Post-mortem Examination.

The general appearance suggested that of a child of 11 years of age. The body was well nourished and plump. No deformity of the limbs was noted. There was a bald patch, apparently alopecia areata, on the back of the head.

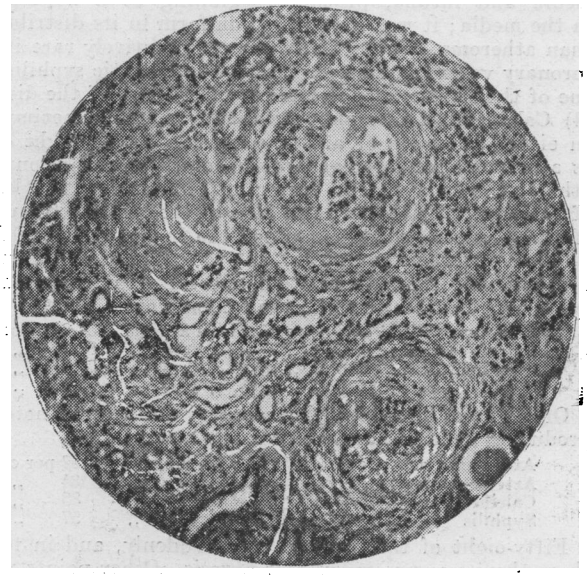

FIG. 3.

Chest.—Both lungs showed old chronic tuberculosis and tuberculous broncho-pneumonia. The thymus was not persistent, and there was no increase or decrease in the size of the thyroid gland. The heart presented no peculiarity. The large vessels showed no degenerative changes.

Abdomen.—Tuberculous mesenteric glands. The spleen and liver presented no abnormality. The uterus and ovaries were very small and undeveloped. The intestine showed no abnormality.

The brain showed some oedema and flattening of the convolutions. No tubercles were seen. The pituitary gland appeared normal.

The kidneys specially described (see Figs. 1 and 2). These were very small. The surfaces were granular and the capsules stripped freely. A small cyst was present in the right kidney. The cortical area was greatly diminished. On section (see Figs. 3 and 4) the tubules of the kidney were dilated. The glomeruli (Fig. 3) showed slight fibrotic changes, but were otherwise normal. There was marked interstitial fibrosis, the arteries showing considerable thickening (Fig. 4). The condition was that of a progressive interstitial nephritis.

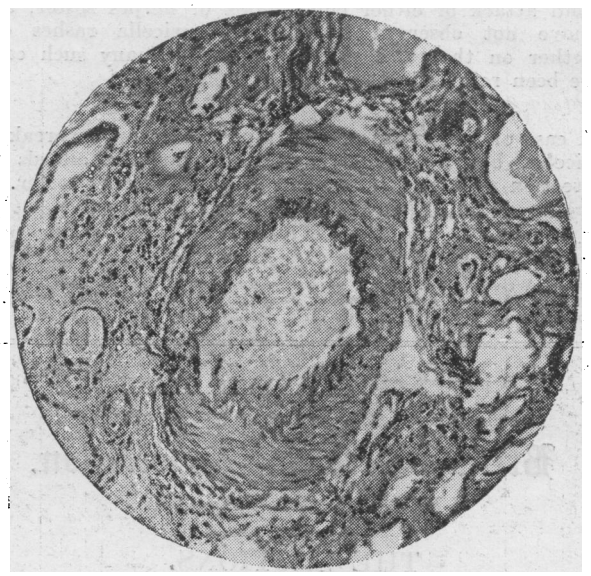

FIG. 4.

During life an endocrine defect was suspected in the child, and it was only at the *post-mortem* examination that the condition of the kidneys was fully appreciated.

I am indebted to Dr. R. Mair, assistant physician to the Royal Infirmary, Sunderland, whose case this was, for the clinical notes.

HERPES AND VARICELLA.

BY

N. GRAY HILL, *M.C.*, M.B., B.S.

TOWARDS the end of last century von Bokay noted the occurrence of herpes zoster and varicella in the same households at the same time. Since there is a marked similarity of the skin lesions in the two conditions, he suggested that there might be a common cause for the two diseases, or, to put it in other words, the two conditions might be different manifestations of the same disease. During the last thirty-five years many papers have been published referring to outbreaks of varicella which have appeared to owe their origin to contact with cases of herpes zoster. The relationship of the two diseases has frequently been discussed, but no definite decision has yet been reached.

