very nervous about his task. Saline hypodermoclysis was given in both axillæ. The patient was anæsthetised. The bladder was catheterised and as facilities existed on the spot the urine was again centrifugalised and the sediment showed nothing beyond hyaline casts.

Operation.—The operation was performed by Dr. B. Rama Baliga Avl, B.A., M.B., C.M., District Medical Officer, Vellore, assisted by me. The usual gall-bladder incision was made on the right side commencing over the tip of the right 9th costal cartilage and extending downwards for about 3 inches. Not a drop of blood was visible till the peritoneal cavity was reached. When the peritoneal cavity was opened the first object that presented itself was the omentum, loaded with fat. When the structure was pushed aside the fundus of the gall-bladder peeped out and at the same time dark red blood-stained fluid (practically venous blood) began to well up from the wound. On collecting a sample of this fluid in a tablespoon fat globules were seen floating on the surface. Knowing that an acute pancreatitis is one of the causes of "acute abdomen" though rare, the presence of dark venous blood in the peritoneal cavity with fat globules left no doubt as to the fact of the case being one of the acute hæmorrhagic pancreatitis. At this stage of the operation the patient had a convulsion, his breathing became shallow and he expired on the table.

With the consent of his friends and relatives the incision was extended downwards, the appendicular and gall-bladder regions were thoroughly explored and found to present nothing abnormal. The peritoneal cavity was dried as far as possible and the intestines were found to be distended. The visceral peritoneum was inflamed, red and angry-looking and small white opaque spots of fat necrosis were visible in the omentum and mesentery. When the omentum and transverse colon were turned up, the whole of the transverse meso-colon, part of the mesentery and an extensive area of the posterior abdominal wall and the retro-peritoneal tissues were found to be infiltrated with blood. The pancreas itself was swollen and dark red in colour, due to infiltration with blood. The gland was removed for pathological examination which bore out the diagnosis of acute hæmorrhagic pancreatitis.

Discussion.—Acute hæmorrhagic pancreatitis, though rare, is a distinct clinical entity. Rapidly fatal termination of this disease is ample proof of the necessity for very early diagnosis and a wide knowledge of its signs and symptoms is quite essential. In my whole career of 18 years as medical student and as an assistant surgeon I have come across these cases only twice, once when I was a medical student in the year 1911 and now a second time 15 years later. The symptoms make up a clinical picture which is quite clear and the diagnosis can in most cases be made sufficiently early. The image left on my mind by the above clinical picture is now so clear that I would not fail to recognise it a third time. Regarding the ætiology it is doubtless an acute infective process due to the presence of germs. It is said that it is not infrequently found in association with cholangitis and gall-stones which may be found blocking the ampulla of Vater. So our tentative diagnosis of gall-stone was not far from wrong. At any rate it is nearer the truth than to diagnose the condition as appendicitis or appendicular perforation. Unfortunately we could not hold a complete post-mortem.

In conclusion, I wish to express my thanks to Dr. B. Rama Baliga Avl, B.A., M.B., C.M., District Medical Officer, Vellore, for having permitted me to publish these notes.

OPERATIONS ON OLD MEN.

By BANTA SINGH, M.B., B.S., D.T.M. (Bengal),
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IN the presence of an accident or other affection threatening life, an urgent surgical operation may become necessary. In such cases the age of the patient may influence the prognosis, but not the necessity for immediate operation. In a patient suffering from strangulated hernia or depressed fracture of the skull or from some tumour of the body one would not hesitate to operate because the patient was aged.

Case.—An old man, some 80 years of age was admitted to the Phagwara Hospital, Kapurthala

State, in February 1922, with the following history. Twenty-five years previously he had noticed

that the left testicle appeared to be larger than the right. It increased very gradually in size, until ultimately a blister formed on its most dependent part; this ruptured, and foul smelling semi-fluid matter escaped of a brick-red colour. His condition on admission was as shewn in the photograph.

A diagnosis of adenoma testis having been made, he was thoroughly overhauled with regard to his heart, lungs, kidneys, etc., and appeared to be a fair operative risk. The operation was conducted in a very poorly equipped dispensary, with no assistant except a compounder, who gave chloroform anæsthesia, and as rapidly as possible to reduce risk. The parts were thoroughly cleansed, a tumour-like mass dissected out, and a drainage tube inserted into the dependent part. The patient made an uneventful recovery. Healing by granulation was naturally very slow in a patient of this age, but he was discharged cured on the 40th day.

