producing a negative intracavernous pressure, thus allowing the pericavernous atelectatic tissue to re-expand. It combats the biological factor by removing the inflammatory matter and debris, thus cleaning the walls of the cavity.

DRAINAGE TECHNIQUE: The lung must be adherent to the parietal pleura in the region of the cavity, so that the process of drainage will not cause a pleuro-pulmonary fistula. The position of the cavity, and the site of entry are determined by careful radiological examination. The latter must be such that a recumbent position can be maintained afterward. The intercostal space is anaesthetized at the chosen point and a long fine needle is passed through to ascertain the position of the cavity. The direction of the needle can be controlled by fluoroscope. The fine needle is withdrawn and a trocar introduced along the path. A cannula is inserted and the trocar withdrawn. A suitable catheter is introduced and left in position when the cannula is removed. The catheter is fixed to the chest wall and covered with a dressing.

Aspiration is begun in twenty-four hours, a filter pump connected with a manometer being used. The initial pressure must be very low, and the increase gradual. The cavity slowly closes and the drain is removed when the cavity is nearly closed. Final obliteration of the cavity usually will not take place till the drain is removed. The period of drainage usually lasts three to six months.

The results obtained on the cases tried were very remarkable. The efficacy of this treatment as regards permanent closure cannot be estimated without a longer period of observation.

CASE REPORTS

TWO CASES OF ECTOPIC GESTATION

(Presented with the permission of the staff of the Prince Edward Island Hospital)

CASE I.

Mrs. M., white, female, aged 40 years.

Admitted to hospital December 29, 1940, for diagnosis.

COMPLAINTS:
1. Pain in abdomen.
2. Fainting attacks.
3. Nausea and vomiting.

HISTORY: In the latter part of November, 1940, patient was seized with a sharp stabbing pain in the right side of the abdomen. She fainted at once and again an hour later. She became nauseated and vomited several times. The next day she began to "menstruate" and she had what she described as a normal period, the discharge stopping after 5 days. Though she did not feel entirely well at any time, having some lower abdominal pain and discomfort daily, she carried on till December 6, 1940, at which time she had another "period" which lasted 8 to 10 days and was associated with much crampy lower abdominal pain. On December 23, 1940, she again began to bleed p.v. and this continued for 5 days to December 27. For the first time the patient admitted that the discharge was not like her usual, being thicker in consistency, dark brownish in color, and scanty in amount. On December 28, she had a very severe attack of pain in her right lower abdomen. She had much nausea and vomiting and a feeling of extreme weakness though she did not faint. By December 29 the pain had spread over the whole abdomen and she was so tender that she could not bear the weight of the bed-clothing.

MENSTRUAL AND OBSTETRICAL HISTORY:

Periods began at age 13, 5/28 day type. Always regular.

Patient has had 9 pregnancies, all normal in every respect.

PHYSICAL EXAMINATION:

On admission, Temperature 100.4. Pulse 92. Respiration 28.

Abdomen. Contour normal. Moves very slightly on respiration. Extreme tenderness over the whole lower abdomen, most marked in the right lower quadrant. Very slight rigidity. Skin sensitivity very marked especially in the right lower quadrant. Suggestive shifting dulness on percussion. No palpable masses. Impossible to make complete examination due to great tenderness.

P.V. Much lower abdominal pain caused by moving the cervix. Very slight brownish discharge noted coming from the cervix. Suggestion of a mass in the right postero-lateral fornix though bimanual examination under anaesthesia was not performed.

LABORATORY FINDINGS:

Blood:	R.B.C.	2,240,000.
	Hb.	44%
	W.B.C.	6,400.
Urine:	Negative.	

TENTATIVE DIAGNOSIS: Ectopic Gestation.

OPERATION: Patient was given a transfusion of 500 c.c. whole blood pre-operatively.

Mid-line incision, umbilicus to pubis.

Abdomen filled with considerable quantity free blood and clots. A blood-clot the size of a goose-egg was in a ruptured right Fallopian tube, which was adherent to the surrounding bowel. Tube was ruptured in the mid-portion. There was a moderate sized clot in the Pouch of Douglas. Blood removed by swabs and suction. Ovary and distal two-thirds of tube were removed and vessels ligated. Stump buried in the broad ligament. Left tube and ovary normal. Appendix removed.

