

- obtained in the pyrexial stage, both clot and serum to be frozen as soon as possible.
3. Further serum after 14-21 days and possibly later.
  4. Further stools after 2 weeks, 4 weeks and 6 weeks if virus has been found in any of the original specimens. This is to determine the duration of excretion, and therefore of possible infectivity.
  5. Any other material which may contain virus, e.g., C.S.F. if there are signs of involvement of the C.N.S.
  6. Stools and serum from family and close contacts with additional serum in 3-4 weeks.
  7. From a population group comparable in age, etc., living in the same area, but not contacts, stools and sera as in 6.

An investigation such as this might well occupy several months and would have to be confined to a single outbreak involving half a dozen people in the first instance. The main weakness in planning lies in the unpredictability of an outbreak at the time that the first patient is seen."

The stages which Dr. Macrae has outlined in the above account of the steps to be taken in the linking of a virus with a hitherto undiagnosed disease may be read by us as a chastening exercise and a warning that only a limited number of hares can be hunted by the Epidemic Observation Unit at any one time.

ANNOTATIONS BY MEMBERS OF THE  
RESEARCH REGISTER

SHERE FEVER

Dr. G.I. Watson

The story of this condition has taken an interesting turn with the report by Dr. Macrae that Coxsackie Virus has been recovered from the 'acute' stools preserved from two of the original cases and that neither contained poliomyelitis virus. It has yet to be shown whether the viruses are of identical strain and whether the convalescent serum of Case 9 has any neutralising antibodies to either of these strains.

Will those members who saw similar cases and have not yet sent me their clinical and epidemiological notes please do so as soon as convenient.

MESENTERIC LYMPHADENITIS

Dr. F.E.B. Kelly,  
Leicester.

Dr. Kelly has forwarded the following notes on the condition which he has been studying for some time. Enlarged abdominal glands have been found in children and young adults suffering from symptoms and signs similar to those of acute appendicitis. Members of the Register who may have observed this condition in their practices are asked to report its occurrence to Dr. G.I. Watson.

Pathology Enlarged glands, varying from two or three in number as big as a small egg, which may sometimes be felt by abdominal examination, to very many small pinhead glands. They are inflamed, and situated in a triangle with the apex at the umbilicus, extending into the right iliac fossa. They are not thought to be tuberculous nor to be caused by any known organism.

Incidence Males and females equally affected, my earliest case was three years of age and the oldest twenty-eight years, although I have a likely case at the moment of a woman aged 42 yrs. The time of year does not seem to make any difference.

Symptoms These cases resemble appendicitis in varying degree, from the acute stage with sudden onset, vomiting, and acute pain in the right iliac fossa, to spasmodic pain on varying degree accompanied by nausea.

Signs (Acute type) All the signs of acute appendicitis, with or without rigidity of the right iliac fossa. Rectal examination reveals nothing more.

Signs (Chronic Type) Some tenderness may be felt in the R.I.F. and glands may be palpable, tongue usually furred and patient complains of lassitude and 'being off his food'.

Progress The acute type is invariably operated on for appendicitis sooner or later. At operation a normal appendix is found, and removed as a rule. The patient seems to improve, but the condition recurs and in my opinion the temporary recovery is due to the rest following the operation rather than to the operation. The glands are usually quite easily demonstrated during operation. The chronic type invariably clears up with treatment as does the acute case.

Treatment The only treatment I have found in any way effective is a milk-free diet. This clears up over 90% of cases. I am dealing with a population living in a city who obtain their milk from large dairies and these cases become symptom-free in a very short time if they cut milk, in every form, right out of their diet. If however these cases can buy milk from a farm or buy milk which has been bottled on a farm, they can drink as much as they like without symptoms.

I have had one youngster who lived in the city and had these abdominal pains. For a while the family lived in the

country and the child was free from symptoms, which reappeared when he came back to live in the city. He was brought to me and I put him on a milk-free diet and he cleared up. I made an arrangement with a local dairy, as I have for all these cases, for raw milk bottled on the farm, and there has been no more trouble.

Another peculiar feature of the condition is that it occurs after exercise, and sometimes after a particular exercise, e.g., a P.T. instructress who only had the condition in the summer when she played tennis.

Conclusions My conclusions on these cases, (I have seen 20-30 such cases in the past four or five years) is that the adenitis is an anaphylactic reaction to some sensitivity to some protein change which takes place in the processing (? Pasteurisation) of milk. I cannot of course be in any way scientific on this matter as my observations are purely clinical, but the condition seems to be to be somewhat analogous with the sensitivity reaction in rheumatic fever which gives rise to Aschoff Bodies.

