

and elbows, and she saw a doctor, who, while examining the urine, found that she was passing sugar. She did not complain of any symptoms of diabetes whatsoever and was quite unaware of the glycosuria till she was told of it by the doctor.

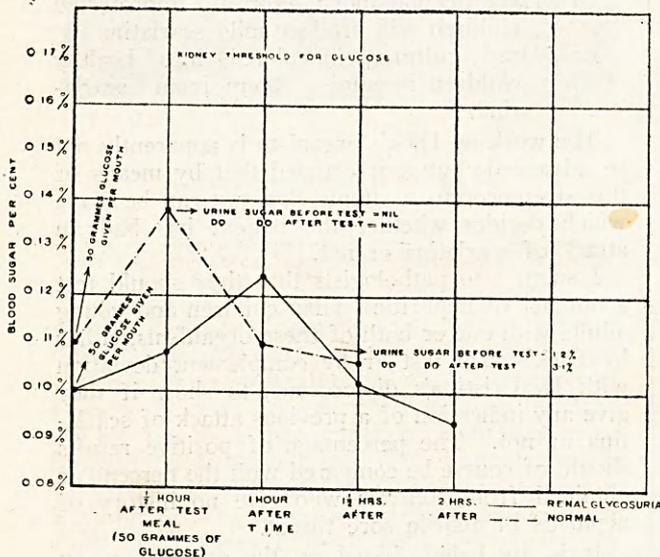
Her general condition was good and she had nothing to worry her except the pain in the joints. She was taking ordinary European diet.

Physical examination.—Nothing important to note.

Chemical examination.—The urine showed the presence of 1.2 per cent of glucose. No other abnormalities were found in the chemical examination of the urine. The blood sugar, however, came to 0.11 per cent. which is quite normal.

Family history.—Her family history did not reveal anything worth recording, but I insisted on the urine examination of all her brothers and sisters and curiously enough found that two of them were passing traces of sugar.

Glucose Tolerance Test.—I did a glucose tolerance test on the patient, which may be considered as the best test for differentiation of the glycosurias* of various origin, and obtained the extremely interesting blood sugar curve which is given below.



From the above curve the following two main points are evident:—

(1) That the patient is passing sugar in the urine, whilst the blood sugar is quite normal.

(2) The ingestion of 50 grammes of glucose does not seem to have any abnormal effect on the blood sugar as will be evident by comparison with the normal curve (dotted line) shown in the chart.

My object in recording this case is:—

(1) That it is a rather rare variety of glycosuria.

(2) That it differs from true diabetes mellitus in all its essential features.

* *Indian Medical Gazette*, Vol. LVIII, No. 6, June, 1923.

(3) That it is quite harmless *if left alone*, and the use of insulin in such cases, based upon examination of the urine only, is likely to produce very harmful, if not disastrous, results.

Comments.—The aetiology of renal glycosuria is still unknown. The patients suffer from no discomfort till they have to consult a doctor for some disease other than glycosuria and on routine examination sugar is revealed in the urine. The patient is usually put on to a strict anti-diabetic treatment with the idea that the diabetes was the primary cause of the complaint for which consultation was sought, and the patient loses weight and suffers from discomfort from this drastic anti-diabetic treatment. I say drastic, because I have known a few cases in England in whom carbohydrates were entirely cut off from the diet and even then the patients were passing sugar in the urine. The erroneous prognosis usually arrived at in such cases is that the diabetes is of a very severe nature because the patient is passing sugar even on a protein and fat diet.

Explanation.—In normal individuals the blood sugar content is near about 0.10 per cent. After a meal the blood sugar begins to rise but seldom goes above 0.16 per cent. At this stage the carbohydrate-storage-mechanism comes into play and the liver and the muscles convert the surplus sugar circulating in the blood into glycogen and the blood sugar consequently comes down to normal within an hour or an hour and a half after a meal. No sugar is excreted in the urine because the level at which glycosuria occurs has been found on an average to be 0.18 per cent.

In renal glycosuria the carbohydrate metabolism is normal, but the "leak point" of the kidneys is unusually low—about 0.10 per cent. instead of 0.18 per cent. in normal cases, so that the patients pass sugar in the urine even while their blood sugar level ranges within normal limits.

Conclusions.

(1) Renal glycosuria is never accompanied by hyperglycaemia. It has been compared with phloridzin glycosuria in which condition there is glycosuria without hyperglycaemia. In a few cases only the glycosuria was found to be associated with parenchymatous nephritis.

(2) It is usually hereditary and familial.

(3) It is usually quite harmless, in fact some authorities call it "diabetes innocens".

(4) A satisfactory diagnosis of this condition cannot be arrived at without the blood sugar test and a glucose tolerance test.

(5) Insulin is absolutely contra-indicated; the best treatment is to leave the patient alone.

AN UNUSUAL CONDYLOMATOUS TUMOUR OF THE LIP.

By A. G. TRESIDDER, M.D., B.S. (Lond.),
MAJOR, I.M.S.,

Surgeon to His Excellency the Governor of Bombay.

THE diagnosis of syphilis is always an interesting problem in whatever stage of the

disease it occurs, and as the case here illustrated is a somewhat unusual one I venture to report it.