PATHOLOGICAL REPORT:

There is a large mass consisting of a sac about the size of goose-egg which, on opening, was seen to contain an organized blood-clot. No foetus could be seen in the contents. There is a portion of tube attached, thickened and hard. Gross appearance is that of a ruptured ectopic pregnancy.

POST OPERATIVE COURSE:

Uneventful. Patient discharged 14 days after operation with prescriptions for tonics containing haematinic principles.

CASE II.

Mrs. T., white, female, aged 24 years.

Admitted to hospital January 2, 1941, as acute appendicitis.

COMPLAINTS: 1. Pain in abdomen.
2. Nausea and vomiting.

HISTORY: On December 31, 1940, patient was seized with a sharp cutting pain in the abdomen. This was diffusely spread over the whole lower abdomen and lasted for some hours. She did not faint though she

nearly did so and she was seized with nausea accompanied by violent vomiting. During the two days before admission she vomited several times. After the initial pain had passed she continued to have much dull pain in the right lower quadrant and became extremely tender in that area. At no time did she have bleeding p.v. Patient stated that for the past year she had had several attacks of right sided abdominal pain accompanied by vomiting.

MENSTRUAL AND OBSTETRICAL HISTORY:

Periods began at age 14, 6/28 day type. Last menstrual period December 1, 1940. Patient states that the following period is several days overdue. Hitherto, always regular.

Had one pregnancy, 7 years ago. None since.

PHYSICAL EXAMINATION:

On admission, temperature 97.2, pulse 88, respirations 18.

Abdomen. Normal contour. Abdomen thin. Moves slightly on respiration. Whole abdomen below umbilicus very tender, more marked on the right. Slight muscle rigidity over the same area. Rebound pain marked on the right side. Skin sensitivity very marked all over lower abdomen.

P. V. Much tenderness on moving cervix. No masses could be felt bi-manually. No discharge noted coming from cervix.

LABORATORY FINDINGS:

Blood:	R.B.C.	4,730,000.
	Hb.	98%
	W.B.C.	17,000.
Urine:	Negative.	

TENTATIVE DIAGNOSIS: Ectopic Gestation.

OPERATION: Mid-line abdominal incision, umbilicus to pubis.

Some free blood in the abdominal cavity. Left Fallopian tube was ruptured in the middle half. Attached to it was a small blood clot. Distal two-thirds of tube was removed and bleeding points ligatured. Right tube normal.

PATHOLOGICAL REPORT:

Confirms operative findings. No foetus seen.

POST OPERATIVE COURSE:

Uneventful. Patient discharged 12 days after operation symptom free.

COMMENT:

The above cases are presented to show the diagnostic problems which may arise in ectopic pregnancy.

Case 1 with the history of acute abdominal pain, the fainting attacks, the intermittent bleeding p.v. for a month, and the marked anaemia, produce a picture which is not easily confused with any other condition.

Case 2 presents a more difficult diagnostic problem. This case was diagnosed acute appendicitis before being sent to hospital. In favor of this diagnosis there is a history of several attacks in the past year of nausea and vomiting and right sided pain. The elevated leukocyte count together

with no anaemia and no bleeding p.v. helps to substantiate this diagnosis. Undoubtedly bleeding would have developed had operation been deferred a few days. The tendency to faint, the suddenness and acuteness of the attack of pain, and the overdue menstrual period, together with the normal temperature and pulse point to ectopic gestation. The pelvic examination contributes to the diagnosis of ectopic pregnancy. In difficult differential diagnosis the symptom of fainting is a very great aid. If a careful history is taken this will very rarely be absent.

