but no pus was found in the urine, and unfortunately no culture was made from the gum pockets after the extraction of the stumps.

The laboratory report on the 20th October, 1928, stated that the urine was sterile, although this was about the middle of the period of her second relapse, which is difficult to account for; but finally on the 26th October she was given 2 c.c. of a 40 per cent. solution of urotropine with very striking results, and from now onwards rapid convalescence ensued and on the 1st November the patient was discharged from hospital.

Discussion. The salient features in the case are:—

(*a*) *Source of infection.* Was a mild pyelitis present and was that responsible? It is said that these organisms filter through the gut into the kidneys. Be it remembered however that this patient gave a negative history to any bowel complaint. Was the condition of the gums the source?

(*b*) *Course of the disease and laboratory findings.* In conjunction these two factors are of interest, though it is difficult to account for the relapse. Thus on the 3rd October, 1928, the laboratory reported the finding of lactose-fermenting coliform organisms from the urine which agglutinated by the patient's serum in a dilution of 1:3,000; and on the 19th October, 1928 this dilution figure was reduced to 1:1,000 (*see* chart). Finally the urine was found to be sterile on the 20th October, 1928.

(*c*) *The long course of the disease.*

AN INTERESTING EARLY RIGHT-SIDED GOITRE.

(*With a mild paratyphosus A complication.*)

By Lieut. A. BAYLEY DE CASTRO, I.M.D.,

Military Family Hospital, Quetta.

THIS case presented certain features of interest, both in the patient and the train of symptoms she developed.

Mrs. S., a well developed, and healthy looking woman, first came under my observation in June 1928, when she attended the out-patient department of the Military Family Hospital for the treatment of her goitre.

In January 1928 she had received protective inoculation against enteric fever in London. In March she arrived in India, her first station being Jubbulpore, and finally she arrived in Quetta in June of the same year.

Her chief complaint then was palpitation and insomnia. Breathlessness was not complained of. An acceleration of the pulse was often noticed. The area of cardiac dullness was not increased, and the blood pressure was normal.

The goitre was at first the size of half a cricket ball and had developed from the right lobe of the thyroid, but a week after her third injection of sodium iodide it had diminished to some extent. Unfortunately at this period she developed a neurotic tendency, and I fear—influenced by her husband—started discrediting the treatment.

Nervous System.—The right pupil was more dilated than the left, and the voice was turning hoarse, which factors indicated pressure on the right cervical sympathetic and recurrent laryngeal nerves. All reflexes were brisk, but not pathological. The plantar reflex was flexor. Optic discs normal.

In connection with the goitre, the past history of the patient is of some interest to adherents of the intestinal toxæmic theory. During her girlhood and especially between the ages of 5 and 9 years she suffered from a "weak stomach" and during all this time attended the Great Ormond Street Hospital. The symptoms of this "weak stomach" as described by her, were pain and vomiting, she does not remember any diarrhœa. Even now when it gets cold or damp she suffers from abdominal colic. She married at the age of 20, and a year later the goitre became very noticeable. Her father died at the age of 52 from a heart affection following rheumatic fever. There is insanity in the family on the father's side. Apart from this the family history is negative. According to the patient's statement she felt ill on the 4th August 1928 for the first time since coming to India, and on the 7th, after running a temperature at home for 3 days was admitted to hospital. Five c.c. of blood for culture sent to the laboratory was reported on the 11th to show *B. paratyphosus A*, which according to Manson is the most common enteric infection in India.

The pyrexial period of the disease was remarkably mild. On the 14th August, however, the patient suddenly developed a pain in the right wrist and forearm, and next day there was a distinct swelling on the palmar aspect of the wrist, while careful palpation made evident a teno-synovitis with a myositis of the muscles. The next day the left elbow was painful, but not to the same degree as the right wrist, which for two nights caused disturbed rest. The pain in the left elbow disappeared completely in 48 hours, but that in the right wrist not till the 22nd August 1928.

The urine, examined on several occasions, was never found to be excessively acid.

The patient was discharged on the 15th September 1928, but shortly after began to suffer from headaches and backaches. She was unable to perform her household duties, and suffered from a weakness of the right arm. The grip of the right hand was weaker than that of the left, and a weakness of the lower extremities had also developed. She was finally invalided and left for the United Kingdom on 21st November 1928, and so I lost touch with her.

APYREXIAL PNEUMONIA.

By U. A. KRISHNA IYER.