The case illustrates the powers of recovery in an old man whose cardiac, pulmonary and renal systems were still in good order. A patient of 30 or 40 years of age with defective organs would have been a worse operative risk. Even in advanced age it is often possible to perform necessary operations; should a general anæsthetic be contra-indicated, a local one can be substituted; whilst a semi-sitting position can be substituted for the dorsal decubitus.

TWO INTERESTING CASES.

By S. K. GHOSH DASTIDAR, M.B., D.T.M.,
Assistant Surgeon, Orissa Medical School, Cuttack.

HADI SAMAL, Hindu male, aged 30 years, of Salepur village in Cuttack district was admitted to this hospital on the 13th July 1925, under Dr. B. C. Chatterji, D.T.M., Teacher of Medicine and Pathology and myself for irregular fever off and on for some time, marked enlargement of the liver, and scabies all over the body; there was slight œdema of the legs and round the ankles. He had had no treatment of any kind.

Physical examination: The liver extended three finger-breadths below the right costal margin, above to the 5th rib in the midclavicular line, and 7th rib in the midaxillary line; was slightly tender but hard and without any trace of jaundice. The spleen was not at all enlarged, but just palpable in deep inspiration. Other systems revealed no abnormality.

The blood was examined on the 15th July 1925: total leucocytes 10,000 per c.mm., polymorphonuclears, 70 per cent, large mononuclears 12 per cent, small mononuclears 18 per cent, no malaria parasite was found, but the aldehyde reaction was very strongly positive. The urine showed the presence of excess of phosphates, triple and amorphous, but no bile or other abnormality. The stool was normal and the microscopic examination revealed nothing abnormal. On the 20th the leucocyte count was 9,375 per c.mm., and by that time the scabies was cured after active treatment with sulphur and zinc oxide ointment.

Thinking the case to be one of hepatitis, emetine hydrochloride gr. i was administered each day for 6 days from the 20th, and the liver began to shrink very rapidly, so that by the 6th of August it was hardly palpable and the leucocyte count fell to 5,625. The patient appeared to be progressing favourably.

All of a sudden a few days later he developed severe diarrhœa which did not respond to any medicine, as a result of which he died on the 13th. A post-mortem examination was conducted by me next morning. The liver was slightly enlarged and weighed 2lbs. 8 ozs.; was hard and cirrhotic; on section, of nutmeg appearance; the histological examination showed signs of chronic passive congestion. The spleen weighed 6 ozs. and was slightly fibrous. Smear examination of both the liver and spleen failed to show *L. donovani*. The intestine showed numerous small ulcers scattered throughout with a little congestion round them. The bladder wall was thickened and fibrous, and it contained thick pus-like urine with phosphatic deposit.

The points of interest in the case were:—

(1) the aldehyde reaction was strongly positive in a case of hepatitis, which was proved therapeutically by administration of emetine and subsequent fall of the leucocyte count to be such.

(2) the aldehyde reaction was positive even when no *L. donovani* could be detected in liver and spleen smears.*

II. *An Unusual Case of Ascending Pyelonephritis.*—Joykrishna Routh, a Hindu male child, 11 years old was admitted to this hospital on the surgical side on the 30th August, 1925, under Rai Bahadur Dr. J. Row, Teacher of Surgery, for severe agonising pain all over the abdomen, especially on the right side in front and behind with very irregular fever varying from 100° to 103°F and scanty micturition, lasting for more than a month.

Physical examination showed a very rapid pulse without any hurried breathing, peculiar abdominal facies, with absence of tympanites and of any swelling or tenderness at McBurney's point or any other part of the abdomen. On the 31st the leucocyte count was 25,000 per c.mm., with the polymorphonuclear cells 90 per cent and the urine was practically suppressed. The following day the leucocyte count fell to 22,875 per c.mm., but by evening the patient collapsed and died.

Post-mortem examination was conducted by me the next morning with very interesting findings. Nothing abnormal in the lungs and heart. The liver was deeply yellow and of nor-

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* Failure to find the parasites after death is not conclusive evidence that the patient did not suffer from kala-azar.—Ed.