and the soles of his feet were one mass of scales—with syphilitic onychia. No eruption on any other part of the body.

He was ordered Iodide of Potassium and Donovan's solution in Decoction of Hemidesmus. The second case was a Brahmin female, æt. 50, whose husband had syphilis. She has got pinkish scaly rings on her arms, legs, chest and back, but none on the palms or soles of feet, which is very unusual in syphilitic psoriasis. The rings were not quite symmetrical, being incomplete at points of contact. The eruption was dry, and there was much itching. In this case the woman was affected by her husband years ago. She is a widow now. I ordered Iodide of Potassium and Bichloride of mercury. I find a similar case was lately reported at a meeting of the Clinical Society of London, where a woman tainted with syphilis through her husband was attacked with psoriasis in her head and neck, while her hands and feet were free.

8.—*Cases of Malarious Fever with hypertrophied spleen and enlarged liver.*

Scores of cases of this description presented themselves. In some the hypertrophied spleen was very large and quite hard, and would bear favorable comparison with the classical drummer boy with whose case Dr. Maclean illustrates his lectures at Netley.

The hypertrophied spleen caused in some a sort of gnawing pain, and this is attributed either to temporary congestion after meals or during the cold stage of ague when the blood recedes from the surface, and accumulates in the viscera, and sometimes to a sort of movement of the spleen. The fever which accompanied the cases was of various types—quotidian, tertian, quartan, bi-weekly, weekly, fortnightly or even monthly. Some patients imagined that the changes in the moon, new and full, exercised a baneful influence on them and brought on febrile attacks. This coincidence may be only accidental, and requires further observation before it could be confirmed. The complications met with in many cases were excessive anæmia, œdema of feet and legs, general dropsy, ascites, jaundice, melæna, dysentery, epistaxis, *cancrum oris*, night-blindness, hemicrania, &c. There is a type of fever which I am anxious to bring prominently forward, *viz.*, the double quotidian fever. I have seen several cases and confirmed their diagnosis by thermometric observations. Two distinct exacerbations of fever are noticed, one during the day and another at night. In all the cases I have seen there was enlargements of the liver with pain and tenderness. The Hindu *Kobirajes* attribute double quotidian fever to hepatic complications. I would like to have the opinions of medical officers on the subject. In children the liver becomes quickly affected, and sometimes before the spleen The fever which attends such cases proves more obstinate than others with splenic enlargement only. Strong counter-irritation over the liver is necessary. I have used the red ointment of mercury in 8 or 10 grains strength with great benefit in spite of the prohibition of mercury in malarious subjects.

GUN-SHOT WOUND OF THE RIGHT ARM: AMPUTATION: RECOVERY.

By W. M. Courtney,

Surgeon, I. M. D.

About 9-30 A. M., on the 6th April, a great commotion was caused at the mess-house of the 38th N. I. at Meerut, by the native officer of the day and several sepoys running in an excited manner to announce that a young sepoy by the name of Chedee, on account of some fancied or unredressed grievance, had just then attempted to shoot the subadar of his company by discharging a loaded rifle at him when about four paces off, and was then stalking on the parade ground, expressing his intention of shooting a native officer, or a 'sahib.'

The subadar, who was undergoing the process of shaving at the time the attempt was made on his life, happily escaped, but the unfortunate barber, Pathan Din, received the bullet through the lower part of his right arm, the bone being completely shattered at the site of injury, and the brachial artery ruptured. Owing to the fear and excitement of the moment the wounded man was not brought to hospital for nearly an hour after the occurrence. He was then extremely faint from loss of blood, which was very profuse, and little hopes of his rallying were entertained. The wound of entrance was on the outside, and somewhat posteriorly, about 3 inches above the point of the elbow, and was small, well-defined, with depressed margin, and admitted the point of the fore-finger. The wound of exit was on the inside, and somewhat anteriorly, about the junction of the lower with the middle third of the arm, but involved all the soft structures, the muscles being lacerated and jagged very extensively in every direction, and the entire wound large enough to admit 4 or more fingers. On the posterior surface of the middle third of the arm there was a small opening about half an inch in diameter, apparently caused by a splinter of bone driven from within outwards. There was also a contused wound, about an inch in length, over the middle of the right 7th rib; a deeper contused wound on the inside of the lower third of the right thigh; and another, similar, on the inner side of the leg below the knee. All these lesser lesions appear to have been caused by splinters of the comminuted bone forced through the original wound, the direction of the bullet being, apparently, from a point superiorly, posteriorly, and externally, on the right side, downwards, forwards, and inwards, towards the left. There was no pulse at the wrist, and as there was no possibility of saving the arm, it was determined to remove it, to which the man consented after due explanation was made to him. Amputation was performed by antero-posterior flaps a little above the junction of the lower with the middle third. At first the stump showed a tendency to slough, but under a liberal diet and antiseptic dressings the wound rapidly healed, and the man is now able to perform the duties of '*chaukidar*' or watchman, his occupation of barber being gone.

