Heart.—Muscle fibres adjacent to the epicardium showed cloudy swelling. The epicardium showed fibrinous flakes on its surface. The sub-epicardial area was infiltrated with mononuclear cells and showed a coagulative necrosis. *Entamœba histolytica* were seen in this layer. A round cell infiltration was also evident in some places in the sub-epicardial layer but was not pronounced.

Commentary.—The cause of death was rupture of an amœbic abscess of the liver into the pericardial cavity. The interesting point is that there had been a leakage of amœbic pus into the pericardium for some days prior to death as was evidenced by the microscopic lesion of the epicardium—in other words an amœbic pericarditis had been established.

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My thanks are due to the Director of Medical Services, G.H.Q., India, for permitting me to publish this report.

OXYTOCIC ACTION OF NEPTAL

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A WOMAN, age 35, 6th para, 8 months, was admitted for general anasarca. She was intensely anæmic, conjunctiva pale as paper, earthy colour of skin, pitting œdema from face down to dorsum of feet, with some fluid in the abdomen, labia majora were like ovoid blisters and giving rise to great discomfort. There was a blowing murmur in all areas of cardiac region and distress in breathing.

She was given 2 c.c. of neptal intramuscularly at 6 p.m. on the second day of stay in hospital. At 7 p.m. she went into labour and at 10 p.m. was delivered of a male baby, puny and probably about 4 lb. in weight—*no weighing machine available.* She urinated profusely and by 9 a.m. next morning was so shrivelled up as to be unrecognizable. Mother and baby are well at the time of writing. Treatment for ankylostomiasis is being initiated.

The leaflet in the box of ampoules—the only literature at hand to consult—does not mention any action of this drug on the uterus and that is why this note is sent for publication to invite the attention of the profession to it, and confirm or refute my inference.

Therapeutic Notes

NOTES ON SOME REMEDIES

XV.—DRUGS IN SYPHILIS (contd.)

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III. Cardiovascular syphilis

SYPHILIS attacks the blood vessels after a long latent period, and then the brunt of the attack falls on the aorta at its origin. It is a chronic inflammatory process of the vessel wall leading to dilatation and regurgitation or anginal attacks by implicating the mouths of the coronary arteries. In the past too energetic treatment with powerful remedies was the cause of rapid heart failure from the Herxheimer reaction or proved too toxic for the already damaged heart. In other cases it was followed by immediate clinical improvement and then by a downhill course ('therapeutic paradox') caused by rapid resolution of the syphilitic tissue with the resulting scarring and fibrosis of the aorta. Treatment should therefore be cautious, even in uncomplicated aortitis, with the insoluble bismuth and iodides, the doses being gradually increased according to tolerance. After three months of this treatment NAB may be started with a dose of 0.15 gm. gradually increased up to a maximum of 0.3 gm. If no unfavourable reaction occurs the arsenical course is completed with 10 or 12 injections. After an interval the patient requires another similar treatment and thereafter annually a course of bismuth followed by arsenic unless signs of heart failure develop. Provided that the disease is not advanced, its progress may be arrested by the above treatment. In aortic regurgitation it is most important to avoid any reaction. Acetylarsan is a convenient preparation for this condition, but in the U.S.A. bismarsen is more popular. No arsenic should be used in the presence of true angina, dyspnœa or congestive failure and in such cases it is better to use mercury instead. Penicillin is not recommended in cardio-vascular syphilis, as sufficient data are not yet available.

IV. Neuro-syphilis

Broadly speaking, there are two main types of lesions : (1) meningo-vascular, *e.g.* gummata, meningitis, vascular disease causing thrombosis, and meningo-myelitis, and (2) parenchymatous, in which the main changes are in the nerve cells and fibres and which includes tabes dorsalis and general paralysis of the insane. Neuro-syphilis may be asymptomatic when the only sign is an abnormal spinal fluid. Vascular lesions respond well to energetic treatment which is begun with bismuth (or mercury) and iodides followed after a month by NAB and bismuth for ten weeks. Four such courses are given in a year and thereafter depending on clinical and serological improvement the patient will probably require at least one course a year for several years as a safeguard against recurrence. In acute cases, *e.g.* severe meningitis, it is important to avoid intensive treatment and not to use arsenicals until the patient is under the influence of bismuth and iodide as this may lead to a reactionary increase of the syphilitic process.

In parenchymatous syphilis, damage to the nervous tissue beyond a certain point cannot be