skiagrams showed a gradual clearing of the opacity commencing at the periphery. In "epi-tuberculosis," clearing of the lung, which is usually uneventful, occupies a period of some months, commences at the periphery, and when complete, leaves little if any damage or pulmonary scarring.

Pathological Examination.—Owing to the absence of sputum, the ordinary tests for tubercle bacilli cannot be carried out. The Mantoux or von Pirquet tests, if "positive," merely prove that the child has, at some time received a tuberculous infection. A negative response to the test should lead us to reconsider our diagnosis. Tubercle bacilli should be sought for by swabbing the tonsil, collecting particles of spray from a laryngoscopic mirror held over the glottis, in stomach washings, or by examination of the fæces.

Conclusion.—The patient manifests the condition commonly known as epi-tuberculosis. This may be the result of an allergic reaction around a tuberculous focus in the right upper lobe occurring in a child who was, at the time of infection, already in a sensitised condition as the result of massive infection from his mother, or the condition may have resulted from an enlarged mediastinal gland pressing on the right upper bronchus and causing atelectasis of the corresponding lobe. The prognosis is favourable. The treatment should consist in prolonged convalescence in some suitable locality, preferably on the coast, under careful medical supervision.

(A concise and clear description of Epituberculosis is given by B. Goldberg and B. M. Gasul, in the American Journal of Medical Science; 1930, CLXXX, 824.)

A CASE OF COMPLETE HEART BLOCK.

Case presented by K. SHIRLEY SMITH, M.D., F.R.C.P.

History.—The patient, a compositor of sixty-four, gave no history of rheumatism and denied syphilitic infection. Early in 1931 he began to get short of breath on effort. He noticed that the breathlessness was succeeded by epigastric pain, and that he was then compelled to rest, the symptoms thereupon disappearing in a minute or two.

Examination.—The patient looked ill and became dyspnoeic and somewhat cyanosed on exertion. No engorgement of the cervical veins or liver was present, nor any pulmonary or other oedema. The apex beat was heaving in quality and situated in the anterior axillary line in the sixth space. The heart beat regularly at 36 per minute, the rate being uninfluenced by exertion. It was noticed that the first sound was from time to time accentuated, and the soft sound of auricular contraction could be frequently distinguished in the diastolic intervals. The blood pressure was 215/85, and the peripheral arteries were thickened and tortuous. Radiological examination showed enlargement of the heart, the left ventricle being grossly hypertrophied, and the aorta moderately dilated; the dissociation between auricular and ventricular contractions could be well seen. The electrocardiogram confirmed the presence of complete heart block and showed some involvement of the right bundle branch. The Wasserman reaction was negative.

Discussion.—The diagnosis in this case was not difficult. It was clear that the greatly enlarged heart indicated a severely damaged myocardium, and that the implication of the conducting system had led to heart-block. Several post-graduates assumed that the auricular-ventricular dissociation was complete, and had not considered the possibility of a 2:1 partial heart block. When complete heart block exists, the auricles and ventricles synchronise more or less exactly from time to time, producing variability and sometimes reduplication of the heart sounds. The presence of this sign and the constancy of the heart rate indicated in this patient the true nature of the arrhythmia. Regarding ætiology, it was suggested by some post-graduates that syphilis was the probable factor. At later ages (as in this patient) coronary sclerosis is a much commoner cause of heart block, while the nature of the history and the presence of generalised cardiovascular disease supported this view of the ætiology. The nature of the epigastric pain ensuing upon exertional dyspnoea was discussed. This pain was probably not of coronary origin. When paroxysmal pain related to exertion occurs in the epigastrium as a sequel to dyspnoea and does not radiate, it is believed to originate in ventricular stress rather than in myocardial ischæmia. The high systolic pressure in this patient, and the large pulse pressure (130) are in part related to the arterial condition. They are also in a measure compensatory, and due to the complete filling of the heart during the long period of relaxation, followed by a correspondingly augmented stroke volume.

CASE DEMONSTRATED AT THE F.R.C.S. CLASS.

Case presented by PERCIVAL P. COLE, F.R.C.S.

Mr. S. B., Aged 34. Occupation, Labourer.

Complaint.—Swelling on inner side of left thigh.

Duration: Two months.

History.—Noticed swelling 2 months ago, accidentally, which gradually increased to the present size. One week before admission he developed pain in the swelling. Has been in the country all his life. No history of venereal infection.

Previous History: Nil of importance.

Family History: 3 children, well.

On Examination.—Large elongated swelling on inner side of thigh extending from middle of thigh up to pubic ramus. No enlarged veins.

Palpation.—Consistency: Soft, no fluctuation, hard nodule at upper end. Surface smooth. Edge merges into surrounding tissue.

Relation: Adductor longus and gracilis muscles anteriorly. Hamstring muscle behind becomes fixed on contraction of adductor magnus. Not compressible and no murmur on auscultation.

Special Examination. W.R.: Negative. Hydatid skin test: Positive. 6% eosmophilia.

Pre-Operative Diagnosis.—Intra muscular sarcoma, Lipoma or Fibroma.