I wonder if some powerful desensitising agent such as cortisone would clear up the condition. I have not tried anti-histaminics, but am doubtful if they would act.

### Examples

#### Case No. 6

Girl born 19/7/49  
August, 1952

Abdominal pain after meals, constant after two to three months, getting steadily worse.

April, 1953.

Collapse due to abdominal pain, sent to hospital, operated for appendicitis, appendix normal, widespread mesenteric adenitis, put on full diet including milk following operation, pains unabated.

July, 1953.

Milk-free diet, Definite improvement in two weeks, followed by steady improvement.

November, 1953.

Back at school, symptom-free, on milk-free diet (but cannot take Ovaltine)

December, 1953.

Seen again. Very occasional pains when other infection present, e.g., tonsillitis. (this has been a feature of other cases in the past).

#### Case No. 7.

Boy, born 9th November, 1946. Previous history nasal

catarrh and bronchitis.

3rd October, 1952. Crampy abdominal pain - N.A.D.  
?Mesenteric adenitis - thin and  
underweight but very energetic,  
milk-free diet.

31st October, 1952 Very much improved

27th November 1952 No pains since - still 'off' milk

23rd March, 1953 Sent to child specialist because  
underweight - specialist reports  
all tests negative, no signs of  
disease, and 'I think that he  
should have milk again as it seems  
a pity to deprive him of this ess-  
ential food when he is having such  
frequent infections, and I doubt  
if keeping him off will make any  
difference.'

Subsequently to this, milk  
was tried by parents on two occasions  
with renewed attacks of abdominal  
pain. Still on milk-free diet and  
very well.

Case No. 8.

Boy born 30th August, 1946. At ten days, haemolytic  
anaemia, ? Rh incompatibility

Early 1951 Attack of tonsillitis

July 1951 Investigated in hospital for abdominal  
pain, N.A.D. Put on milk-free diet

December 1953 Still on diet, no pain or symptoms, diet  
supplemented by virol and adexolin, fine  
strong boy above average in height and  
weight and with plenty of energy.

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PYREXIA OF UNKNOWN ORIGIN

Dr. Robert Howard  
Ringwood.

2nd December, 1953

I wonder if there have been other reports of a somewhat  
unusual type of P.U.O. which has been occurring in this area.  
I have had four cases and five miles to the North there have  
been others, but not many to the South.

The condition is one of very sudden onset of shivering, malaise, with increasing low back pain, instability and difficulty in vision. T. 101-103.

One seems to be called to the patient about eight hours after the onset.

Course: Fever for two or three days, with marked instability on walking. No central nervous system signs have been seen.

### Examples

Case I November 24th: A farmer aged 50. Onset of shivering while ploughing. General malaise with increasing low lumbar pain becoming intense about six to eight hours later. Some mild cerebral irritation with difficulty in concentration. The pain in the back could be produced by fully flexing the head. Very reddened fauces. No gross C.N.S. signs.

Case II November 29th: Similar picture in a woman aged 40 years. Temperature 102. Feeling of instability on sitting up more marked.

Case III December 1st: Man aged 35. Back pain very intense, only relieved by morphia. Had been taking chloramphenicol for a minor infection for twelve hours prior to the onset.

No urinary tract infection has been observed in any of these cases, there has been marked asthenia following subsidence of the fever within 36 hours.

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### EPIDEMIC VERTIGO?

Dr. C.A.H. Watts  
Ibstock.

10th December, 1954

Two similar cases of intense vertigo without ear signs or symptoms have recently occurred in this area. The features of the condition are so typical that if similar cases are occurring in other parts of the country they would readily be recognised.

The onset is acute, the patient being able to state exactly when the attack started. Vertigo is intense and persistent, vomiting follows the attack. The patient is only comfortable lying down with his eyes closed. In neither case was there any fever of onset, or at any time in the course of the disease. There was no deafness or persistent tinnitus. The

Rinné test was positive on both sides and there was no Weber deviation. In one case there was wax present. This was removed with the patient lying flat on his back in bed. The operation did not increase the vertigo and the removal of wax gave no relief. There was no other evidence of organic nervous disease. The ages of the patients were 33 and 43. The total period of disability in each case was about three weeks.

Are these two cases part of an epidemic vertigo?

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MEASLES IN GENERAL PRACTICE

Dr. C.A. Leeson  
Leicester.

A study of 260 cases.

