

For some months she continued well, but in February, 1950, she was readmitted to hospital with severe decompensation. During the next few weeks her condition gradually worsened; blood cultures were sterile. Gross cardiac failure developed on May 15, 1950, and death occurred the next day. Permission for necropsy was refused.

Bacteriology

When the staphylococcus was first isolated (May 10, 1950) it was thought to be a skin contaminant, as it is generally accepted that most albus strains isolated from blood cultures fall into this category. The striking feature of the organism, however, was the degree of haemolysis produced on blood agar; the zone of clearing round each colony was almost as great as that found with a haemolytic streptococcus. In other respects the organism appeared to be an ordinary albus strain; the coagulase test was negative. When similar organisms were isolated from further blood cultures (May 16 and 17) contamination seemed unlikely, and the patient's serum was investigated for antibody content.

The results of the various tests showed that the serum did not contain any agglutinins but that a bacteriolysin was present. This bacteriolysin was evidently specific for the staphylococcus isolated from the blood cultures (see Table).

Bacteriolytic Effect of the Patient's Serum on a Range of Organisms

Organism	Serum Dilutions—Reciprocals										
	2	5	8	10	20	40	100	200	500	750	C
<i>Staph. albus</i> A	+	+	+	+	+	+	+	+	±	—	—
" " B	+	+	+	+	+	+	+	+	±	—	—
" " C	+	+	+	+	+	+	+	+	±	—	—
" " 1	—	—	—	—	—	—	—	—	—	—	—
" " 2	+	±	—	—	—	—	—	—	—	—	—
" " 3	—	—	—	—	—	—	—	—	—	—	—
" " 4	—	—	—	—	—	—	—	—	—	—	—
<i>Staph. aureus</i> Oxford	+	—	—	—	—	—	—	—	—	—	—
<i>Str. pyogenes</i>	—	—	—	—	—	—	—	—	—	—	—
" <i>viridans</i>	—	—	—	—	—	—	—	—	—	—	—
<i>Bact. coli</i>	—	—	—	—	—	—	—	—	—	—	—
<i>B. friedländeri</i>	—	—	—	—	—	—	—	—	—	—	—

Staph. albus A, B, and C = the organisms isolated from the three positive blood cultures.

Staph. albus 1, 2, 3, and 4 = four strains isolated from other patients' blood cultures and classed as contaminants. All non-haemolytic.

+ = Clearing of the suspension. — = No change. ± = Partial clearing.

Similar tests were carried out with sera from 12 other patients, including two known cases of S.B.E. due to *Streptococcus viridans*, with negative results. The bacteriolysin was still present in the patient's serum several weeks later, but the lytic titre had fallen to 1:4 within three months. The haemolytic activity of the organism gradually diminished after several months' storage on Dorset's egg medium, and had almost disappeared when examined three years after isolation.

Comment

The anaemia in this case was no doubt due to the haemolytic activity of the staphylococcus: the occurrence of a haemolytic strain of *Staph. albus* in S.B.E. has been noted previously by Allen and Riecker (1949). The development of specific bacteriolysin does not appear to have been reported in other similar cases, and may be a purely isolated finding. Absence of post-mortem data makes it difficult to assess the effect of the septicaemia on the course of the patient's illness, but the degree of cardiac damage was so great that it is feasible to assume that early death was inevitable, irrespective of the blood infection.

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Medical Memorandum

Amoeboma of the Caecum

A male clerk aged 34 was admitted to hospital on November 20, 1949, with a three-days history of right-sided abdominal pain.

On examination he had a normal temperature and pulse, there was a tender mass palpable in the right iliac fossa, and the white blood cell count was 11,000. The case was thought to be an appendix abscess, and was treated with antibiotics. As there was no diminution of the mass after twenty days, an exploratory operation was performed.

Operation.—On December 9 a Rutherford Morison incision was made and a firm, rather inflamed mass was found occupying the caecum and ascending colon. This was thought to be a neoplasm or a non-specific granuloma, and the affected bowel was exteriorized after suturing the ileum to the transverse colon preparatory to a double-barrelled colostomy. Three days later the affected loop was removed and the intervening spur was crushed soon after. Within three weeks there was considerable excoriation of skin around the colostomy, and this rapidly developed into spreading infection with sloughing of the abdominal wall, which increased steadily until *Entamoeba histolytica* was identified in the skin edge and appropriate treatment given.

The condition improved gradually and sloughs separated, but a large granulating area resulted with a faecal fistula in the middle of it. Closure was effected after the third attempt some eight and a half months from the original operation. Tantalum mesh proved useful in bridging the gap in the abdominal musculature, and the skin defect was made good by sliding and grafting. Bowel action has been regular and normal ever since, but two small sinuses developed which discharged sero-sanguineous fluid but no faeces. Part of the mesh had been extruded and cut off, but it was thought best not to interfere further.

When last seen the patient was enjoying excellent health and going to business as usual.

COMMENT

This case illustrates the importance of excluding amoebiasis when doubtful masses are found in the bowel, especially in view of the relatively large number of persons who have been abroad in recent years. Amoebic ulceration of the abdominal wall seems to be more frequent in the United States—often coming on after appendectomy in an infected case (Hunter, 1951). Hawe (1945) writes on the surgical aspects of intestinal amoebiasis, and refers particularly to the need of excluding acute caecal amoebiasis before operation for appendicitis in endemic areas. Donald (1940) describes two cases simulating carcinoma of the rectum. It would seem that the cases most likely to cause confusion in endemic areas are those of acute caecal or appendiceal amoebiasis, while the presence of unusual masses in the rectum or elsewhere in the bowel may call for a search for *E. histolytica* in the stools before proceeding to surgery.

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Epsom.

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