leucocytes, a very uncommon appearance, was a remarkable feature of the blood film taken half an hour before the death of the patient.

REFERENCES

Knowles, R., and Das Gupta, B. M. (1931). Clinical Studies in Malaria by Cultural and Enumeration Methods. *Indian Med. Gaz.*, Vol. LXVI, p. 1.

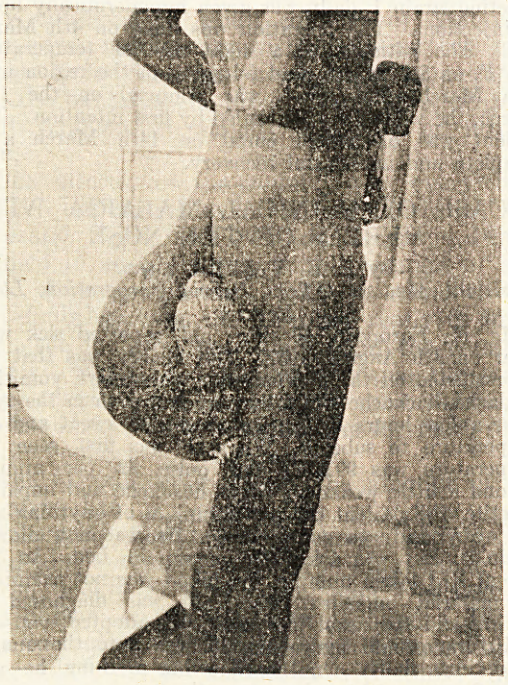
Sinton, J. A. (1924). Methods for the Enumeration of Parasites and Leucocytes in the Blood of Malarial Patients. *Indian Journ. Med. Res.*, Vol. XII, p. 341.

Thomson, J. G., and Robertson, A. (1929). *Protozoology*. London: Baillière, Tindall and Cox.

A CASE OF LARGE PEDUNCULATED LIPOMA OF THE GLUTEAL REGION.

By J. F. ROBINSON, M.D., F.R.C.S. (E.)
Mysore University
and
T. SESHACHALAM, M.R.C.S., L.R.C.P. (Eng.)
Mysore University

A MALE, aged 35 years, was admitted to the hospital for a large tumour of the left gluteal region. It had been present for ten years gradually increasing to the present size. The



Right side view.

tumour was pedunculated, bi-lobed and was hanging from the left gluteal region (*vide* illustration). The skin over the tumour was ulcerated in places following the application of irritants.

The growth was quite painless but caused great inconvenience by its bulk and weight.

The tumour was removed under local anæsthesia. The pedicle contained a number of large veins and some arteries. The tumour weighed 16 pounds and was found to be a lipoma with no secondary changes. The pedunculated nature, the large size, the weight, and the bi-lobed character of the lipoma are interesting features.

GENERALISED EPILEPSY CAUSED BY A DURAL CYST

By V. MAHADEVAN, M.R.C.P. (E.), F.R.C.S. (E.)
MAJOR, I.M.S.
Surgeon, Government Royapuram Hospital, Madras
and
T. BHASKARA MENON, M.D., M.R.C.P.
Pathologist, Government Royapuram Hospital, Madras

THAT focal fits could be caused by lesions in the brain was first pointed out by Hughlings Jackson and ever since then Jacksonian epilepsy has come to be recognized as a type where focal lesions in the brain caused a focal discharge, which exteriorised in the form of a twitch, starting at a particular part or limb, gradually extended, and became a well-defined convulsion. This was often confined to a particular limb or to one side of the body. The gradual march of the spasm, as the discharge spread through neighbouring regions of the brain, was looked upon as characteristic. There was no loss of consciousness, and after the attack a residual paralysis was another feature indicating the location of the lesion. Afterwards it was recognized that such local fits could occur without any noticeable lesions, as a part of 'idiopathic' epilepsy. Still later, it was found that fits due to lesions of the brain might take the form of generalised convulsions without any localising features. The discharge spread rapidly through the whole cortex and generalised convulsions resulted. In such cases, loss of consciousness may occur because of the wide area of the cortex involved.

The following case of dural cyst is of great interest since it caused generalised epilepsy showing all the features of idiopathic epilepsy.

C. R., a labourer, aged 45, was admitted to the surgical wards of the Government Royapuram Hospital under the care of one of us (V. M.) for a lacerated wound of the left eyebrow due to a fall. The patient was subject to epileptic fits, had fallen down from the verandah of a house in a fit, and had cut his forehead just over the left eyebrow. During examination it was noticed that there was a depression over the opposite eyebrow with scar, where the frontal bone appeared to be driven in. On a careful analysis of the history it was found that 25 years ago, when the patient was wrestling with other boys of his own age, he had a fall and had hit his forehead against a stone, which had resulted in the depression noticed. There was a wound on the skin and severe bleeding at that time. After the fall he was unconscious for some time, he had gradually recovered and the wound had healed up without any further trouble, but the depression had remained. Some years after the fall the patient started getting fits accompanied by loss of consciousness. There was some unsteadiness in the gait, the patient being unable to walk in a straight line. A careful inquiry into the history showed that the only sign of any localising value was the occasional occurrence of a sudden mist before the right eye while the patient was walking, so that he suddenly staggered. The fits occurred by night and by day, and were always accompanied by loss of consciousness. Incontinence during the fit was unusual.

