

at a point one inch to the left of the umbilicus and went through the left rectus. The course of the pellet was followed through four separate coils of the small intestine and the perforations being very small were partially closed by retraction of the muscular layers. There was only slight evidence of contamination of the abdominal cavity by faeces. The perforations were closed one by one by purse-string sutures with no. 000 catgut. On reaching the fifth coil only one entering perforation could be found. The pellet was searched for but could not be located and it was presumed that it had lodged in the lumen. Two small apertures in the mesentery were not sutured. The abdomen was closed and a small glove drain was retained for 24 hours.

The pellet was recovered from a normal motion on the third day following operation. The patient made an uneventful recovery.

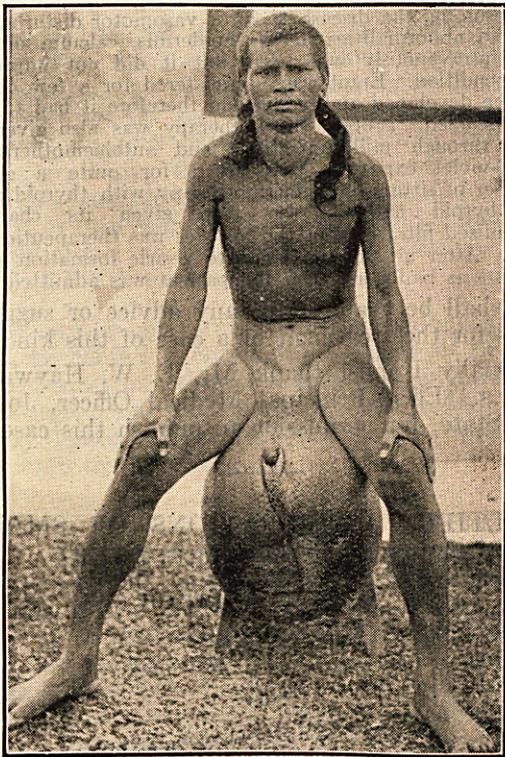
This case is described to show the surprising amount of damage that a small unlicensed air-rifle can cause and, secondly, it illustrates the value of early laparotomy in gun-shot wounds of the abdomen.

FILARIASIS IN THE MIKIR HILLS

By P. N. MITRA, M.B., D.T.M.

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THOUGH I have been working in different parts of Assam for the last twenty-three years, I have only rarely seen clinical filariasis. The disease is occasionally seen among people coming



from Bengal, Bihar or Orissa; but the infection in such cases was contracted outside Assam. I have seen a few cases of elephantiasis of the legs among the indigenous population but I never succeeded in recovering microfilariae from such persons and it was otherwise doubtful whether

these cases were due to filariasis. However, in the Sibsagar District, in Golaghat, I came across well-marked clinical filariasis among the Mikirs. The Mikirs live in a low range of hills, running on the south of and more or less parallel to the Brahmaputra river, extending through the districts of Sibsagar and Nowgong in Assam. These hills are covered with dense jungle and are well watered with numerous springs and streams. There are no roads or bridges in these hills and no wheeled traffic is possible. The nearest hospital is at Golaghat about thirty miles away.

Elephantiasis of the legs and scrotum and enlarged lymph glands are the types that are met with. The photograph of one case shows the enormous size the scrotum had attained. Microfilariae were searched for in this patient as well as in others. The patients were available only during the day and venous blood was withdrawn with a syringe and poured into 2 per cent acetic acid, in water. By this method sheathed microfilariae were seen many times. One specimen was sent to the School of Tropical Medicine at Calcutta, and was reported upon as follows:—'The embryos are sheathed, have a smooth body, and show distinct and clear nuclei. They measure about $250\mu \times 8\mu$. They appear to be *Microfilaria bancrofti*'. In view of the fact that the filariasis in the North Cachar Hills was found to be due to *M. malayi*, I had expected the same species to be found here also. There were no opportunities for a search for the vector. It appears that the disease is limited to the Mikir Hills because clinical filariasis is not seen among the people outside this area.

The tumour was successfully removed.

FULMINANT CASE OF ULCERATIVE ENDOCARDITIS

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and

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CONVICT no. 4741 was committed to this jail on 14th January, 1938. He was overhauled and classified III-L. (Health of convicts is classified as I-H, first class, fit for hard labour, II-M, second class, fit for medium labour, and III-L, third class, fit for only light labour.)

His condition was as follows:—

Previous history.—He had had four attacks of fever attended with shivering and pain all over the body. These attacks lasted two or three days and occurred at intervals of about a month.

Condition on admission to the jail.—The apex beat of the heart was in the normal place. There was no dilatation or hypertrophy, but there was a double mitral murmur. Nothing organically wrong was discovered in other systems.

