was discharged on 15th March, 1937. The patient had no burning sensation. The urine was clear and did not contain any pus cells nor any *Bacillus coli*.

This case shows the beneficial effect of prontosil in infections other than streptococcal.

2. *A case of erysipelas.*—A female, married, aged about 18 years, was admitted into the Government Royapuram Hospital, on the 8th February, 1937, for fever and headache for seven days. Her previous history was that she had fever for about eight days a month back; and that she was in this hospital for fibrosis of the lungs one and a half months back.

The present complaint started with high fever which was continuous for the past seven days. She was a thin individual and of delicate health. Pulse was rapid but full. Liver and spleen were not enlarged. Urine was quite normal. Respiratory system did not show anything in particular beyond a few crepitations here and there. Peripheral blood did not show any malarial parasites but there was distinct increase of polymorphonuclear cells. On the day of admission she was found to have an erythematous patch very slightly raised above the surface, about two inches in diameter, over the front of lower third of the right leg. The part was tender and painful. Thinking it might be localized lymphangitis, lead and opium lotion was applied. But the fever continued high and the local lesion was increasing. Widal reaction for typhoid group of bacilli was negative. As the swelling and redness in the right leg began to increase and the temperature persisted, 10 c.cm. of antistreptococcus serum was given intramuscularly on the 11th. This also did not have any effect, either on the temperature or on the local condition. So, on the 13th, prontosil 5 c.cm. was given intramuscularly. By this time the local redness had spread up to the knee, and the patient was in a toxic state. There was retention of urine and she had to be catheterized. Next day, there was a definite improvement both in the general and local condition. Prontosil was repeated on the 15th and 17th. The temperature came down to normal, and the local condition was definitely better. The patient was given two more injections on the 19th and 21st. By this time the erysipelas inflammation had completely disappeared and the temperature came down to normal, and since then the patient made an uneventful recovery and was discharged cured on the 3rd March.

The above two cases were admitted under Captain Rao Bahadur P. Krishnaswami, B.A., M.B., C.M., M.R.C.P., first physician and superintendent of the hospital, and my grateful thanks are due to him for going through these notes and also for permission to publish them.

[*Note.*—In case 1 the temperature might possibly have subsided without prontosil.—EDITOR, *I. M. G.*]

SALYRGAN IN PHLEGMASIA ALBA DOLENS

By R. L. SONI, M.B., B.S., F.R.H.S.

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ENCOURAGED by the favourable results produced by salyrgan in the treatment of various generalized and localized œdemas, I was led to use the drug in a case of phlegmasia alba dolens, the thrombotic form of which is essentially a variety of localized œdema brought about by femoral thrombosis towards the end of the puerperium. The beneficial influence exerted by the drug in relieving the condition prompts me to record the case :—

Mrs. K., a banker's wife, aged 21, had her first confinement on the 5th April, 1937. The delivery was complicated by an extremely unusual obstetric emergency, namely separated symphysis pubis, and so naturally damage to the soft parts was great. The child was born dead, hæmorrhage was severe, the perineal tear was large and deep reaching the rectum, and anteriorly a large retro-pubic niche was formed by the separation of soft structures which had fallen back.

The puerperium obviously could not be uneventful. She had a very bad time but serum, prontosil, liver preparations, tonics together with properly planned local dressings and careful nursing, controlled the situation. On the 14th day she had serum sickness which was followed by a generalized mild œdema. Anæmia which had developed during the puerperium was severe. Calcium, sulphate of iron, campolon and oral hepatex were used. Œdema rapidly cleared in the rest of the body but the left foot continued getting worse. On the 20th day the foot was markedly swollen and pitted on pressure. Next day the swelling extended higher and in another day the thigh was tense. Temperature rose a little and there was slight rigor, but pain in the calf and thigh was intense and even slight movements were resented. On the 23rd day the foot and leg were large and still pitted on pressure; the thigh was swollen, tense, hard and very painful. Novalgin one to two tablets a day in divided doses was given. The leg was fomented, gently wrapped in cotton, put at rest on pillows and immobilized with side-pillows. In addition to the blood-building measures already in progress she was given salyrgan 1 c.cm. intramuscularly, with the idea of draining away the localized œdema. The response was gratifying inasmuch as a profuse flow of urine brought about an appreciable reduction of the œdema of the foot and leg within 24 hours, though the swelling of the thigh did not appear to be noticeably affected. The pain was less relieved than the œdema. Encouraged by the result another injection of salyrgan was given on the 26th day. It was followed by a steady improvement, but on the 29th day though the temperature came to normal and pain and hard stiff swelling of the thigh was getting less, œdema of the foot was once again noticed. She was given ammonium chloride grs. 15, t.d.s., and with the morning dose salyrgan was administered orally (1 c.cm. of a 10 per cent solution) on the 30th and 31st days and 2 c.cm. on the 32nd and 33rd days. By the 35th day œdema of the foot had disappeared and the tense swelling of the thigh had gone down to a marked extent. By the 40th day even the thigh was clear.