The tongue was not bitten. The fit itself was generalised like idiopathic epilepsy, but there was no well-defined aura and the patient could never anticipate the fit. Oftentimes he fell and hurt himself. The unconsciousness was profound and it was some time later that the patient recovered. Examination of the fundus showed that the right disc was more swollen than the left. The visual fields were normal and the vision was normal. There was nothing noticeable in the nervous system except that there was a doubtful extensor plantar response on the left side and that the left epigastric reflex was more sluggish than the right. There were no signs of oculomotor paralysis, and no signs of any involvement of the cranial nerves. In the history itself there was nothing else to indicate a cerebral lesion such as headache or vomiting. The mental condition was rather irritable and cerebration was slow, the patient taking time to answer questions. His memory for past events was not good. There was no tremor of any kind, but there was a tendency to reel towards the left side, the patient holding himself with his body slanting towards the left so that there was a slight scoliosis. The left foot was often crossed and placed in front of the right. The pupils were medium and reacted to light and accommodation.

The general nutrition was good, the heart and lungs showed no abnormality. There was no enlargement of the liver, spleen, or lymphatic glands. The alimentary functions were normal. There were seborrhœic patches on the face and forehead. The blood pressure was 98/55.

As there were definite signs of involvement of the pyramidal tract it was decided to operate and raise the depressed bone. On trephining it was found that there had been a depressed fracture at the site of the old injury, about half an inch above the outer half of the right eyebrow. A dural cyst about the size of a lime had formed at the site of fracture and had caused pressure on the frontal lobe just in front of the precentral gyrus. The cyst contained thin brownish fluid, apparently altered blood. The wall was thick and was formed by the dura. There was a cicatrix on the outer side corresponding to the site of the depression on the inner table. This fracture had apparently caused a small tear in the dura, and this was followed by hæmorrhage which had limited itself and resulted in the formation of a defining cyst wall. This had caused some pressure on the corresponding region of the frontal lobe and had exteriorised in the form of fits. The doubtful extensor response on the left side and the diminution of the epigastric reflex would be due to the slight involvement of the precentral gyrus.

The operation was carried out on 31st July, 1932 and since then the patient has had no fits. An examination after operation showed that the signs of pyramidal involvement were still present, but the fundus was normal. The gait was unaltered the left foot being crossed over and placed in front of the right when walking. The mental condition was still the same.

The importance of this case is to demonstrate that generalised epilepsy may sometimes be due to well-defined organic lesions which call for surgical treatment.

A NOTE ON TREATMENT OF LIVER ABCESS BY ASPIRATION

By S. L. BHANDARI, M.B., B.S.
Assistant Surgeon, In-charge Civil Hospital, Sheikhupura

B. S., a Sikh male, aged 35, was admitted to hospital for swelling at the site of the liver for the last 22 days. There was a history of pain in the region of the liver for one month prior to onset of swelling. He had had several attacks of malaria but no dysentery. On admission the swelling was 6 inches by 6 inches by 2 inches—it was reddish blue in colour and tender. Fluctuation could be elicited at the most prominent part, which was over the left lobe. Temperature was normal.

Treatment.—Under local anæsthesia and strict aseptic conditions a small incision was made at the most prominent part of the swelling, and about a pint of deep-chocolate-ccloured sterile pus was removed by Potain's aspirator. Pus came out freely, and the needle went in 3 inches or 4 inches, and could be easily moved within the cavity without the slightest obstruction. The needle was then withdrawn and the wound stitched up. Ten grains of quinine sulphate in 10 c.cm. of sterile water were injected into the cavity before removing the needle. Emetine, grain 1, daily was given hypodermically up to 12 injections. The operation was done on 4th March, 1932. The patient had a slight rise of temperature, 99.5°F. on 8th March, and felt pain in the region until 12th March. The stitch was removed on the 14th March, the wound having healed by first intention. The patient was discharged cured on 14th March after complete and uneventful recovery.

A CASE OF CLINICAL MALARIA WITH HERPES OF THE NOSE

By P. K. V. IYER, L.M.P.
Assistant Medical Officer, Burma Corporation, Ltd., Bawdin

MR. E., European, 50 years old, reported sick with fever on 4th August, 1932. The history was that the fever started on the previous day with rigors, vomiting, headache, backache and a burning sensation in the eyes. After a few hours the patient began to sweat and the temperature to subside. When he was first seen his temperature was 99.2°F., and pulse 82 per minute. Beyond a little weakness, slight headache and impaired appetite, the patient did not complain of anything and was even ready to go on duty. He was not allowed to do so but was asked to remain in bed. As the patient had taken quinine, the blood was not examined for malarial parasites. The case was diagnosed as malaria and the usual treatment was adopted, *viz:*—

Mistura quinini hydrochloridi (grs. x to the ounce) three times daily. On the following morning he was given 2 ounces of a saline purgative.

The temperature remained above normal with slight variations till the 6th morning, when it came down to normal after profuse sweating. On the evening of the 5th August a few blisters were seen on the lower lip. By next morning these had extended to the upper lip and whole of the nose. The nose and lips were red and slightly inflamed, and they were dusted over with a little talcum powder morning and evening. On the 10th August the eruption began to subside and completely disappeared in about a week's time.

The only reason for reporting this case is the appearance of herpes of the nose, which seems to be a rare condition in malaria.

I am extremely thankful to Dr. Spreadbury, A.C.M.O., for encouraging me, and to Dr. Hughes, C.M.O., Burma Corporation Ltd., Namtu, for kindly permitting me to send these notes for publication.