As one does not often get an opportunity of practising surgery proper in a regimental hospital, in times of peace, the above case may be thought worthy of insertion.

Meerut, May 17th, 1881.

DISCHARGE OF A THIN WATERY FLUID FROM THE EAR AND ITS IMPORTANCE.

By Surgeon D. Basu,

Civil Surgeon, Faridpur.

Sudduruddy, a Mahomedan male, aged about 20 years, was admitted into the Faridpur Charitable Dispensary at 8 P. M. on the 27th of March last, with a small contused wound ½" × ½" on the left temporal region about two inches above the left ear. He had also elongated marks of bruises on his forearms and back.

His condition on admission was as follows:—He was quite sensible, answered questions rationally. His movements were perfect; pupils normal, rather contracted. He was not restless; did not complain of severe pain in his head. His pulse was slow, and there was a slight watery discharge from the left ear. He had vomited once, and had been insensible for a short time immediately after receiving the injury.

He was ordered cold to the shaven head and stimulant mixture containing chloric ether and aromatic spirit of ammonia.

For about seventy hours he appeared to improve. Had no fever; pain in the head diminished; wound healed; discharge from the ear continued. On the 30th he got fever. Pulse 98, temperature 101·4°; complained of pain all over his head.

Fever mixture every three hours and a blister to the nape of the neck were ordered. Up to the 6th of April he remained about the same. Had fever and other symptoms of acute meningitis. At 11 P. M. he became delirious, restless ; pupils were slightly dilated ; he was tossing about on the bed, and failed to answer questions. At 7 A. M. on the 7th his condition changed, he began to get general convulsions ; deglutition became difficult, breathing labored, limbs rigid. His bladder was full, urine was drawn by catheter. At 5 P. M. he had general paralysis, irritability of limbs had nearly gone. Pulse small and frequent ; and the discharge from the ear continued. At 7 A. M. on the 8th he was groaning; paralysis was marked. Died at midday.

Post-mortem examination revealed that the left temporal muscle was slightly infiltrated with blood. The left temporal bone showed a fracture from about two inches above the left ear to the groove for the left cavernous sinus, the line of fracture corresponding with the line of junction of the petrous with the squamous portion of the temporal bone, and with the great wing of the sphenoid. The dura mater was covered over with yellowish white lymph both on its upper as well as under surfaces. The membranes were more or less agglutinated together, and were firmly adherent to the surface of the brain itself. On puncturing the membranes about an ounce of thickish pus flowed out from the posterior part of the sub-arachnoid space. There was about half an ounce of turbid fluid in the cavity of the left lateral ventricle, the right cavity containing less. The cerebral pulp was considerably softened from external as well as internal pressure. The left tympanic membrane was torn, and a little sanious pus was found in the external ear.

It will be observed from the above details, that when the man was admitted, his condition was apparently not so bad. He was sensible, could answer questions. His volition, motion and sensations were all in good order. His pulse was slow, and he was evidently suffering from the shock of the injury. But there was one particular sign of great importance, which at once revealed the true nature of the case, I mean the discharge of a watery fluid from the ear. It is true that there are cases in which the discharge of a watery fluid from the ear was the result of slight injury to the temporal bone, and was independent of injury to the brain and membranes, but the weight of evidence is much heavier on the side of the grave nature of this sign. Professor Erichsen says, "This discharge of a thin watery fluid from the interior of the skull is of rare occurrence, but when it happens, it may be considered as pathognomonic of fracture of the base". Mr. P. Hewett has said, "a profuse watery discharge from the ear has always been held as one of the very worst features in an injury of the head." On the strength of the above, I diagnosed the case to be one of fracture of the base, and had the man's deposition taken on the next morning. But for this sign it would have been impossible to make a correct diagnosis, and consequently all other things would have gone wrong.

