kobiraj. I elicited the following history: The patient went to the Delhi Durbar; on his return to his home in Calcutta, a few days after he felt feverish and fell ill with an "ague fit" and vomiting. He had had quinine for a long time without effect. Headache was present all along. Thirst was a prominent symptom and also perspiration. He had a little cough with expectoration of blood. On June 23rd, 1903, I found catarrhal condition of both lungs, larynx and pharynx. The spleen was very much enlarged indeed, protruding to the middle line, to umbilicus and downwards into left groin. The stomach was pressed to the right side and the liver dullness was very small. There was great tendency to emesis. The bowels were open daily. There was no joint pains and no rash. I decided to make a blood examination, but this idea the patient would not listen to, and I was never permitted, in consequence of raising this idea, to see the patient again. From all the circumstances of the case of which the temperature chart is very suggestive, I made the diagnosis of the case to be one of Malta fever. The kobiraj could not agree with me. I may add, that I have seen a large number of cases of Malta fever at the Military Hospital at Malta when temporarily at Malta. It is, of course, open to any one to question my diagnosis in the absence of a blood examination, and to say, it was a case of typhoid in a malarial subject, and I am open to arguments which can convince me of any other diagnosis in this case. It is to be remembered that at the Delhi Durbar the patient could possibly catch the infection from any infected person who came there at that time, that a long course of quinine had no effect on his temperature, that he had no diarrhœa or tenderness in right groin suggestive of enteric, that his temperature would have taken on an enteric character some time for so long an illness is unlikely to take such an irregular course, that *his perspiration used to be profuse*, that he had not the aspect of a case of enteric, and that except when feeling specially weak, or with a high temperature would sit up in bed in preference. The tendency to emesis is, of course, explained by the presence of the spleen in the stomach, and the slight catarrhal condition would not explain the temperature or the perspiration. Up to the 29th June, the patient's temperature was still hanging about 101°. I was told afterwards that a leading physician of the I.M.S. in Calcutta had also regarded the case as one of Malta fever.

OPERATIONS FOR EXTIRPATION OF THE SPLEEN.

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SEEING in the *British Medical Journal* of 30th June 1906, a notice of Latouche of Autun's case on "Rupture of spleen: Splenectomy: Recovery" taken from the Bull. et Mēm. de la Soc. de Chir. de Paris, November 28th, 1905, I am tempted to refer to a case of mine which was published in the *Lancet* of January 27th, 1900, entitled "Excision of the spleen for injury". My patient was a well-built adult, 45 years of age, who was, in the course of a quarrel, struck with a sharp-edged weapon on the left hypochondriac region. The blow resulted in an incision through the whole thickness of the abdominal wall, two and a half inches long and three-quarters of an inch wide, the splenic capsule being at the same time incised for one and a half inches and the pulp of the organ projecting through the rent. The interval which elapsed between the time the wound was received and the patient admitted to hospital, amounted to several hours as the man had to be conveyed a considerable distance into town by the police. Apart from the differences in age and manner of occurrence of injury, there are several points in which the case reported by Latouche differed from that described by me. In my case the pulse was inclined to be feeble, the patient suffered from well-marked shock, there was no tympanitic distension of the abdomen and no signs pointing to anything like rupture of intestine; the splenic lesion being manifest and the site of the injury corresponding with the region over which the blow was inflicted and not being on the opposite side of the abdomen. In the manipulations that followed in the management of the case, no difficulty arose in the way of escape of intestines and consequently none associated with the reducing of these. The method I adopted in dealing with the case in my charge and the reason for each step I took, have been carefully detailed in the published report alluded to.

The mortality following rupture of the spleen is undoubtedly very high as instanced by the cases quoted by Vulpius of Heidelberg which ended fatally. The mortality following operations for extirpation of the organ, that is splenectomy, also remains high, especially when done for leucocythæmia, chronic congestion, albuminoid degeneration and syphilitic enlargement. Indeed so much so is this the case that the method of dealing with such conditions by means of this operation has come to be regarded as unjustifiable. As I have stated elsewhere the results have been considerably better when the procedure was adopted for simple and malarial enlargement of the organ or for floating spleen. Where excision is undertaken for rupture, the mortality statistics quoted by Février are sufficient to indicate the seriousness of the operation. There cannot be the slightest doubt regarding the correctness of the opinion of that surgeon as to early operation being a *sine qua non* of success. While on the question of the desirability of early operation, I may say that it is inconceivable that any but a very small

