minute, weak and thready; the extremities very cold; blood oozing from the gums, nose and eyelids with subconjunctival hæmorrhage.

First aid by incision and washing with potassium permanganate solution was given and a tourniquet was applied at the humerus. Concentrated anti-venom (polyvalent) serum 10 c.cm. intravenously and locally, calcium gluconate 10 per cent 10 c.cm. intravenously, and adrenalin ½ c.cm. subcutaneously were given. Next day the anti-venom serum and calcium were repeated and an attempt was made to stop the bleeding from the gums and nose by plugging and application of adrenalin chloride diluted in normal saline.

The œdema and oozing continued. The site of injections also kept on oozing, with hæmatoma formation all round and blood was passed in urine and stools. Intravenous calcium was therefore stopped and subcutaneous injections of colloid calcium and ostelin 2 c.cm. and calcium gluconate 1 dram orally thrice daily were started. The bleeding stopped 8 days after the bite and the wound healed after two weeks. The patient was now very anæmic and was given iron mixture and, polyhæmin, pills. Five weeks after the snake bite the patient was enabled to resume duty.

A CASE OF ACUTE YELLOW ATROPHY OF THE LIVER*

By C. P. TANDON, M.B., B.S.
and
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A HINDU police constable, aged 28 years, was brought to this hospital on 27th October, 1944, at about 3 a.m. in an unconscious state, very restless and delirious and screaming at times. The history was that he got a severe headache at about 7 p.m. the previous evening for which his medical officer prescribed the usual A.P.C. powder, and six hours later he began to get delirious and very restless.

On examination, the tongue was dry; there were fine tremors in the hands; the pupils widely dilated, equal and not reacting to light; temperature 96.6°F., pulse 88 per minute; spleen and liver not enlarged.

Weil's disease was ruled out as there was neither fever nor enlargement of the liver and spleen. As the pupils were dilated, he was given treatment for dhatura poisoning, and after the stomach wash, etc., he actually quietened down.

In the morning he was still unconscious; pupils were slightly contracted but equal; slight icterus noticed in the conjunctivæ; blood pressure 146/80. Neck rigid; ankle clonus present but other deep reflexes deficient. A catheter specimen of urine showed the presence of bile and traces of albumin; a few pus cells and crystals of triple phosphate were also present. Blood picture showed nothing abnormal except for some poly-leucocytosis. Lumbar puncture revealed the cerebrospinal fluid under pressure (about 100 drops per minute); the fluid was clear, contained a little albumin but no micro-organisms or sugar.

The patient died that night without regaining consciousness.

On post-mortem examination, all the cutaneous tissues and meninges were stained yellow; the spleen, liver, kidneys, heart and lungs had petechial hæmorrhages; the lungs were deeply congested; the liver was small with a wrinkled capsule over it; the spleen was slightly enlarged; the gall-bladder was empty; the stomach contained a few ounces of coffee ground fluid; the intestines were green in colour; the blood vessels of the brain were engorged.

This case is interesting for its unusually short history, the absence of ætiological factors in the previous history, and the symptoms which were suggestive of dhatura poisoning.

* Paper rearranged by editor.

The authors are thankful to Lieut.-Colonel J. B. Vaidya, I.M.S. (retd.), for giving permission to publish this report.

[The diagnosis of this case appears obscure.—EDITOR.]

COMPOUND FRACTURE OF THE LEG WITH GAS GANGRENE TREATED WITH PENICILLIN*

By T. D. RAJOO
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A PATIENT was admitted to hospital on the 24th December, 1944, with injury on his right leg due to a fall from a bullock cart. Examination revealed a compound fracture of both the bones of the right leg with gas gangrene spreading up to the lower portion of right iliac fossa. The patient's general condition was poor; he was toxic and the pulse rate over 140 and feeble.

Under a small dose of pentothal sodium, a guillotine amputation of the thigh was done as quickly as possible, and the raw surface was covered with septanilam powder and vaseline gauze and dressed with extension. Fifteen thousand units of penicillin were given intravenously in the theatre and continued every three hours; six injections were given intravenously and the rest intramuscularly. Anti-gas gangrene serum, 60,000 units intravenously on the first day and 30,000 units intramuscularly on the second day, were given. The patient rallied on the third day and has continued to progress since then.

I am grateful to my chief, Colonel L. K. Ledger, O.B.E., I.M.S., and to the military authorities for making penicillin available.

EMPYEMA WITH CONTRA-LATERAL PNEUMONIA TREATED WITH PENICILLIN*

By K. U. THATAKIA, M.D.
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THE patient, aged 30 years, was admitted to hospital on 28th December, 1944, for right-sided empyema and left-sided pneumonia. Both the lesions were confirmed by screening.

As the patient was markedly dyspnœic and cyanosed on admission, 200 c.cm. of pus were aspirated. Bacteriological examination of the pus revealed staphylococci. 'Cibazol' was given, 4 tablets stat. and 2 tablets four-hourly. The dose was maintained for 4 days and then decreased. A total of 24 gm. were given in 5 days but the patient did not show any improvement; the temperature and the dyspnœa persisted. Three hundred c.cm. of pus were removed on 31st December, 1944, and 500 c.cm. again two days after.

On 2nd January, 1945, 20,000 units of penicillin were injected intrapleurally in 30 c.cm. of normal saline and this was repeated the next day. On the third day 15,000 units were given four-hourly. A decline in the temperature, a less toxic look and other signs of improvement began to appear from the fourth day. The pus was cleared as much as possible and a similar course of penicillin was repeated. Six days after treatment with penicillin the patient appeared quite well; the temperature which was swinging from 100 to 103°F. came down to 98°F.; there was no dyspnœa and no cyanosis. The patient was screened again; the right side of the chest was absolutely clear without any evidence of fluid and the left side showed a slight mid-zone haziness due to resolving pneumonia. The temperature continued to be normal and the pneumonia completely resolved afterwards. The sputum showed no acid-fast bacilli.

* Paper rearranged by editor.