES WITH AMIDOPYRIN.

BY

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THESE observations are intended as a preliminary communication on the curative effects of amidopyrin in the treatment of measles. This drug is a white crystalline compound, slightly bitter, and easily soluble in water. According to the French *Pharmaceutical Codex* the maximum single dose is 15 grains, the maximum in twenty-four hours is 45 grains.

In the following case of measles drastic measures seemed to be indicated, and I decided to utilize the powerful antipyretic property of the drug. The discovery that it seemed to exercise an almost specific action on the disease itself was fortuitous, and led me to make a search of the literature. I found that Loewenthal[1] had used the same drug in the treatment of measles, but it does not seem to have been generally adopted.

The patient, a girl aged 8, had a history of whooping-cough in 1928, leaving her with chronic bronchitis. In September, 1929, she had lobar pneumonia, and while convalescing, though still weak and coughing, she developed measles. I was called to see her one afternoon when the rash was just appearing behind the ears and on the forehead. Her temperature was 104.5°; there was marked coryza, and Koplik's spots were present. The pre-existing cough was more severe. She was immediately put on amidopyrin, 5 grains four-hourly day and night. The next morning (about twenty hours after she was first seen) the temperature was down to 100°. Instead of the anticipated profuse eruption only a faint morbilliform rash was showing. The drug was continued