CLINICAL RECORDS

DR. TEMPLETON described the following cases :

A. Subarachnoid hæmorrhage in a case of Periarteritis nodosa.

Mrs. B., æt. 28. Onset of pain knees, feet, and ankles, hands, shoulders, with pyrexia for 12 months. It was thought she might have acute ulcerative endocarditis but blood cultures were negative and the therapeutic test with antibiotics was a failure. After 5 months she developed left foot drop with weakness and loss of sensation in the distribution of the right ulnar nerve. Two months later severe asthmatic attacks occurred and an eosinophilia was discovered. Her E.S.R. was persistently high, and the pyrexia continued. Her liver and spleen were easily palpable. Biopsy of petechial spots (hand) showed allergic vascularities. She had several hæmoptyses but sputum was negative as were X-rays of lungs. A definite diagnosis of polyarteritis nodosa was made and *Cortisone* therapy commenced with a rapid fall in temperature and improvement in most of the symptoms. Some days after discharge from another hospital she developed a severe occipital headache spreading to the front of the head and eyes with nuchal rigidity, a positive Kernig, absence of knee jerks, nystagmus on looking to the left, fulness of the retinal veins and early optic neuritis. C.S.F. showed blood and was negative for any organismal growth. The picture was that of a subarachnoid hæmorrhage presumably from rupture of a small aneurysm of one of the cerebral vessels, a condition common to the pathology of periarteritis nodosa and of which occurrences of rupture have been reported.

Her symptoms of cervical pain spreading to the occiput and head with extreme pain on lateral and downward movement of the eyes were well covered by *Gelsemium* as was a peculiar sensation of "as if enlarged". *Gels.* 200 was given 2-hourly with relief and improvement ; this drug, 4-hourly, was repeated in the 1*m* and the symptoms and signs, including regression of

P.M. examination showed microscopically classical "wire loop" changes in the glomeruli and Hodgkin-like cells in the pancreas. A similar finding was present in Case 1.

The typical L.E. cells in the blood were not found in this case, but there was no doubt as to the diagnosis. *Lachesis crotalus* and *Sulphur* were given at various stages but without effect.

(3) Female, æt 45. A polyarthritis for months with fever. Admitted 3 months before present admission and after numerous tests (there was no rash present) the diagnosis was mitral stenosis and subacute rheumatism. The fever subsided and the joints became less painful, one thought, under the administration of *Bacillinum* 200, one dose.

On readmission she had failed; there was not much arthritis and the general picture was asthenia B.P. 100 only and some pigmentation legs and folds, but serum sodium readings did not suggest an Addison's disease. She had had some pleurisy at home and this recurred on both sides with some accumulation of fluid. Fever was intermittent and again there was a leucopenia swinging between 6,000 and often being as low as 3,300. E.S.R. 112/132. She, in the absence of a typical rash, was seen by many colleagues and the diagnoses were as many, from Tuberculosis, Carcinoma stomach to Addison's, but by a process of elimination one of the Collagen diseases was considered the most likely. Ultimately by a new technique the blood showed many L.E. cells and with the administration of *Cortisone* at another hospital she responded dramatically, the fever dropped, she began to put on weight and for the moment she is very much better. Strange to say, she was seen three years previously with a single patch of what was called a "lupoid" eruption which, at that time, disappeared with the administration of *Bacillinum* 200, one dose. On this later occasion there was no facial eruption to help in the diagnosis.

The action of *Cortisone* is considered to be one of suppression of tissue reaction and in this disease the general conclusion is that it does not prolong life nor offer any cure but seems to tide the patient over in the hope of a natural remission.

Diagnosis, as will be seen, is often difficult in the absence

of a typical rash but, running through each of the cases, is a picture of a polyarthritis, an irregular fever, a leucopenia and pleurisy with effusion, with evidence of nephritis especially the presence of R.B.C.'s.

The common misdiagnoses are the cases of acute and subacute polyarthritis behaving as rheumatic fever, chronic progressive polyarthritis behaving as rheumatoid arthritis, and myalgias and arthralgias behaving as fibrositis. Cases may be fulminating, acute, or a vague ill-health or chronic becoming acute. Allergic causes are postulated on the lines of AUTOANTIBODY disease. Antibodies formed against exogenous antigen, e.g. *Strep.* or T.B. react not against the original antigen, BUT with a tissue of the body of similar chemical composition, resulting in collagen fibrinoid degeneration and fibrosis especially of the capillaries and arterioles of any organ of the body.

