narrowed or the canal completely obliterated beyond the artificial anus; so I was unable to complete the operation.

A CASE OF STRANGULATED DIAPHRAGMATIC HERNIA

By M. Y. KHAN, M.B., B.S., P.C.M.S.
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ON 17th June, 1931, I was called to a village about five miles from my dispensary to see an injured person, S. R., a 4½ years old Hindu male child, who was the victim of a murderous attack along with certain other members of his family. I reached the place about 4 hours after the accident. The child had many wounds over his body, alleged to have been caused by a 'burchha' (spear) and a 'churi' (a long knife). He was restless with quick pulse and shallow rapid breathing. Besides many wounds, of more or less minor importance, there were two penetrating wounds of the chest.

(1) On the right side of the chest about 2 inches below the nipple 1½ inches by 1 inch externally.
(2) On the left side just below the inferior angle of the scapula ½ inch on the surface.

Air was passing freely out of both the wounds, and the subcutaneous tissues around them, especially on the left side, were swollen with air. All the wounds were cleaned and sterilized and stitched up except that on the right side which was only partially closed on account of its dirty appearance. Within an hour of the examination the surgical emphysema extended over practically the whole of the trunk, neck and face. The child was brought to the hospital the same evening. The subsequent history is briefly as follows:

From 18th June to 23rd June, 1931, his general condition improved: surgical emphysema was slowly subsiding. All the stitched wounds healed by first intention. The wound on the right side, however, became septic so that it had to be enlarged. On 21st June, 1931, a piece of cartilage was removed to give free drainage. During this period the patient was running a temperature in the evening up to 101°F.

On 23rd and 24th the child showed signs of inflammation in the chest with numerous crepitations and rhonchi on both sides, more marked on the right; temperature was 101°F. to 102.5°F.

On the 25th the temperature and signs of catarrh in the chest began to subside.

From 26th to 30th he was improving in every way, cough only occasional, chest practically clear, no fever, appetite normal, and the wound clean and healing. To all of us, his recovery seemed only a question of a few days.

Suddenly on the 30th evening he began to suffer from vomiting, anything he took was brought up immediately. Temperature rose to 101°F. During the subsequent night he was very restless with severe pain in the epigastrium and persistent vomiting, even water was brought up every time it was taken.

The abdomen was quite soft without any appreciable tenderness or rigidity and the chest was also clear. He was treated symptomatically for the pain and vomiting but to no effect. On the morning of 1st July, 1931, he was much exhausted and had the appearance of a patient after profuse hæmorrhage—very anæmic with shrunken face and feeble pulse. His condition deteriorated rapidly and he expired on the same afternoon.

On post-mortem examination the left pleural cavity was found to contain about seven ounces of hæmorrhagic fluid and a dark coloured viscus was protruding into this cavity through the left crus of the diaphragm. This was the stomach, the diaphragm constricting it in the pyloric region so that the major portion of the stomach was herniated into the pleural cavity. The wall of the herniated portion was dusky red from extreme vascular engorgement and its cavity was full of blood clots.

It seems that the left diaphragm was injured during the stab on the left side of the chest. The weak spot thus caused seems to have given way due to some sudden strain, *e.g.*, a paroxysm of coughing with the consequent production of the strangulated hernia.

I thank K. S. Dr. Munirud-Din, P.C.M.S., Civil Surgeon, Mianwali, for his kind permission to publish these notes.

A CASE OF ACUTE DILATATION OF THE STOMACH

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H. S., aged 18 years, student of a local college, was brought to the medical out-patient department of the Civil Hospital, Amritsar, on 10th May, 1932, complaining of pain, vomiting and a swelling of three days duration in the left hypochondrium.

The patient looked seriously ill. He had acid eructations, great thirst, loss of appetite and bowels constipated.

The swelling occupied the epigastric and the left hypochondriac regions and conformed to the shape of the stomach.

Examination of the other systems did not reveal anything abnormal except that there was a temperature of 99.4°F.

Before coming to the hospital the patient was treated by the resident medical officer of the college with purgatives, enemas, stomach washes and local application of mustard-plaster, with no result.

Taking into consideration the definite history of overloading of the stomach, the form of the swelling and excluding other possibilities it was diagnosed to be a case of acute dilatation of the stomach and the youth was admitted to the hospital and treated on the following lines and discharged cured on 11th May, 1932 :—

1. Enema saponis Oij at once with no result.
2. An attempt to wash out the stomach with soda bicarb. lotion failed.
3. Atropine sulphate 1/100 grain hypodermically, followed a few hours later by
4. Pituitrin ½ c.cm. hypodermically.
5. Normal sterilized saline Oj per rectum by drops.

On enquiry from the medical officer of the college it is reported on 13th May, 1932, that the student is doing quite well since his discharge from the hospital.

This case is of interest because acute dilatation of the stomach is rare and is generally fatal. The cause of dilatation in this case was probably reflex spasm of the