E. J. GORDON, '41.

A RARE MANIFESTATION OF CEREBROSPINAL FEVER

HENRY ROSS, B.Sc. '42

THE onset of Cerebrospinal Fever has much in common with many other infectious fevers. One is often misled by this general symptomatology, only to suddenly note the gradual onset of neurological signs. Rarely the disease leads the observer even further astray and herein is presented a case in which the initial symptoms were similar to a diabetic coma. De Massary and Tockmann claim that glycosuria is rare in cerebrospinal fever, while Kinnier Wilson merely mentions without comment that it may be one of the extra-neural symptoms. Recently, however, Ward and Driver of Leeds, England, reported a case which began as a diabetic coma and presented a most difficult problem of diagnosis. It is because of the similarity with the case in Leeds, that the following case history is submitted.

A young woman 19 years of age, well nourished and developed, was found unconscious on the floor of her home in Lunenburg, at 8:00 a.m., January 2, 1941. The only history obtainable was that she had been previously in perfect health but had over-indulged during the holiday season to an excessive degree. Admitted to the Victoria General Hospital at 12:30 p.m., she was semi-conscious and could only be roused with great difficulty. Pupils were equal and reacted to light. The mouth and lips were dry but there was no odour of acetone on the breath. The respiratory, cardiac, gastro-intestinal and G-U examinations revealed no abnormalities. The pulse was regular and of good quality. Some neck rigidity was noted but Kernig's and Babinski's Signs were negative. No ankle clonus present. The reflexes were sluggish but equal. Patient was very irritable when disturbed.

T:97° (ax); P: 65; R: 20; B.P.: 124/70.

R.B.C.: 4,880,000; W.B.C.:=26,800.

Urine Examination:

Acetone: + + + +

Sugar: + + + +

Alb: neg.

Blood Chemistry:

Total N.P.N.:	30.78	mgrs. per 100 cc
Urea Nitrogen:	14.38	" " " "
Blood Sugar:	0.224	" " " "

Clinical Course:

3.00 P.M. 20 units unmodified insulin s.c.

5:00 P.M. Condition unchanged. 20 units unmodified insulin s.c.
Sugar: + + + Acetone: + + + +

6:00 P.M. Condition appeared worse. Definite nuchal rigidity now present. Positive bilateral Kernig's. Patient very restless. Lumbar puncture revealed cloudy spinal fluid under pressure and containing meningococci. Soludagenan 2 ampoules (30 gr.) i.m.

9:30 P.M. Patient admitted to Infectious Diseases Hospital with reported diagnosis of Diabetes and Cerebrospinal Fever. She was in coma, could not be roused and was extremely restless. At times the extremities twitched violently. The hands exhibited a marked tremor. The pupils reacted sluggishly to light and a slight nystagmus was present. Nuchal rigidity was marked and positive bilateral Kernig's Sign present.

T. 99.6°F; P: 100; R. 22

Catheter specimen showed: sugar + + + +
20 units unmodified insulin, s.c.
Soludagenan 2 ampoules i.m.
Morphine gr. 1/6

12:00 P.M. Patient resting quietly. Pulse strong and full. Respiration normal.
Rectal saline 7 oz.

2.00 A.M. Catheter specimen of urine negative for sugar.
400 c.c. 5% Glucose intravenously.
Soludagenan 1 ampoule i.m.

3:00 A.M. T: 101.2°F (ax); P: 110; R: 22.
Resting quietly. Respirations at this time became very shallow.
Coramine: 1 ampoule s.c.

5:00 A.M. The patient once more became restless. Cynosis was very marked. The respirations were shallow and laboured. Pulse was regular, strong and bounding. Oxygen relieved the cyanosis, but complete respiratory failure intervened and the patient died at 6.00 a.m.

The reported case of Ward and Driver was as follows: A young healthy male, age 19 years, became drowsy, complained of headache and in several hours lapsed into coma. Acetone odor was present on the breath; the urine contained sugar and acetone bodies. T. 99.8°F; P: 84; Resp: 32. Diagnosed as diabetic coma and treatment was instigated. During a period of five hours the patient received 3 pints of saline containing 75 G. of glucose and 110 units of insulin. He became conscious and asked for a glass of water, again complaining of severe headache. Blood Sugar: 190 mg. per 100 c.c. The headache became associated with photophobia, ptosis of left eye, and slight neck rigidity. Spinal tap re-

vealed a cloudy fluid containing meningococci. The patient made an uneventful recovery, after treatment for meningococcal meningitis, except for a transient facial paralysis. Before his discharge a month later, it was proven that there were no abnormalities of his carbohydrate metabolism at that time.