Le Feuvre, working among families living in isolated farmsteads in South Africa, made out a strong case on clinical evidence for the common origin of herpes zoster and chicken-pox, and Netler observed over a hundred cases, mostly French, in which herpes appeared to have given rise to varicella or varicella to herpes. On the other hand, chicken-pox was made a notifiable disease in Burton-on-Trent between November, 1922, and December, 1924, and the medical officer of health, Dr. Cowie, or his assistant investigated every one of the 813 cases reported in 559 families. In only nine—that is, 1.6 per cent. of cases—was there a history of recent herpes in the family.

In Queen Mary's Hospital for Children, Carshalton, twenty-nine cases of herpes zoster have occurred among the patients and staff during the last two years. In spite of the fact that all cases of herpes and chicken-pox are isolated, eight of the herpes cases seem to be very closely associated with outbreaks of chicken-pox, as is shown in the accompanying table. This would suggest a common origin

The Relationship between Chicken-pox and Herpes Zoster.

Ward.	Date of Onset of First Case of H.Z. or C.P.	Date of Onset of Subsequent Cases.	No. of Days between Onset of H.Z. and 1st Case of C.P.
C. 6	H.Z. 24/11/27	C.P. 10/12/27 „ 11/12/27 (3 cases) „ 25/12/27 (3 cases) „ 28/12/27 „ 1/1/28 „ 11/1/28 „ 14/1/28	Sixteen days.
E. 4	H.Z. 3/11/27	C.P. 13/11/27 „ 16/11/27 „ 27/11/27 „ 28/11/27 „ 3/12/27 „ 7/12 27 „ 16/12 27	Ten days.
D. 6	H.Z. 10/4/27	C.P. 27/4/27 „ 11/5/27 (2 cases) „ 12/5 27 (2 cases)	Seventeen days.
F. 1	H.Z. 24/1/28	C.P. 11/2/28 „ 13/2/28 „ 26/2/28 (2 cases)	Eighteen days.
C. 5	H.Z. 1/5/26	C.P. 15/5/26 „ 31/5,2	Fifteen days.
A. 3	H.Z. 18/3/28	C.P. 2/4/28 „ 15/4/28	Fifteen days.
E. 4	H.Z. 9/8/26	C.P. 24/8/26 „ 9,9/26	Fifteen days.
E. 1	C.P. 13/11/26	H.Z. 3/12/26	Twenty days.

C.P.=Chicken-pox; H.Z.=Herpes zoster.

of the conditions. But against this finding we must place the fact that an attack of varicella does not confer any immunity against herpes zoster, seven of the twenty-nine patients gave definite histories of having had chicken-pox, and scars on the skin supported these statements. In not a single case have I seen, or obtained histories of, a second attack of either chicken-pox or herpes zoster, and I have not observed herpes and varicella rashes out together on the same patient, although many such cases have been recorded.

Conclusion.

A case of herpes zoster may give rise to an outbreak of varicella, but a previous attack of varicella affords no protection against a subsequent attack of herpes zoster.

LITERATURE.
W. P. Le Feuvre: *Brit. Journ. of Derm. and Syph.*, No. 29, 1917.
A. Netler: *Bull. de l'Acad. de Méd.*, April, 1924.
J. M. Cowie: *British Medical Journal*, March 28th, 1925, p. 642.
Parkes Weber: *Brit. Journ. of Derm. and Syph.*, No. 28, 1916.
Geoffrey Dudley: *British Medical Journal*, August 22nd, 1925, p. 346.
Gautier and Peyrot: *Arch. de Méd. des Enfants*, Paris, May, 1925.

NINETY-SIXTH ANNUAL MEETING
OF THE
British Medical Association.
Held at Cardiff, July, 1928.

THE SECTIONS.

SUMMARY OF PROCEEDINGS.

ARRANGEMENTS have been made to publish, during the next few months, full reports of the opening papers communicated to the Scientific Sections of the Annual Meeting at Cardiff. The summaries printed below and those which will appear in subsequent weeks are intended to give members who were not present a general view of each day's proceedings.

SECTION OF MEDICINE.
Wednesday, July 25th.

DISEASES OF THE CORONARY ARTERIES.

SIR THOMAS LEWIS, President of the Section, who took the chair at the opening session of this Section, said that the generalization associating a man's age with his arteries should be limited more particularly to the cerebral and coronary vessels. The discussion about to be opened was timely in view of the recent growth in knowledge about this subject, and it might be recalled that rather over a century ago a small group of men in the counties bordering Wales had contributed materially to the little that was then known.

