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Editorial

Before the start of the present conflict, there was much discussion by the laity as to the treatment of criminals. Two schools of thought were present—the old die-hard school which did not understand the term "mercy," and the new school which suggested that all crime was the effective reaction of an unfortunate psychological upbringing. Maybe there is much to be said for both viewpoints. But it must be apparent to all thinking men that, in any discussion on penal reform, the opinion of the physician who has made a particular study of the mind and its disorders, must be placed high in the assessment of the more rational treatment of criminals. We are glad to be able to publish an article on "The Sociopathic Offender" by W. NORWOOD EAST, whose experience in this particular line of medical specialization is large, and we hope that it may lead the way to clearer thinking by the rest of the profession on this most difficult question, which so often involves the searching of our consciences.

ALMEYDA'S article on the association of Herpes Zoster and Varicella is of interest. We feel, as does the author, that it was unfortunate that the brain and spinal cord were not examined in the one fatal case. The occurrence of an encephalitis would have explained the symptom of hiccough, which was so distressing. Might it not also have had some bearing on the haematemesis? Repeated stimulation of the red nucleus in the midbrain has been shown by CUSHING to produce peptic ulcer in the experimental dog. Might not an inflammation of this region produce haemorrhage in a peptic ulcer patient?

We feel that we cannot close this editorial without reference to the valuable work of DR. ERNEST FLETCHER, during the past five years as Editor of this Journal. Fortunately we are not losing touch with him since he has agreed to place his valuable experience at our disposal by remaining on the Executive Committee as Honorary Advisory Editor. We wish to express to him our appreciation of all the good work that he has given to this journal, and to acknowledge our debt to him for past accomplishments.

Comment.—The relationship between gastro-intestinal infection and the subsequent polyneuritis in this case is open to doubt, but the infective nature of the latter illness is confirmed by the raised protein content of the cerebro-spinal fluid.

In the absence of any demonstrable septic focus, and from the clinical course of the case, it seems reasonable to assume a virus infection of the nervous system as the most likely aetiological factor.

I am indebted to Dr. A. M. C. Macpherson for permission to record this case.

CASE II

A NOTE ON THE TREATMENT OF NEPHROTIC OEDEMA

The following case is of some interest on account of the therapeutic problems presented.

Case Note

Mrs. P., aged 60, developed symptoms of diabetes mellitus six months ago, for which she was given a diet but no insulin. Four months later she noticed increasing breathlessness on exertion, which was followed by swelling of the legs, arms and abdomen to such an extent that she became unable to get about. Her sight had been failing for six months.

There was a history of "kidney trouble" during pregnancy some thirty years ago, but there had been no recurrence of urinary symptoms until the onset of her present illness. Diet had been largely vegetarian of late; no history of alcoholism. On admission to hospital she presented a picture of extreme anasarca, with pallor, orthopnoea, ascites, and bilateral basal hydrothorax. Liver and spleen were moderately enlarged. Temperature, pulse and respiration rate were normal. The blood pressure was 190/100 mm., and there were signs of left and right ventricular hypertrophy. There was marked finger-clubbing. The ocular fundi showed silver-wire arteries, old bilateral retinal haemorrhages and advanced diabetic retinitis, and visual acuity was grossly impaired.

The urine contained sugar and albumin in considerable amount, and a trace of acetone. Microscopy showed red cells and a fair number of hyaline and epithelial casts.

Pathological Investigations

The blood showed a moderate degree of hypochromic microcytic anaemia (Hb 70 per cent), with a normal leucocyte count.

Blood urea	100 mgm. per 100 c.c.
Blood cholesterol	250 mgm. per 100 c.c.
Total plasma protein	4·5 grams per 100 c.c.
Fasting blood sugar	210 mgm. per 100 c.c.
Wassermann and Kahn reactions	Negative

Case Management

From clinical and biochemical observations it appeared probable that the gross generalised oedema in this case had a combined renal, cardiac and dietetic basis, but that the most important factor in its perpetuation was a hypo-protinaemia.

The diabetes was easily stabilised on a diet containing 150 gm. of carbohydrate, 100 gm. of protein, minimal fats and restricted fluids and salt, together with protamine zinc insulin,

20 units, and soluble insulin, 15 units, daily. Ferri. ammon. cit., gr. xxx, was given thrice daily to improve anaemia.

During the first month of treatment an attempt was made to reduce the anasarca by giving large doses of alkalies (potassium citrate, gr. xc, four times daily), with saline purgatives and vitamin B_1 (Aneurin, 2 mgm. tds.). These measures produced no appreciable improvement, and it was therefore considered justifiable, despite the presence of diabetes and of chronic nephritis, to resort to local treatment. Multiple incisions were therefore made, not without trepidation and not without strict asepsis, into the skin of both legs and dorsal aspects of the feet. During the ensuing week the patient drained 50 pints of fluid through the incisions, which healed aseptically in due course (possibly helped by ascorbic acid, 50 mgm. daily).

In order to consolidate this improvement, it was decided to give 50 c.c. of quadruple-strength plasma by slow intravenous infusion. Following this procedure, the plasma protein, which had fallen to 2·5 grams per cent after the above drainage fluid, rose to 5·5 grams per cent. The blood urea was now 70 mgm. per cent, and it was thought reasonably safe to commence weekly intramuscular injections of Salyrgan, 2 c.c.

It was noted that the diuretic effort of these injections was markedly increased if vitamin B_1 was given for three days before and after the Salyrgan. A high protein diet of adequate vitamin content was continued throughout the treatment of this case. No ill effects were noted from therapy with mercury, and six weeks after making the skin incisions there was no significant return of the oedema and the patient felt very much more comfortable, with no obvious dyspnoea. The blood pressure remained unchanged, as did the finger-clubbing; the latter would appear to be the result of chronic local anoxaemia following upon tissue oedema.

Comment.—This case is considered to be an example of the Kimmelstiehl-Wilson syndrome of diabetes accompanied by the hydraemic type of nephritis. There is, however, some nitrogen retention, as shown by the raised blood area, and there seems little doubt that the renal damage will prove to be progressive. Despite the bad prognosis the symptomatic relief afforded by the above treatment seems to justify the measures employed.

My thanks are due to Dr. Ursula James for permission to record this case.