The absence of reliable statistics of the incidence of complications in measles prompted me to keep records of all cases of measles encountered personally in the normal course of general practice for the last four-and-a-half years. The practice is situated on the edge of a large industrial city in the Midlands.

Records were kept of the age of the patient, the date of onset, the complications in all cases and any unusual features. Routine chemo-prophylaxis was not employed.

Year	Average age	Extremes of age	No. of cases	Complications		
				Otitis	Pneumonia	Atelectasis
1949	3.9	7M 8yr	48	-	-	-
1950	2.9	10M 7yr	24	-	1	-
1951	4.2.	9M 8.5yr	80	1	1	1
1952	4.3	6M 11yr	36	2	2	-
1953	4.5	9M 47yr	72	-	1	-
<u>Total</u>			260	3	5	1

Other complications met with were convulsions - 2, simple croup - 2, subconjunctival haemorrhage - 1, coincident pertussis - 1. One unusual complication was severe menopausal symptoms in the women aged 47.

The interval from rash to rash in secondary cases was as

follows:

7 days (1); 8 days (2); 9 days (3); 10 days (6);  
11 days (3); 12 days (1); 13 days (4); 14 days (3);  
15 days (0); 16 days (1); 17 days (1 case).

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MEASLES IN KENT, 1952-53

Dr. L.A.C. Wood  
Kent.

A total of 117 cases was observed personally. The great majority were first seen on the first day of the rash. In all cases the chest was examined daily during the febrile period. Those showing signs in the chest were followed until clinically clear. The ear drums were examined only in those cases complaining of earache or otorrhoea. All patients were country-folk and previously fit.

Age Incidence 5 cases were seen under two years of age, the youngest being 7 months. 7 cases were adults ranging from 17 to 40 years. The remainder fell between 2 and 17 years.

Prophylaxis No chemotherapy was used except in a few complicated cases. Two cases had received convalescent serum on the fourth day after their exposure. Both these had sharp attacks with high fever and profuse rash, but neither developed complications.

Infants under 2 years 5 cases, aged 7, 12, 14, 15 and 20 months respectively. All had been breast fed during the first three months of life. In all except one the mother had previously had measles. Four had mild attacks, including the one whose mother had not previously had measles. One had a normal attack with pyrexia to 103°. None had complications.

Complications

<u>Chest</u>	9	Cases	8%
<u>Otitis</u>	4	Cases	3%

Most of the complications were very slight, 1 of them came in October, 9 in November, 2 in December and 1 in February.

In 8 of the chest cases signs were present on the first day of the rash. In the otitis cases symptoms appeared 2-4 days after the appearance of the rash.

Conclusions The impressions formed from this small series were that:

1. Routine prophylactic chemotherapy is unnecessary
2. Chest complications tend to develop with the appearance of the rash. Otitis tends to develop shortly after the rash has faded.

3. Infants appear to have relatively mild attacks. The effect of breast-feeding could not be judged owing to the small number of cases.
4. Complications were more numerous during the first half of the epidemic.

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Editorial Note In the above annotation Dr. Wood draws attention to the high incidence of complications in the second month of the epidemic, November, compared with the relative low incidence in February. Whilst this may be a chance occurrence a similar observation has been made by another member of the Research Register.

If any member of the Research Register has figures for a SUMMER outbreak of measles from which the complication rate could be drawn, would they please get in touch with Dr. G.I. Watson.

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A TREATMENT FOR ASTHMA

Dr. J.M.B. Morwood  
Folkestone.

In the April number of the 'Practitioner' there appeared an account of a gramophone method of treatment which I have used with some success in the treatment of bronchial asthma. Since the date of this paper I have been able to obtain further records and I am able to begin to evaluate this method of attack on the disease.

Sixteen patients have been treated by this method, and the treatment has been found popular. Not only can the asthmatic attack be relieved but the frequency and severity of attacks seem to become less. It is assumed that the disease is associated with a tenseness of mind which is relieved by a formula of recorded words in a soothing voice which relaxes this tenseness.

The words of the formula begin "You are drifting down a river in a little canoe on a hot summer's day. The banks are floating past. The distant sound of the harvester cutting corn ... etc... and your breathing is getting easier and deeper, easier and deeper ...."

The classic case has been described thus. "The patient stopped wheezing and the relatives fell asleep -- a satisfactory result."

It now remains to collect a series of cases and controls and to produce a statistical study uncoloured by any subjective bias of mine. I would like to invite members of the Register to get in touch with me if they would care to participate in an investigation into the value of this treatment.

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