L. F. Dispensary, Jammalamadugu.

APYREXIAL pneumonia is not an uncommon occurrence in general practice. Some of the sudden deaths after two days' slight fever might be the result of such a condition. Unless every such case is subjected to a post-mortem examination, the rate of actual death from the pneumonia cannot be correctly estimated.

Case No. 1.—A middle-aged man of about 35, previously hale and healthy, was seized at about 3 a.m. one morning with a slight pain in the chest. By 6 a.m. the pain became severe and he was just preparing to start for the out-patient clinic when he got an attack of sudden pain and had to lie down. There followed some convulsive movements of the body with eye-balls

rolling, struggling of arms and legs, foaming at the mouth, and in a few minutes, he was dead. On post-mortem examination there were typical signs of pneumonia of one lung, the beginning of grey hepatization. His condition before post-mortem examination never gave even the slightest clue that he was suffering from pneumonia. The temperature soon after (10 minutes after) death was 100°F. But for the post-mortem examination, his death would have been classified under some fit of cerebral origin.

Case No. 2.—Patient aged about 30 had attended the out-patient clinic the previous day for slight fever and headache. He was given the routine mixture for fever (diaphoretic) and sent away. He worked that day. Just before meal-time, at about noon, he was going to take his food, but on the way fell down fainting and, before anything could be done, expired. But for the post-mortem examination which revealed definite signs of pneumonia just like the first case, he too would have been considered to have died of heart-failure due to, say, "flu."

AN INTERESTING CASE OF "CHOREA."

By S. B. IMAM,

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A BRAHMIN girl, aged about 9 years, was brought to me from a village in the vicinity of the Nepal border for the treatment of constant sucking movements of the lips, protrusion of the tongue at frequent intervals, and certain awkward movements of the limbs.

Having thoroughly watched the symptoms I concluded that they quite tallied with the book symptoms of chorea.

The intense anæmia, the frequent abdominal pain and the lowered general health of the girl suggested to me that she must be suffering from some worm infection too. On enquiry from the father of the girl I was told that the girl had passed a big "Chali" (round-worm) some two months ago.

I first determined to get the girl freed from the worm infection, and then later on to give her salicylates, arsenic and bromides for chorea.

With this idea she was provided with an ordinary worm powder containing half a grain of santonine.

Four days after I was informed by her father that she had passed some fifty worms in the stool, and that all the other symptoms, viz., sucking movement of the lips, protrusion of the tongue and awkward movements, had ceased.

Having been struck with this information I requested him to bring the girl to the dispensary. The girl was brought to me a week after and to my surprise I found her quite well.

The idea of my writing this article is to show that simply half a grain of santonine could check all the choreic symptoms and hence I conclude that Ascaris infection can also be one of the exciting causes of chorea.

A CASE OF INGUINAL HERNIA WITH A FÆCAL TUMOUR IN THE SCROTUM.

By D. N. GHOSE, M.B., B.S.,

AND

A. K. MITTER, M.B., B.S.

118, *Lukergunj, Allahabad.*

M., an old man aged about 60 years was admitted to the Colvin Hospital, Allahabad, on the 22 November, 1928, with the complaint of slight abdominal discomfort, nausea, loss of appetite and chronic constipation. He said he had been suffering from this condition for the last 3 months and that his constipation was gradually getting worse every day. He had tried all sorts of purgatives but without any avail.

Though old, he was not constitutionally weak and had kept very good health till the onset of this trouble. On physical examination his tongue was found thickly coated, abdomen slightly tumid but soft. No gland or growth could be detected within the abdomen. Liver and spleen were normal, heart sounds were rather feeble and pulse of low-tension. The only thing found on examination was that he had double-sided inguinal herniæ; on the right side it was only a bubonocele, whereas on the left side it was a scrotal hernia complicated with a fairly big tumour situated about the middle of the cord. The tumour, he said, was only three months old and had gradually grown to the present size. The tumour appeared neither connected with the testis nor with the contents of the hernial sac, which, however, could easily be reduced with a gurgle, indicating the presence of loops of intestine. The tumour was as hard as a stone and was about the size of a cricket ball, freely movable and seemed not adherent to any structure. The testis on that side was little, atrophied, and had lost its testicular sensation. The cord was normal and was quite separate from the tumour. As the patient was an old man and as he remarked that with the growth of the tumour his constipation became more and more acute, we were naturally led to think that it was some kind of malignant growth pressing upon the loops of intestines in the sac, causing obstruction to the onward passage of fæcal substance. At the same time we were at a loss to understand how it could cause obstruction when the intestines could apparently be reduced.

At this stage, that is on the third day after the patient's admission in the hospital, his