Correspondence

Cerebral Malaria

Sir,—We read with interest the article in the Dec. 25 issue by Dr. J. B. Sneddon, called "A Fatal Case of Cerebral Malaria." Each year over 600 cases of malaria are treated as in-patients in this hospital. The scheme of treatment for the cerebral cases—reached by a method of trial and error over a number of years—is now the following:

On confirmation of diagnosis by highly positive M.P. film, clear C.S.F. and a low W.B.C., an intramuscular injection of quinine is immediately given. If the patient is very collapsed a small intravenous saline is sometimes given at this time, but never intravenous quinine. Four to six hours later a small intravenous injection of quinine is given: 3 to 6 gr. is ample. Adrenaline is given at all is given intramuscularly just prior to the intravenous quinine. Another small intravenous quinine injection can be given after a further four to six hours up to three such injections or the recovery of the patient. In December of this year we had six cerebral malaria patients. Only one died—an infant of 1½ years who had no intravenous infections.

We have found that large doses of intravenous quinine in cerebral cases in invariably followed by death. These cases all show a highly positive film. We have no copy of the 1942 edition of Manson-Bahr referred to by Dr. Sneddon, but in the 1940 edition, page 114, the following may be found:

"The amount of toxin liberated by the rapid destruction of the parasites after intravenous injection of quinine may be sufficient completely to paralyse the cardiac mechanism, and death may rapidly ensue." In our minds there is no doubt of the truth of this. He goes on to advise intramuscular quinine followed by quinine intravenously.

What the "toxin" is, so far as we know, no one has ever found out. The common finding of jaundice in such cases suggests that it is rather the products of the burst-up red cells that are the cause, but the finding of jaundice by the patients themselves or by nurses that such both of these factors may contribute to the "toxin," which seems to give rise to a form of protein shock—"autoprotein shock," if we may use the phrase.—We are, etc.,

G. B. YOUNG.
C. J. A. MACADEN.

Kala-azar in an Adult Contracted in Malta

Sir,—In the Journal of April 8 (p. 492) Wing Cmdr. Lipscomb and Squad. Ldr. Gibson state: "We can trace only four recorded cases in adults whose infection cannot have occurred elsewhere than in Malta" in 1913-14, 1918, 1933, and 1934. In 1917, while in charge of the Medical Division of the Malta General Hospital, Malta, I was told by a colonel that a case of kala-azar undoubtedly contracted in Malta, and heard of two others similarly contracted. As I left my notes in Malta and am quoting from memory I only can give the salient points, which were deeply impressed on my mind, and are as follows:

In the summer of 1917 a draft of No. 1 Malta Company, R.A.M.C., all British soldiers, paraded for inspection before proceeding to Salonika. At the conclusion of the parade it was remarked that Sergeant "G." was not only the smartest soldier on parade but the fittest. The draft was unavoidably delayed in the island owing to U boat activities, and some weeks later—possibly a month or six weeks—I was called to see this N.C.O., who was feeling ill, sweating, and had lost weight. On admission he looked ill, wasted, having lost 2 st. in weight, and from being a ruddy complexioned man had become sallow in appearance. On examination the only physical sign found was an enlarged spleen.

Colonel Sir Archibald Garrod, consulting physician to the Malta Command, who visited the hospital twice a week, saw him at his next visit and suggested to me that it might be a case of kala-azar. I pointed out that this N.C.O. had come straight from England two years previously and had never left the island since. Sir Archibald Garrod said that was no bar to contracting kala-azar, as he had already seen two soldiers who had contracted the disease in the island. The similarity of their symptoms and appearance plus the spleen enlarged to the size of an orange diagnosed the entity as kala-azar. Acting on his advice splenic puncture was at once performed and Leishman-Donovan bodies demonstrated within a very short time of the patient coming under observation. He was treated by intra-venous antimony injections; so far as I remember the solution was 1% tartar emetic. He always vomited before the needle was withdrawn from the vein, except on three occasions when he developed a severe irritation in one tonsil. He made an uninterrupted recovery, during the course of which he was visited by many people, including the late Lord Methuen, Governor, and Sir Thomas Yarr, D.M.S.

He corresponded with me for several years, and as an instance of the completeness of the story I will tell that while on leave at his father's farm in England dived into a river and rescued a drowning sheep. Later in the war the ship he was in was torpedoes, and though he was in the water and boat for some time suffered no ill effects from the experience. I last heard from him several years ago. He was farming in Ladysham and had a test contracted.

It is interesting to record that shortly after this case I also treated a man of the Egyptian Labour Corps for bilharziasis in a similar manner with satisfactory result, the first time this treatment had been employed for this condition in Malta.

My own case of kala-azar was undoubtedly contracted in Malta, and Sir Archibald Garrod was not the type of man to make a statement like the above without a complete investigation. I believe I am right in saying that his opinion was that kala-azar was of more common occurrence in British adults in Malta than was generally realized. At any rate that is the impression left on my mind after twenty-seven years.—I am, etc.,

Southsea.

R. J. LYTLE.

Sickness Records of Hospital Nurses

Sir,—Dr. Joyce Wright's article (April 29, p. 585) on the sickness records of nurses in hospitals presented many interesting findings, but it would be instructive to compare the sickness records of hospital nurses who were respectively resident and non-resident in hospitals. Such a comparison might throw some light on the vexed question whether nurses should be accommodated in hospital or should be encouraged to live at home or in lodgings. In the hope that other hospitals may record their experiences where they have been similarly staffed, I have set out our experience in this hospital for the year 1943.

<table>
<thead>
<tr>
<th>No. of Nurses</th>
<th>No. of Illness Absences</th>
<th>Days lost from illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident</td>
<td>124</td>
<td>97</td>
</tr>
<tr>
<td>Non-resident</td>
<td>154</td>
<td>163</td>
</tr>
</tbody>
</table>

The longest absence for a resident was 178 days; and the longest absence for a non-resident was 160 days. The hospital is situated in the country at a distance of 2 to 4 miles from centres of population where the non-resident nurses have their homes, lodgings, or billets. The non-resident nurses were under the care of doctors outside the hospital for the most part, though in a few cases treatment had to be given in the hospital.

The age groups of the two classes of nurses were not examined closely, but were known to be similar. The nature of the illnesses was also similar in the two groups to one another and to that given in Dr. Wright's article. The hours of duty for all non-residents amounted to 48 per week, whereas residents on the whole worked rather longer hours, usually about 52.

From these figures it would appear that residence has the advantage in respect of health; they are, of course, too small by themselves to establish a conclusion with certainty.—I am, etc.,

Clatterbridge General Hospital, Wirral.

D. WILKIE.

Tuberculin Patch Test

Sir,—I should like to confirm Prof. Tyler's observations with regard to the efficacy of his tuberculin jelly. Some time ago he very kindly sent me a supply of this tuberculin jelly, which I used on a series of some 40 cases with (a) Mantoux test 1 in 1,000 controls, and (b) commercial patch test controls. I found that the results tallied exactly with those of the Mantoux test, and, so far as the commercial patch-test controls were concerned, the positive reactions with the jelly were stronger and much more reliable. In view of its practical importance it is to be hoped that Prof. Tyler's formula will be soon available for general use.—I am, etc.,


PHILIP ELLMAN.