COMMENT

On inquiry from the patient and her relatives it was established that she was very fond of watercress, which she was wont to gather from roadside ditches near her house, having once been heard to complain that "the cows had eaten it all."

A feature of the case was the entire absence of a history of the occurrence at any time of an acute febrile illness with "liver pain," such as is characteristic of the invasive (larval) stage of the disease. For this reason it is difficult to fix the time of infection, but the duration of the attacks of colic and the grossly pathological condition of the bile-duct indicate that it was not later than 1959, and as that was a very dry year, unsuitable for the development of the fluke, 1958 seems the latest time—this was the year of the outbreak previously referred to.

Acknowledgments are due to Dr. E. J. O'Keefe (Medical Officer of Health) for investigating the source of the watercress; to Mr. F. P. Forrest for permission to publish the case; to Dr. T. J. Wickham for the post-mortem report; and to Dr. R. V. Facey for his help and encouragement to publish this report.

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Constrictive Pericarditis Resulting from Dracunculosis

The presence of a guinea-worm in the coelomic cavity is rare and its presence in the body cavities other than the peritoneum has not been reported. Recently we came across a guinea-worm infestation of the thoracic cavity which had produced constrictive pericarditis.

CASE REPORT

A Hindu man aged 35 was admitted to hospital for exertional dyspnoea and progressive abdominal distension of six months' duration. He had also noticed some puffiness of the face and oedema of the feet.

On examination pulsus paradoxus was apparent on palpation. B.P. in the arm was 96/70 mm. Hg. Systemic examination revealed a greatly distended abdomen. The liver was enlarged three fingerbreadths below the costal margin. The spleen was not palpable. Marked ascites was evident. The apex beat was not palpable. Heart sounds were feeble and no murmur was heard. Eosinophilia was not detected. A radiograph of the chest showed moderate enlargement of the cardiac silhouette with fluid in the left pleural cavity. Fluoroscopy revealed feeble cardiac pulsations. Electrocardiogram: low-voltage and flat T waves in all leads. The venous pressure in the antecubital vein was 290 mm. of water at rest. Right heart catheterization revealed intracardiac pressures within normal limits. No abnormal shunts or passages were discovered.

A diagnosis of constrictive pericarditis, probably of tuberculous origin, was made. The patient was treated with bed rest, diuretics, low-sodium diet, and anti-tuberculosis drugs for two months prior to surgery.

Operation.—On September 23, 1960, the heart was exposed through a T-shaped median sternotomy, Holman-type incision. The pericardium was much thickened and showed calcification along the left border. A small abscess cavity was found in the region of the transverse sinus. As the contents of this abscess cavity were being evacuated a coiled-up worm buried in the necrotic granulation tissue was detected and removed almost intact. The entire abscess cavity was then excised and the wound was closed with a drain.

The patient made an uneventful recovery. Further inquiry into the past history revealed that the patient had had a guinea-worm abscess of the leg a year before admission.

At follow-up seven months after operation the patient showed remarkable improvement in his tolerance for physical exertion. The neck-vein congestion was greatly diminished. The liver was not palpable. No ascites or oedema was seen. The venous pressure in the antecubital vein was 160 mm. water at rest.

The post-operative radiograph of the chest showed significant diminution in the size of the cardiac shadow and clear lung fields. Fluoroscopy revealed good cardiac pulsations. The E.C.G. showed improvement in voltage and T-wave changes.

Pathological Report.—The dead worm removed measured 53.5 cm. in length and 2 mm. in thickness. The tail end could be easily identified because of the characteristic hook-like bend. Head parts were not seen. Typical rhabditiform larvae with striated cuticle came out on light squeezing, revealing the identity of the worm. Sections from the pericardium showed granulation tissue infiltrated with mononuclears, neutrophils, and eosinophils. No evidence of tuberculous inflammation was seen.

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Subdural Haematomas Complicating Anticoagulant Therapy

From time to time it is worth while to report the occurrence of clinically significant bleeding in patients receiving anticoagulant therapy. It serves to re-emphasize the importance of carefully controlled patient observation and therapeutic discrimination, which are essential to the administration of these potentially dangerous drugs.

Although more accurate methods for the measurement of the various blood-coagulation factors now exist (Owren, 1959), the increasing tendency to treat patients on an ambulatory basis (Cronhelm, 1961) may be expected to increase the number developing haemorrhagic complications. This may be partly explained by the occurrence of bleeding at levels of prothrombin activity within or above what is thought to be a desirable therapeutic range, and because in the final analysis accurate control depends upon the intelligent understanding and co-operation of the patient.

Intracranial haemorrhage, though less frequent than other bleeding manifestations, is more often fatal, and more hazardous from a prognostic point of view because of the irreversible nature of the changes produced in the central nervous system. Subdural haematomas are the least common form of intracranial haemorrhage, but are the most amenable to surgical treatment and pathological reversibility.

CASE 1

A 52-year-old woman was discharged from hospital on digitalis, antidiuretics, and dicoumarol for the treatment