On 25th April, 1938, he was brought to the hospital suffering from fever with rigor. Temperature was 100.4°F . Blood was examined for malarial parasites and found negative. Differential blood count showed polymorphonuclears 68 per cent, lymphocytes 30 per

cent and mononuclears 2 per cent. He was very restless. Auscultation of heart and lungs revealed no new development. Pulse was 100 per minute and thready. He was complaining of great pain in the abdomen around the navel. Focal examination revealed no sign of 'acute abdomen'. At 3 p.m. he started to pass loose watery stools with mucus in them, but no blood. Microscopic examination of stools revealed no dysenteric exudate.

All the reflexes were found to be normal. He became unconscious at about 6 p.m. Lumbar puncture was done and cerebro-spinal fluid was examined. It was clear and not under pressure. King Institute, Guindy, reported as under:—

Microscopically:—Very few cells. No cellular increase. No organisms found.

Culturally:—No growth obtained.

Microscopic examination of deposit from urine showed no red cells. The next morning he became completely unconscious. Breathing was stertorous. Temperature rose to 105°F. and he died at 6 p.m.

A tentative diagnosis of ulcerative endocarditis was made.

Post-mortem findings.—Mitral valve cusps were ulcerated and thickened having a cartilaginous feel. Nodular thickening was present on the aortic valves. Infarction was present in the spleen while lungs, stomach and kidneys showed embolic focal lesions. Unfortunately examination of brain was omitted.

Remarks

Interesting features of the case are:—

1. Very abrupt onset with shivering simulating malaria.
2. Fulminating character with death within 34 hours.
3. Apparent signs of abdominal crisis, cause of which was revealed on the *post-mortem* table, viz, embolic focal lesion of stomach.
4. Unconsciousness caused by embolism.
5. *Post-mortem* findings which left no doubt about the diagnosis.
6. There were no petechiæ on the finger tips nor tender spots in the legs.

We express our thanks to Major P. V. Karamchandani, I.M.S., Superintendent, Central Jail, Cannanore, and Lieut.-Col. S. C. Contractor, I.M.S., Inspector-General of Prisons, Madras, for permission to publish this case.

TRAUMATIC DISLOCATION OF HIP

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TRAUMATIC dislocations of hip may occur as a result of a fall from a height on an abducted hip, a heavy weight falling on the back with the hip in an abducted position or as the result of automobile accidents. 'Dash board dislocation' is the term used by American writers for dislocations that occur as a result of automobile accidents either to the driver or the companion in the driver's seat.

History of case.—In June 1930, a hydro-electrical engineer, aged 40 years, was driving a car and to avoid an accident he swerved. In spite of jamming on his foot-brake he dashed against a wall with a terrific impact. He felt the impact along the whole length of

the right leg and felt a sensation as if something gave way in the right hip joint causing him severe pain and inability to use his leg. He was lifted out of the car and carried to the nearest travellers' bungalow where first aid was given. At a district headquarters hospital without x-ray facilities he was treated for nine days as a case of sprain in the region of the hip. On the 10th day he was admitted in the General Hospital, Madras, under my care.

On admission, a swelling in the region of the right hip with adduction and flexion deformity of hip and flexion of the knee was found. Movements of the hip were very painful and could not be elicited. A real



Fig. 1.—Radiograph showing traumatic dislocation of the right hip, with fracture of the acetabular shelf.

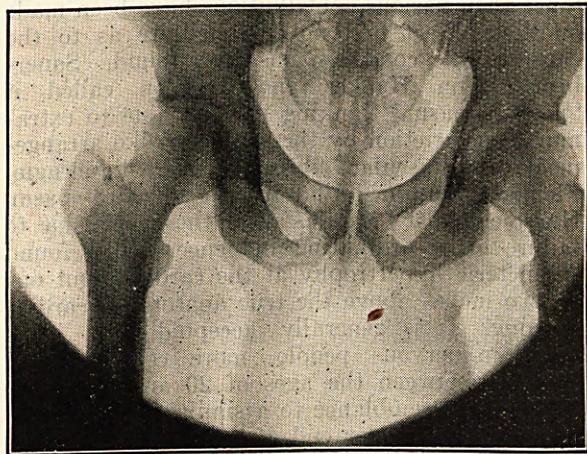


Fig. 2.—Shows the condition of the joint eight years after reduction.

shortening of 1½ inches was found. The tip of the great trochanter was found well above Nelaton's line. The head of the femur was found in an abnormal situation on the dorsum of the iliac bone. X-ray showed fracture of the top of the acetabular shelf with dorsal dislocation (figure 1).

Treatment.—Even though the dislocation was 11 days old, a closed reduction was attempted under general anaesthesia. For 1½ hours all methods of reduction were tried and proved futile. A last attempt was made using Jones's manoeuvre by fixing the pelvis to the table, flexing the hip at a right angle and rotating it medially and resting the flexed knee on the shoulder of an assistant who was directed to push the knee upwards, maintaining an upward traction on the hip