In order to avoid recurrence at least some 2 inches of the rectum above the growth should be removed; in advanced cases this is insufficient (Carson). There should not be the *least strain or tension* on the rectum; for tension always means sloughing. In order to relieve tension, either lengthen the bowel by bringing down the sigmoid or transplant the anus high above the original situation by removal of the cocyx or of a portion of the sacrum. The bowel should not be divided far away from the edge of the mesentery as the part without a mesentery—on account of deficient blood supply—is apt to slough; any length above 2 inches is very risky. Too much eversion of the rectal mucous membrane is to be condemned. Lastly, the bowels should be kept acting regularly with some mild laxative and constipation or straining should be guarded against.

Two photos are given; one is of the part of the rectum removed and kept in formalin, of which the edges are irregularly shrunken and the raised border of the growth is clearly seen; the other is of the patient showing the anus healed up.

TWO CASES OF ACUTE ENCEPHALITIS LETHARGICA.

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As the subject of encephalitis lethargica has been much discussed recently in medical circles in Europe, but very little mention of the disease has been made up to now in the Indian papers, the following report of two acute cases which have lately occurred in Calcutta is given in the hope that it may evoke discussion and lead others to report similar cases, so that some estimate can be formed of the extent to which the disease has now spread in this country. It is probable that many cases are occurring but are seldom recognised in the acute stage, as the symptoms may be misleading. Others may be finding their way to the ophthalmic clinics owing to the frequency of eye symptoms in the prodromal stages.

Case 1.—Ganesha, aged 14, Hindu female, was seen on the 3rd July 1926, owing to retention of urine of 2 days' duration. She had been in good health until 2 months previously when she had been brought from her father's home in Ballia, in the U. P. to Calcutta for treatment of corneal ulceration in the right eye. Since then she had been under regular treatment by an eye specialist with marked improvement. There was no history of diplopia or squint. Her husband's relatives thought she had been rather dull all this time, and she was said to be in the habit of passing urine only 2 or 3 times a day.

On 30th June she was taken ill with moderate fever and marked drowsiness. On 1st July she had difficulty in passing urine, and the next evening a catheter had to be used, as no urine had been passed for 24 hours.

When seen on the evening of the 3rd, she was lying in a heavy drowsy state but could be roused and would open her eyes and try to reply to questions slowly, though she required prompting. She was a well-grown girl with a good colour. There was photophobia in in the right eye and a considerable leucoma. There was marked tetany in the hands at intervals with a little pain. She had no headache but agreed that there was some pain in the middle of the abdomen when a relative reminded her of it. There was a fine papular rash like prickly heat on the face, most marked on the forehead and less on the forearms, which was reported to have come out with the fever a few days before. The pulse was slow and regular. The skin felt a little warm but the temperature was not taken. Examination of the heart, lungs, and abdomen gave negative results. On vaginal examination, nothing abnormal could be discovered to account for the retention of urine. She was then menstruating. Repeated attempts to persuade her to pass urine failed, although she sat up in bed, and even tried on the bed-pan on the floor. During this time she sat as if half asleep supported by relatives and kept asking to be allowed to lie down, but seemed unable to concentrate her mind and make enough effort to pass urine. In the end a catheter was passed and about 10 ounces of clear deep-coloured urine withdrawn.

4*th July*.—The patient was seen again 12 hours later. She was reported to have had a restless night up to 2 a.m. and retched after the medicine, but slept later. No more urine had been passed. She was still in the same lethargic condition. The knee-jerks were doubtful, and the Babinski sign negative. Temperature 100.4°F., pulse 88. The relatives were advised to bring her to hospital, and she was admitted at 4-30 p.m. She could swallow well. An enema gave a constipated result but still no urine came away. Blood test for malaria, negative result.