The discharge from the ear was examined, the quantity being small no specific gravity could be taken, but the fluid contained a little albumen and a small quantity of sugar, but it did not coagulate on being heated with nitric acid.

Faridpur, 27th June 1880.

SPECIAL DETAILED REPORT ON A CASE OF ENTERIC FEVER WITH REMARKS ON THE INFLUENCE OF QUININE ON TEMPERATURE.

BY ASSISTANT APOTHECARY W. WESTON.

History.—Corporal W. W., R. E., age 26 years, service 4 years, landed in India in March 1879, and in October was sent on service to Afghanistan, where he had several attacks of diarrhœa ; on his return to India through the Khyber Pass in August 1880 was attacked with dysentery, for which he was treated in the European Base Hospital at Peshawur and discharged on the 13th September, arriving at Roorkee on the 29th in delicate health. On the 30th he complained again of diarrhœa with pain in the bowels, and was admitted to hospital on 1st October, when his temperature was found to be 103° at 4 P. M. He was discharged convalescent on the 24th November, but to attend for a few days.

RECORD OF TEMPERATURE, PULSE & RESPIRATION.

Date of Observation	Days of Disease.	Temperature.		Pulse per minute.		Respiration per minute.	
Oct.		A. M.	P. M.	A.M.	P.M.	A.M.	P.M.
1	2	...	103	...	...	...	...
2	3	103	105	...	...	...	...
3	4	103	103·6	...	...	...	
4	5	101	102·5	100	108	28	28
5	6	102	102	100	100	28	28
6	7	101	102 2	92	104	28	30
7	8	101·3	102	92	104	28	28
8	9	102	102	104	100	28	30
9	10	101·6	102	100	104	28	28
10	11	100·4	102	108	100	30	28
11	12	100·8	101	96	96	24	24
12	13	101·4	101	100	96	24	24
13	14	99	101	84	88	24	24
14	15	99	101·4	84	92	22	28
15	16	102 6	103	96	98	28	28
16	17	100·6	103	96	100	24	28
17	18	101	103	96	100	28	28
18	19	102	102	100	100	30	28
19	20	99	102	84	96	26	24
20	21	97	105	84	108	20	28
21	22	99	103	100	100	28	28
22	23	101 4	102·5	104	108	24	30
23	24	98·4	103	92	100	28	30
24	25	98	98·4	108	92	32	32
25	26	99	99	92	92	32	26
26	27	97·8	99	92	96	28	30
27	28	98 4	99·4	92	100	28	30
28	29	98	98	84	92	24	28
29	30	98	98	86	88	28	30
30	31	98	98·4	84	86	28	26
31	32	98·4	98·4	82	88	26	27

Observations taken at 7 A M. and 4 P. M.

Diagnosis.—There was no error in diagnosis, the case was well marked from the commencement throughout, the rose spots were present, and there were both pulmonary and hepatic complications, with diarrhœa and flocculent stools.

Infection.—The disease does not appear to have been contracted through personal communication with an individual already suffering from enteric fever. It was imported into the station, as the man arrived from Peshawur on the 29th September and was admitted to hospital on the 1st of October.

Sanitary state of barrack, latrines, &c.—The sanitary condition of the barracks at this station is very good,—the latrines kept clean, the surface drains in good order, and the bazars frequented by the men are also clean but little used.

Water.—The quality of the water used for drinking and cooking purposes at Roorkee is ample and of good quality, but on the march it was inferior, and sometimes bad.

Rations, &c—The quality of the rations and of all the food supplied is satisfactory, but the milk supplied in camp was of doubtful quality.

Opinion.—From the above I am of opinion that the man contracted the disease during his return journey from Afghanistan at Peshawur, but the actual cause or locality is uncertain; he certainly did not become infected at Roorkee, and from the progress of the case from the onset, I consider he was first taken ill with the complaint at Peshawur.

Remarks.—The above report and clinical chart give the history and progress of the case pretty clearly, but what I consider remarkable in this case and wish to point out, is, that on the 19th October (20th day of disease) 10 grains of quinine were given in two doses of 5 grains each, and on the 20th (21st day of disease) the great fall in temperature took place ; now what I feel uncertain about is, whether the extraordinary fall in temperature was due to the quinine or to the "crisis ;" if due to quinine, then I consider it a matter of much importance to be remembered, that in large doses quinine will reduce the temperature in enteric fever, and therefore should be employed in its treatment. The great rise on the same evening is peculiar, but that I consider was probably due to over-stimulation by some brandy and