Comments.—In the presence of anæmia, puerperal sepsis, pelvic cellulitis and other complications it was not surprising that phlegmasia alba dolens should occur. In this case the thrombotic and lymphatic forms co-existed. The reduction in the œdema of the foot and leg that followed the administration of salyrgan by injection was marked. That it was brought about by salyrgan was clear from the profuse diuresis that attended its use. To control the œdema that recurred on the foot it was decided to try the drug orally, as the patient, having become tired of so many injections, resented even ordinary pricks at this stage. Salyrgan administered together with ammonium chloride brought about a rapid improvement in four days. The efficiency of salyrgan appears to be not appreciably depreciated by oral administration. Fleckseder (1931) used it orally and rectally with good results.

The condition of phlegmasia alba dolens is known to take several weeks and sometimes months to clear. In this case it took only 20 days. Though the associated measures (nursing, campolon, tonics, etc.) must have done their respective parts, the effect produced by salyrgan in draining the œdema was definite and it appears was a useful factor in accelerating the cure.

Summary.—A case is recorded of phlegmasia alba dolens in which salyrgan was administered parenterally and orally with benefit.

REFERENCE

Fleckseder, R. (1931). *Wiener Klin. Woch.*, Vol. XLIV, p. 672.

A CASE OF SCARLET FEVER

By BALKRISHNA N. MEHTA, M.B., B.S.

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ON the tenth day of illness I was called in consultation to see a female patient aged about 20 years.

Previous history.—Ten days ago she felt ill and had pain in the throat and was feverish. Next day an eruption was noticed on the face. It was red, punctate and then confluent and spread all over the body within four days. Desquamation started on the eighth day.

She was in bed with a temperature of 101°F. and pulse 120 per minute. The rash spread from head to foot and desquamation had already started. For the most part it consisted of fine scales, while on the palms and soles large flakes—complete glove-like casts—were about to be thrown off. The pharynx was very congested. The tongue was thickly furred and flabby, but not typical of scarlet fever. The lymphatic glands under the right jaw were enlarged and tender; they had been enlarged on both sides, but the left ones had subsided. No enlargement of the liver or spleen was felt. There was no respiratory complication. Cough was slight and pharyngeal in character. There was a great deal of itching all over the body. The maximum temperature was 104°F. The patient was delirious at night. There was a history of passing blood in the urine. The bowels were constipated.

The urine which was examined on the twentieth day contained no albumin or casts. The temperature gradually came down to normal on the twenty-second day; however, it remained fluctuating between 98°F. to 99°F. for about eight days more. Prontosil by mouth was given from the fifteenth day.

The patient had had measles in her youth. The diagnosis of scarlet fever was made from the character of the onset, the type of rash and its desquamation.

During twenty-four years' practice I have only seen three cases of scarlet fever; all were females. The first one, a Parsi woman, was seen ten years ago and survived. The second one, which proved fatal, was seen last year.

[*Note.*—Although very suggestive it is possible that this disease was not scarlet fever because it is atypical in several of its manifestations. It may have been a toxic erythema induced by a septic infection of the throat. If other similar cases had been noted in the district at the time the diagnosis of scarlet fever would have been rendered much more likely. It is difficult to understand how a single case of a very infectious disease could arise without a history of contact with earlier cases and how it was not followed by others, especially in a community that would almost certainly be highly susceptible.—Editor, *I. M. G.*]

PROBABLE RING CARCINOMA OF THE DESCENDING COLON; MANGO FIBRES OBSTRUCTING THE RING AND CAUSING COMPLETE OBSTRUCTION

By S. R. GORE, L.M. & S.

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N. N. P., age 45, was admitted into the hospital on 16th June, 1937, for intestinal obstruction.

History.—She had pain in the left iliac region on 12th June, 1937. The pain was attended with vomiting and constipation. Since 14th June she had absolute constipation. She was given a soap-and-water enema by the sub-assistant surgeon of the nearest dispensary when she passed a little hard stool; after this there was no further stool or passage of flatus.

Her abdomen was distended but not tense when she was admitted. Temperature—98.4°F., pulse—98, and respiration—30 per minute. Soap-and-water enema given in the hospital had no effect.

Immediate laparotomy was done under spinal anæsthesia and the cause of the obstruction was found to be a hard ring carcinoma at the junction of the descending colon and the sigmoid. The constriction was band-like and hard and it was found to be connected with some enlarged glands adjacent to the mesentery. The gut proximal to the stricture was enormously distended. As it was found impossible to do a side-to-side anastomosis a resection of the tumour with the glands *en masse* and an end-to-end anastomosis were done, after making an incision on the antimesenteric border of the collapsed sigmoid to make it fit the distended gut above the stricture.

The patient made an uninterrupted recovery and was discharged on the 9th July, 1937. She has had no more trouble up to the present and she attends the out-patient department occasionally for inspection.

The specimen is preserved. On inspection, it was found that a mass of mango fibres was blocking the constricted lumen of the gut which was just large enough to admit a lead pencil. There was no history of any pain or other symptoms previously and the patient considered herself quite normal up to 12th June, 1937, when pain started. The inner surface of the ring is not ulcerated. The general condition of the patient was quite good, there was not the least trace of cachexia. I have diagnosed this as cancer on account of its hardness and the hard associated glands. There being no means for making a section, microscopic pathological investigation could not be carried out*.

*It should be an easy matter to send the whole or part of the tumour to a pathological laboratory for confirmation of the diagnosis.—EDITOR, *I. M. G.*