5*th July*.—The patient was restless and cried out for 2 hours in the night, but slept later. She passed a stool in bed. Early in the morning a deep scarlatiniform rash was seen on the body and by 8-30 a.m. it had covered the whole patient including the legs, but the face had a spotty look owing to the previous rash. Tongue furred. Mental state as before. As no urine had been passed for 36 hours, it was withdrawn by a catheter and two-thirds filled a large kidney dish. No albumen or sugar was found in it. When roused, the patient complained of a little giddiness and abdominal pain, but only if pressed or prompted. Temperature 99.4°—100.6°. Pulse 84—86.

6*th July*.—Patient was very restless in the night, calling out and throwing herself about repeatedly from 11 p.m. to dawn, and then relapsing into a lethargic state which was deeper than before, as she could hardly be persuaded to open her eyes or put out her tongue, even when spoken to loudly and the eyelids opened forcibly. She fell asleep again after saying 2 or 3 words. Temperature 100°—101°. Pulse 76—84. Bowels opened with enema. Catheter passed b.d.

8*th July*.—Patient no better, but temperature lower, i.e., 98.4°—99.2°F. She slept all day without moving, but woke up in the evening, looked round a little, and later became very restless and noisy and slept not more than 1 to 1½ hours after Mist. Pot. Brom. and Chloral, grs. xx of each. She could swallow well when fluids were put to her mouth. The arms and legs and, to a less extent, the whole trunk were found covered with a deep purplish mottled rash which did not fade on pressure. A little twitching of the hands was noticed when she was asleep. Sometimes tetany occurred in both hands and feet.

9*th July*.—Definite improvement. Patient less drowsy and more observant, and complained of hunger. Had a better night on the whole, though slept very little. Knee-jerks absent. Abdominal reflexes active. Seen by Major Hingston, I.M.S., who confirmed the diagnosis of encephalitis lethargica in the acute stage. The patient passed urine normally for the first time for 8 days, and then slept well after Medinal, grs. vii.

10*th July*.—State unaltered, but patient passed urine twice alone. She complained of pain over the left temple. Conjunctivæ of both eyes congested in the day time after she had been sleeping, but clear in the evening. Temperature 98.4°—99.6°. Pulse 80—86.

17*th July*.—Marked improvement. Patient much less drowsy and could sit up in bed alone, but complained of giddiness when she tried to put her feet to the ground. Sleeping well at night without Medinal. She could feed herself and could smile. No tetany recently. Rash fading. Temperature normal since 14th.

20*th July*.—Improvement continued. Patient still sleeping too much in the day as well as all night, but could answer questions intelligently, though slowly and

briefly. Could walk slowly across the room unaided. No stiffness of gait. Going herself to the bath-room and had full sphincter control. Nutrition good. Purple rash still present on forearms and dorsum of feet, but almost faded from the rest of the body. Skin peeling from all finger tips and part of the feet, like desquamation after scarlet fever. Some complaint of pain in the knees.

22nd July.—Patient much brighter, smiling readily, not drowsy. Relatives considered her practically normal, and wished to take her away to the country in a few days' time. She could get up alone and dress herself, but was very quiet and slow compared with a normal girl.

23rd July.—Left hospital.

30th July.—Reported to be very well; considered quite normal by the family.

Case 2.—Kemolini, aged 9, was admitted on the same date, 4th July 1926, for fever and drowsiness of one week's duration. She had lived in different orphanages to the north of Calcutta for several years, and 3 months before had been transferred to an industrial school as she appeared too slow to profit by ordinary lessons. There it was found that her sight was defective and she could only see enough to get about and wind balls of wool. She attended an oculist who said that the defective vision was due to poor general health. No squint was noticed. No complaint of diplopia. In other ways she appeared normal.

On examination on 5th July she was found lying in a semi-comatose state, with total incontinence of urine and fæces. If the eyelids were raised the pupils rolled upwards. If spoken to loudly and touched she occasionally responded and spoke a word or two, but when left alone she remained quite still and never asked for anything spontaneously. Nutrition poor. No head retraction or rigidity of legs. Temperature 102°, pulse rapid and low tension. Patient could swallow a little, tongue furred but moist.