Two explanations are advanced by Ward and Driver:

(1) that pressure on the floor of the fourth ventricle caused the liver to yield up its glycogen as shown in animal experiment by Claude Bernard; (2) or, that an acute toxemia, acting on already underactive pancreas caused failure of insulin output. Ward and Driver favor the former view.

It would appear that exception may be taken to the explanation that the increased ventricular pressure acting on the floor of the fourth ventricle is capable of producing the hyperglycemia in these two cases. Doubt has arisen, in recent years, as to the validity of Claude Bernard's experiments of needling areas lying in the floor of the fourth ventricle. Irritation, not destruction of nerve fibres in the lower pons and upper medulla, is now believed to be the causative factor. In addition, greater pressures are produced by tumors and injuries, than by meningococcal meningitis and extreme hyperglycaemia has not been recorded. If then, the above diabetic symptoms had their origin in the central nervous system, the more logical explanation would be the direct action of the organisms and their toxins upon the nervous tissues.

The other explanation is not without foundation. Infections of lesser degree can and do produce transient hyperglycemia. Experimental evidence has shown that many micro-organisms interfere with the action of insulin and that the first effects of the products of a severe infection may be to excite the liver tissue to increased glycogenolysis and discharge of glucose into the blood stream. However, until the final page in the field of carbohydrate metabolism and control is written, the true disease process in these two cases will probably not be known.

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PLACES AND DATES OF EXAMINATION - 1941

The Centres selected for the written examinations are Vancouver, Edmonton, Saskatoon, Winnipeg, London, Toronto, Kingston, Montreal, Quebec, and Halifax, on the following dates:

Monday, Sept. 29th; Tuesday, Sept. 30th; Wednesday, October 1st.

Oral Examinations in the Primary subjects, and Oral and Clinical Examinations in the Final subjects will be held at Montreal and Toronto on the following dates:

MONTREAL—Tuesday, October 21st; Wednesday, October 22nd.

TORONTO—Thursday, October 23rd; Friday, October 24th.

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Oral Examinations at **Toronto only**—Tuesday, June 17th.
Wednesday, June 18th.

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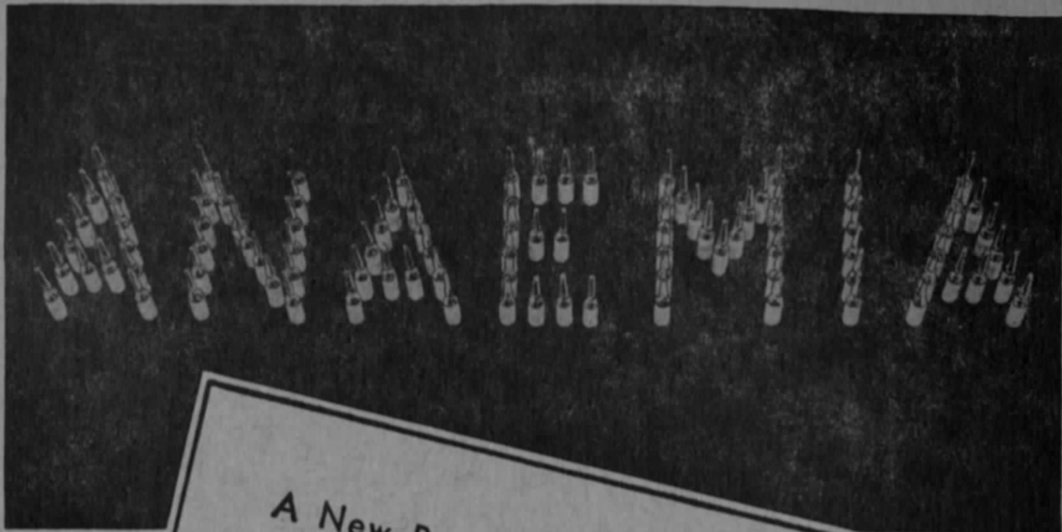

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