(4) A fourth case which came with a symmetrical erythematous eruption of the face just below and to the lateral side of the lower eyelids (almost malar) with a slight rise of fever was diagnosed as a possible acute lupus erythematosus but no L.E. cells were found. *Arnica* 200 (xii) 4-hourly was given on the symmetry of the lesions and the condition cleared with residual pigmentation. It is interesting that the first three cases showed that strange mental state, so typical of *Arnica,* of saying they were well when very ill. But, though *Arnica* was prescribed, it did not seem to affect the course of the disease. The L.E. cells so-called, and the L.E. phenomenon, are demonstrated by adding heparinized blood to normal bone marrow when clumping of polymorph cells is observed and is followed by the appearance of inclusion bodies in some cells.

This is a depressing series of cases, but is offered with the aim of aiding early diagnosis when it is hoped treatment in the early stages may be more effective in producing remissions.

BIBLIOGRAPHY

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British Encyclopaedia of Medical Practice, Vol. 6, p. 375 ; Vol. 8 ; Vol. 2, p. 317.

C. Four cases of nephritis :

(1) Acute. Æt 42. Submucous resection on March 16th.

Three days later developed sudden fever, T. 103, Pulse 150, with early signs of a patchy bronchopneumonia and two days later there was evidence of an acute nephritis with oliguria (4 oz. in 24 hrs.), casts in urine and a blood urea rising to a peak of 440 mg. per cent. *There was no œdema.* He was put on a regime of Bull's diet : Glucose 400 g., peanut oil 100 g., Acacia in water to 1 litre in 24 hrs. In view of the continued rise in blood urea and the oliguria he was given *Eel serum* 6 one-hourly during one day, two-hourly the following day, with reduction of blood urea to 330 with another rise to 375 when the *Eel serum* was given in the 30th potency four-hourly, which was followed by a fall in blood urea to 362, 284, 260, on subsequent days when the *Eel serum* was discontinued, but the fall continued to 114, 112, 84, and 42 on the 16th day, and to 22 mg. per cent. on the 28th day from the peak of blood urea. The urine then showed only a trace of albumin but no casts and no R.B.C.'s. Subsequent check up showed normal figures and normal urine. There was no œdema and the blood pressure never rose above 150/100. According to Boericke *Eel serum* has a toxic action on all the renal elements, there is blood in the urine and anuria results. So it is suggested for acute kidney infections or inflammations characterized by oliguria (or anuria), albuminuria *but without œdema and with hypotension* as opposed to *Digitalis* where there is hypertension and œdema. The choice of potencies was purely empirical.

(2) Chronic nephritis. Æt 20. At least six years' history but admitted on account of rise of blood urea to 400 mg. per cent. with some rise in blood pressure 180/120 ; casts in the urine but no retinal signs. He was put on average protein diet of 2·5 g. per kilo with one rest day weekly, when he had fruit juices only with ample glucose. In spite of this regime the blood urea figures remained high, though under 400, so, in the absence of œdema, he was given *Eel serum* 6th potency t.d.s. for 7 days at a time and subsequently the 12th potency for three days, when his blood urea fell to 160 but no lower. His urea clearance showed only 18 per cent. of normal so that he must be considered a serious case with a poor prognosis, but *Eel serum* seems to have had a beneficial effect but may need more

frequent repetition than is usually advised. He shows, as does this type of case, a high blood cholesterol 400 mg., and his serum globulin is a high normal 2·3 and his albumin a low normal of 3·6, with total protein of 6·3. His blood pressure remained steady at 180/110.

(3) Female, æt 17, with two years' history of gross albuminuria, R.B.C.'s and casts. Serum protein two years from onset 3·9, albumin 1·3, globulin 2·6, blood urea 28. No fundal changes noted. On admission she had gross œdema of the ankles and sacrum with a blood urea of 70 mg. per cent. and a serum protein much the same as above. She had already been on a high protein low salt regime and this was continued. Her symptoms were thirst for large drinks of water, a desire for salt (this was not entirely due to diet but was a characteristic of the patient), fond of bacon, fond of eggs and fried food, dislikes solitude, loves sympathy and fuss, has a fear of thunder and of the dark. Cries easily and loves company.

She was given *Phosphorus* 30, one dose, and within 10 days was much better, the œdema was practically gone and the blood urea was now 35 mg. only. B.P. 120/90. Urea clearance 73 per cent. of normal function. She was what was formerly known as a nephrosis but is now described as Ellis type 2 nephritis.

(4) Female, æt 36, with history of two years' swelling of ankles which has persisted. Her urine showed gross albumin and granular casts and there was gross œdema of feet and legs and a large sacral pad. B.P. 140/80, blood urea 25 mg. She had various remedies but not, until taking a full case when she was given *Pulsatilla,* beginning with 6 repeated, then 12, then single dose of the 30th and subsequently one dose of the 200th potency, did the œdema disappear and the albumen in the urine decline to a trace.

She was a mild person with easy tears, a desire for sympathy and company, quiet, with strong liking for cheese. No dietary regime was prescribed except a diminution in her salt intake which had been observed before she began treatment. She has remained free from œdema for 3 years.

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