proportion indeed of cases of traumatic rupture of the spleen will recover with rest as the only treatment adopted, especially where the organ is already in an unhealthy condition as so frequently obtains in malarious countries. The dangers of delay in making a prompt and free incision are comparatively greater than any that are likely to arise in the course of, or after, operation in the hands of a surgeon who is at all accustomed to dealing practically with abdominal cases. Similarly the danger of overlooking the ruptured condition of the organ must also be very great, as exemplified in the case related by Le Lorier and Bazy and mentioned in the *British Medical Journal* of December 23rd, 1905.

In connection with the carrying out of such operative methods the two questions that have been raised, are indeed most pertinent. The possibility of the surgeon being unaccustomed to abdominal operations, implies a very awkward state of affairs when a case of this nature suddenly presents itself before him, and when he is perhaps the only medical man for miles around, as is not uncommonly the case in countries abroad. The only remedy is for surgeons to take care to train themselves for dealing with this, anything but rare variety of cases. The dangers accompanying the operation and after-treatment of the case, involving the second question raised, may, to a large extent, be minimised by following some careful and simple method such as I have described in my paper referred to. The abdominal wound in my case, while it undoubtedly simplified the diagnosis of the exact nature and extent of the lesion, rendered the liability at least to septic infection of the peritoneum, correspondingly great. The tissues making up the splenic pulp are very ill-adapted for the application of sutures or of ligatures to vessels, but this difficulty in my experience does not extend to the tissues composing the pedicle of the spleen even where the organ is somewhat enlarged and affected with malarious disease. At any rate, ligatures in the case I have described held admirably and the patient had practically recovered in a fortnight after the operation.

A CASE OF EXTRA-UTERINE PREGNANCY

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I THINK the following case is of sufficient rarity and interest to justify its publication.

The patient, a Hindu woman, aged 38, was admitted into the Hospital at Khargpur in September, 1905. She gave the following history :— She was married at the age of 14, and has had 4 children, all living and well, the youngest now aged 10 years. Seven and half years ago she again became pregnant. The pregnancy was accompanied by pains and was unlike any of her previous ones. At the 7th month she was suddenly seized with violent pains which were so severe that she became unconscious. After this attack pains resembling those of labour continued for about a fortnight and there was a scanty red discharge. The discharge continued for some time about a month, and then gradually ceased ; menstruation recommenced about 4 or 5 months later, it was scanty and ceased 3 years ago. The abdomen became slightly smaller after the attack.

Four months ago the present pains commenced, and they have got so bad lately that she has not been able to get about at all. She thinks the pains were started by a blow which she had over the tumour. Bowels have always been regular.

Present state.— Patient is very emaciated and feeble. In the lower part of the abdomen there is a large tumour reaching as high as the umbilicus. It is obliquely situated, the upper part being to the right, and the lower part to the left of the middle line. It is very irregular in shape and extremely hard. The upper end is rounded and separated from the rest by a groove. There is a small area in front, about the size of the palm of the hand, which is soft and fluctuating.

The tumour can be moved very slightly. P. V. there is a smooth round mass occupying the left side of the pelvis. The cervix is displaced downwards, is small and very soft. The body of the uterus cannot be made out separate from the tumour. Slight movement can be detected by pressing on the tumour from the abdomen.

Operation.—The abdomen was opened in the usual way. The soft fluctuating area was found to be a cyst formed between the abdominal wall and the tumour and contained two or three ounces of treacly fluid. On separating adhesions the anterior surface and limbs of a fœtus came into view. Posteriorly the intestines were adherent, but the adhesions were, for the most part, of a recent nature and easily separable. Some, however, were dense and firm and only separated with difficulty. The lower pole of the fœtus was resting in the left side of the pelvis and embedded in soft, friable, deeply blood stained tissue, apparently the remains of the placenta. On separating the fœtus from this, it was delivered without further trouble. Hœmorrhage was easily controlled by pressure with mops. No attempt was made to remove the placental tissue.

The uterus was small and soft. The right tube and ovary appeared to be normal; on the left side they were so matted together with the placental tissue and intestine that they could not be found.

The abdomen was closed and the patient made an uneventful recovery, slight constipation during convalescence being the only trouble.

The fœtus presents a mummified appearance and has in parts undergone fatty changes.