Dr. G. A. ALLAN, in opening the discussion, said that disease of the coronary arteries had been recognized for a considerable time, and its association with angina pectoris had been widely accepted. In recent years prominence had been given to certain anginoid symptoms which had been found associated with coronary blockage, usually thrombosis. In this country the papers by McNee and by Gibson had helped to focus attention on the subject, but Lindsay Steven had made a careful analysis of the literature as far back as 1887. Coincident with this increased attention to the clinical aspect important anatomical investigations had been made by Gross and his collaborators; in addition to making an accurate survey of the part of the heart supplied by each coronary artery he had also shown that the heart was perhaps the richest organ in the body as regards capillary and pre-capillary anastomoses between branches of the same artery as well as between branches of both arteries, and that as age advanced there were anastomoses between the vessels in the epicardial fat and adjacent parts and the coronary arteries. The morbid processes affecting the coronary arteries might be classified into four clearly defined conditions. (1) Atheroma, the commonest primary lesion, was a patchy disease first affecting the deeper layers of the intima with degeneration of the deeper parts, proliferation of the fibrous elements, and encroachment on the lumen of the vessel. It was quite irregular in its distribution through the body, and might be well marked in the coronary vessels when there was no indication of it in the accessible arteries. (2) Arterio-sclerosis, a diffuse process characterized by thickening of media and intima, probably beginning as a hyperplasia in the media; it was much more uniform in its distribution than atheroma. (3) Syphilis was comparatively rare in the coronary vessels in spite of the fact that aortic syphilis was one of the commonest visceral manifestations of the disease. (4) Calcification was most frequently found superimposed on either atheroma or arterio-sclerosis; but it might occur as a primary medial degeneration, and its association with atheroma was a potent factor in diminishing the lumen of the vessel. To obtain some idea of the relative frequency of these lesions he had examined the figures collected from 1,000 consecutive autopsies in the Western Infirmary, Glasgow. In these there were 371 cases in which naked-eye lesions had been noted; the lesions were—

Atheroma ...	80.6	per cent.,	with	fibrosis	in 51.2	per cent.
Arterio-sclerosis	45.3	,,	,,	,,	54.7	,,
Calcification ...	10.8	,,	,,	,,	77.5	,,
Syphilis ...	3.5	,,	,,	,,	38.0	,,

Of 97 cases in which the coronary lesion was noted as producing definite narrowing of the lumen—

Atheroma was present in	85,	with	fibrosis	in	82	per cent.
Arterio-sclerosis ,, ,,	31,	,,	,,		84	,,
Calcification ,, ,,	33,	,,	,,		85	,,
Syphilis ,, ,,	7,	,,	,,		57	,,

Fifty-eight of the patients died suddenly, and in ten of these there was no evidence of fibrosis. Other points which emerged from this study were: (1) severe narrowing of the artery might be present without obvious myocardial lesion; (2) severe old-standing lesion and even occlusion might be present with no clinical history of its occurrence; (3) patients might die with symptoms suggesting coronary occlusion in which no such lesion was found. Disease of the coronary arteries in general tended to produce diminution of the lumen; this caused starvation of the parts supplied, followed by replacement fibrosis, or, if sudden complete occlusion occurred, infarction resulted with subsequent fibrosis. It was apparent that there could be no diagnostic symptomatology to cover all cases of coronary artery disease; in the series quoted 35 per cent. of cases showed no gross lesion of the muscle, and of the remaining 238 only 58 patients could be said to have died as the immediate result of the coronary lesions. When the blockage was abrupt certain features were present with such regularity as to make diagnosis reasonably sure; these would be dealt with by subsequent speakers. The features that demanded attention were the duration and situation of the pain, the associated symptoms such as vomiting, collapse, respiratory and mental distress, and such signs as the rate and rhythm of the heart, fall of blood pressure, etc., and the information to be derived from the electrocardiogram. The ultimate prognosis was in almost all cases bad; but judging from old lesions found at necropsy, those who made a good recovery, at least temporarily, must be fairly numerous.

Dr. CAREY F. COOMBS (Bristol), discussing the etiology of the two great coronary syndromes, ischaemia and infarction, gave an analysis of 1,600 cases of organic heart disease seen during the previous ten years. Both kinds of coronary attack occurred most often in the seventh decade of life, though ischaemia cordis was almost as frequent in the sixth, and appreciable in the fifth, partly owing to its relation to syphilis. Infarction was relatively more common in males than was ischaemia. Dr. Coombs showed a slide indicating that cardiac rheumatism, ulcerative endocarditis, and cardiac syphilis seldom excited the coronary syndromes, except that ischaemia was more frequent in cardiac syphilis in consequence of the liability of the coronary orifices to stenosis in aortic syphilis. Some coronary disorders might, however, be traced to endocarditis lenta, and even a preceding phlebitis.

Dr. IVOR DAVIES (Cardiff) commented on the importance of symptoms in disease of the coronary arteries, and referred especially to intermittent peripheral arterial claudication. Coronary sclerosis might be considered as a generic term to include angina pectoris and coronary