Lungs	No appreciable disease.	Knee-jerks, doubtful.
Heart		No Babinski reflex.
Abdomen		No rash. No nocturnal restlessness.

8th July.—Condition worse. Patient could hardly swallow. Diarrhœa present. Temperature 99°—101°. Pulse 160. Patient lying in a comatose condition all the time.

9th July.—Diarrhœa less. Patient opening her eyes more but did not speak. Lumbar puncture done and clear fluid withdrawn at normal pressure. No abnormal constituents found. Temperature 98°—100°. Pulse very rapid. Muscles slow to relax when tongue put out.

13th July.—Child still very drowsy. She sometimes lay with her eyes half open, vacantly staring. Temperature normal. Diarrhœa stopped. Very little food taken. Replied sometimes when spoken to firmly.

20th July.—Child better on the whole. No incontinence the last few days, and she could ask for the bed-pan. Bowels constipated. She still slept most of the day. Temperature irregular, some days 99° and below, other days up to 100.4° and 101.6°. Some complaint of pain round about umbilicus. Child very thin.

23rd July.—Right ear discharging pus, but no pain or tenderness.

27th July.—Child considerably less drowsy but still heavy and talked very little. No discharge from right ear, but a little pus seen in left ear. Temperature still irregular. No knee-jerks obtained.

2nd August.—Child much brighter. Answered questions intelligently, and was seen to smile. Temperature normal. No discharge from ears. Still no knee-jerks.

12th August.—Talking like a normal child to next patient for past week. No longer drowsy, but very thin and weak. She could just stand holding on to furniture, but still almost too weak to sit up for more than a few minutes without support or to lie down by herself quickly.

23rd August.—Child bright and smiling. Walking well but still a little weak. Knee-jerks returned. Sight good and she can read print easily.

26th August.—Discharged well. Nutrition still very poor but improving daily.

After these notes were completed, a 3rd case in the chronic stage was seen in the out-door department. She was a woman of about 30, who showed the Parkinsonian syndrome of 1½ years' duration, following an attack of obscure fever and general illness which lasted a month, 6 months previously.

A CASE OF CEREBRAL MALARIA, PRESENTING UNUSUAL FEATURES.

By A. BAYLEY-DE CASTRO,

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IN the *Indian Medical Gazette* for June 1926, K. C. Bannerjee of the Leesh River Tea Company published an article entitled "An Interesting Case of Malaria," and I am of the opinion that the publication of such cases helps to keep fresh in the minds of medical practitioners the vagaries of malaria.

In this settlement of the Andamans we every now and then meet with rare, irregular, and interesting forms of malaria, and when you get such a case without the presence of other infections, it becomes doubly interesting, as I hope the notes below will show.

Case.—Prisoner No. 45798, a young man of average height and fair build, but slightly under weight, and of poor muscular development, reported sick on the morning of the 12th April 1926, stating that he had had fever for 3 days with slight rigors, and vomiting, followed by profuse diaphoresis. His previous admissions to hospital were for diarrhœa once, for bacillary dysentery once, for benign tertian malaria once.

Palpation revealed a tender spleen enlarged to 1 inch beyond the costal margin. The liver was normal, circulatory and respiratory systems normal, urine of specific gravity 1024, dark in colour, and loaded with phosphates.

Blood examination elicited a moderately heavy infection with *Plasmodium vivax*. He was given a preliminary purgative and put on the alkaline and quinine treatment.

I must now ask my readers to carefully study the temperature chart, while following the progress of the case.

Nothing of any interest happened till the 16th April when the patient at 9 a.m. had a short, sharp rigor with a rise of temperature to 102°F. He complained of severe headache, and had a very flushed face. There was also a slight cough but nothing was detected in the lungs.

On the 18th April the temperature was still rising and it was apparent that the influence of quinine was lost. The pulse, it was noticed was slow in proportion to the range of temperature. Constipation was marked and headache was persistent,