May 19, 1918.—During the afternoon patient had a sharp rigor, and temperature rose to 105° F.

May 20, 1918.—Temperature normal and feeling comfortable. Wound dressed, and looked clean and satisfactory in all respects. No tenderness in neck or any gland enlargement in carotid triangle.

May 21, 1918.—Rigor occurred about 2.30 p.m., and temperature rose to 105° F.

May 22, 1918.—Temperature and pulse normal. No signs of intracranial complications. Patient says he has never had malaria and has never been in a malarious district. There is no evidence of splenic enlargement. He looks anæmic.

May 23, 1918.—Rigor in early afternoon; temperature rose to 103° F. No change in physical signs. On questioning, patient admits having been bitten by mosquitoes while in France.

May 24, 1918.—Blood films show malarial parasites. Temperature and pulse normal.

May 25, 1918. Rigor at mid-day. Temperature 105° F. Quinine sulph., gr. v, with acid sulph. dil., prescribed every four hours.

June 7, 1918.—There has been no further rise of temperature, and patient is looking well and feeling well.

The advent of a rigor in association with any suppurative disease in the middle-ear cleft suggests the onset of an intracranial complication which calls for immediate attention. In the present case, the extent to which the mastoid was implicated by the pyogenic disease—the presence of healthy bone covering the sigmoid groove and bulb—the severity of the rigors, the apparently complete recovery on the following days and the absence of other signs of intracranial mischief—caused one to consider the possibility of some other explanation of the acute constitutional disturbance. At the same time the absence of a malarial history and the fact that the patient had not at any time lived in a malarial country were somewhat disconcerting, and added to one's feeling of uncertainty about the diagnosis. I am afraid we were, perhaps, too much taken up with the endemic nature of malaria, and inclined thus to overlook the fact that it is a disease which may be acquired wherever the infected mosquito exists.

The onset of malaria in association with trauma and surgical operations is such a common experience in endemic areas that one wonders why, in the present case, the symptoms were delayed till after the performance of the third operation.

I am indebted to Col. G. G. Adams for permission to publish the notes of this case.

POST-CRICOID SPASMODIC STRICTURE.

By Dan McKenzie.

Two cases lately under my care have afforded an opportunity of seeing a spasmodic stricture of the pharyngo-œsophageal orifice behind the cricoid cartilage.

Both patients were women; their symptoms were similar and the appearances almost identical.

Case 1.—Hospital patient; female, aged forty-five. Ever since childhood the patient had been subject to difficulty in swallowing, and for ten years the obstruction had been so great and so constant that she had not been able during that period to sit through a meal. No matter how carefully she chewed the food and how cautiously she proceeded to swallow it, at some time or another during the meal the food became absolutely arrested, and she had to retire from the table and empty her throat by a regurgitant effort. Then she began again, and so by perseverance and continual effort she contrived to get

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enough food down to keep her alive. But so objectionable did she feel this behaviour to be that never once during those ten years had she eaten a single meal outside of her own house.

An X-ray examination with the screen was made by Dr. Ironside Bruce, and he reported that the bismuth meal was arrested at the level of the cricoid. There was no indication of pouching and a photograph was not taken.

The appearances seen on making the direct examination and the treatment adopted were the same in both cases and are detailed below:

Case 2.—Private patient; female, aged fifty. She had become subject to fits of "choking" during meals six years before she came to consult me. At first the attacks had continued regularly for several months, then there was an interval lasting for two or three years, when the swallowing was normal. But again the difficulty had come on and had continued regularly ever since.

As in the first case, the difficulty in swallowing was constant, not intermittent. It attended every meal and every effort to swallow. She was able, however, to go through a meal without interruption if she chewed her food very thoroughly. But if a large or imperfectly masticated piece was swallowed then she felt it arrested in the throat, and there it remained for two or three minutes, finally passing slowly down of its own accord. The piece of food arrested was not regurgitated. But if she attempted to ignore the obstacle and continued her meal then regurgitation took place. Liquids, however, could be forced past the obstruction, but they made a splashing noise. On one occasion a small tabloid had stuck, but it also passed down of its own accord.

The pharyngeal and lingual tonsils in this case were enlarged. Otherwise, no abnormality was detected on ordinary examination.

Direct examination with a small-calibre œsophageal tube—preferable for the first examination except in cases of foreign body—showed in both cases at the lower end of the post-cricoid sphincter a definite stricture or narrowing of the lumen to a small circular orifice of from 3 to 5 mm. in diameter. It had the appearance almost as if a thread had been tied under the mucosa.

In both of the cases pressure was maintained upon the stricture by the end of the tube for two or three minutes, but it resisted dilatation, and, indeed, on shifting the end of the tube from side to side, it was possible to pull on the stricture and render it crescentic in shape and even slit-like. I naturally concluded, in the first case, from this appearance and behaviour that the stricture was cicatricial, and I proceeded to endeavour to pass a bougie through it by way of the direct tube. To my surprise the bougie passed at once without any sensation of obstruction whatever, and on withdrawing it I found that the stricture had disappeared, and that the examining tube could now be passed on down the œsophagus with ease.

The bougie was, however, reinserted for half an hour, and in neither case have the symptoms of obstruction recurred. Both patients are now able to swallow their food without any difficulty whatever.

The first case was treated eighteen months ago, and I have repeatedly examined her since without finding any sign of stricture.

In the second case after the dilatation I was struck with the liveliness of the contraction wave in the œsophagus immediately below the seat of the stricture.

I must add that in neither case could any sign of an organic lesion be discovered.

We have been able to establish the existence of spasmodic stricture of the œsophagus at the cardiac end and in mid-thorax; and now, as these cases show, we may encounter the same kind of stenosis at the upper end of the œsophagus (or lower end of the pharynx).

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