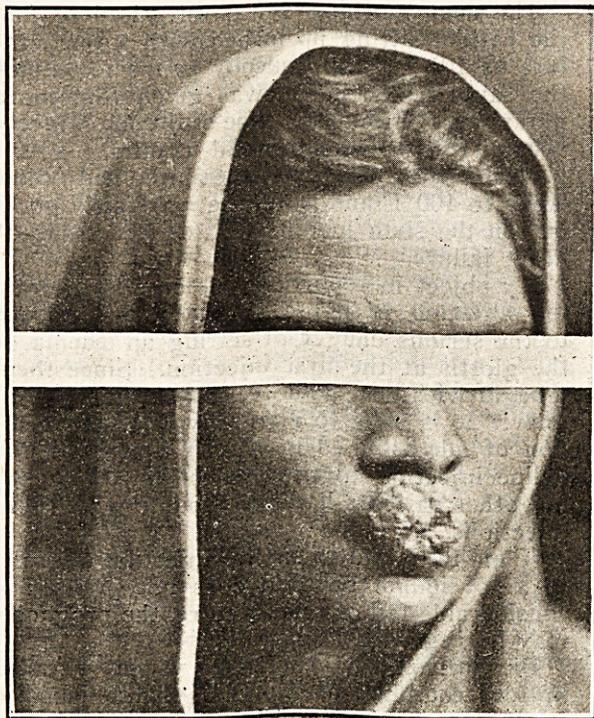


Fig. 1.

The lesion depicted in Fig. 1 occurred in a Marathi woman. Her age was 30; she had been a widow for about a year and when I first saw her she was employed as a servant in an officer's house, her duties being to assist in the washing of the dishes, etc. in the kitchen. There was a large cauliflower-like excrescence situated on the middle third of the upper lip; the diameter of the mass measured $1\frac{1}{2}$ inches and its most prominent central part projected for about $\frac{1}{4}$ inch from the lip surface. Its upper circumference touched the columella and its lower edge extended downwards to just below the level of the red margin of the lower lip. It presented a well-defined edge and a fissured surface with a scanty mucopurulent secretion. The history was to the effect that the lesion had appeared four weeks previously as a small pimple on the upper lip and it had gradually got larger. The submaxillary glands on both sides were enlarged and shotty, as also were those in the posterior triangles of the neck. The epitrochlear glands were not enlarged nor were the inguinal set. On the tonsils and faucial pillars were typical mucous patches and the voice was hoarse; there was no rash on the body. Examination of the external genitals, vagina, cervix uteri and of the anal skin showed no lesion. The Wassermann reaction was strongly positive.

Fig. 2 shows the appearance one month later, after two injections of "606."

In arriving at a diagnosis one had to consider the following conditions:—

- (1) New growth.
 - (a) Non-malignant (papilloma).
 - (b) Malignant (epithelioma).
- (2) Syphilis.
 - (a) Primary (chancre).
 - (b) Secondary (condyloma).

The short duration of the lesion and its rapid development, its situation on the upper lip and the age and sex of the patient were all evidence against the lesion being epitheliomatous in nature.

At first sight one was inclined to consider the lesion to be a chancre, its site and the age of the patient being in favour of this diagnosis; but the swelling did not present the induration characteristic of a primary lesion, nor did the lip show the eversion and pouting so typical of a chancre in this situation. Also in a chancre of this size one would have expected some ulceration in its centre. Its cauliflower-like appearance, together with the evidence of secondary lesions in the mouth led me to diagnose the condition as a secondary syphilitic one, viz. a condyloma of an unusually large size.

Since writing the above, Major Pierce Power, R.A.M.C., Dermatologist to the Poona District, has kindly reviewed this case for me. In his opinion this case would appear to have been a very early secondary lesion, in fact, a

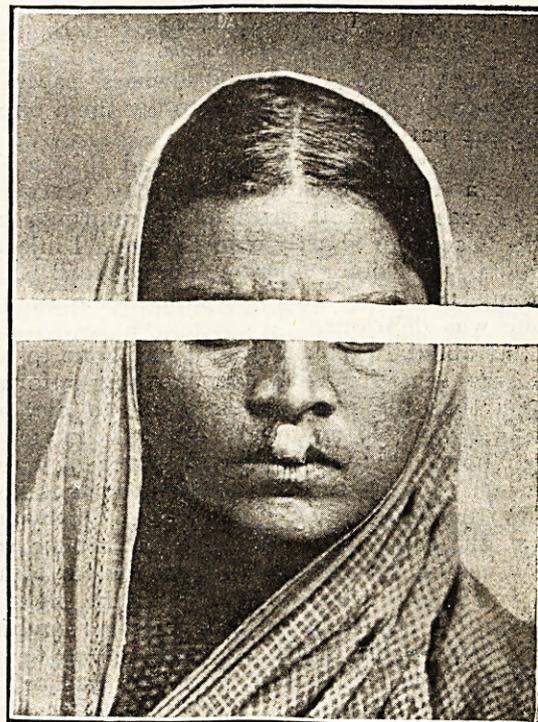


Fig. 2.

border-line case between a late primary and an early secondary lesion. He considers the period of four weeks from the appearance of the pimple on the lip too short for the development of such definite secondary symptoms, these usually not being evident until after the lapse of six to ten weeks from the appearance of the primary chancre. The fact that the Wassermann reaction was strongly positive was evidence in confirmation of this view; the reaction is always negative for the first seventeen days after the appearance of the sore and it is often negative up to thirty days, about this time becoming "positive" and "strongly positive" after the chancre has existed for six weeks.

Major Power considers that the condyloma shown in the photograph marked the site of a true extra-genital chancre, which, owing to its development in the neighbourhood of a moist surface, had taken on the characteristics of a secondary condylomatous lesion.

(*Note*.—Primary extra-genital chancres are very common in medical practice in India, and the possibility should not be overlooked. At the Calcutta School of Tropical Medicine during the past three years, eight cases of primary chancre of the anus in young children have been seen, the ages ranging from 2½ to 8 years; whilst a case recently seen was one of primary chancre of the lower lip in a female patient aged 32. In this particular case the lesion shewed more induration than in Major Tresidder's case, and no tendency to assume a cauliflower type. In all of these cases *S. pallida* was demonstrated by dark-ground examination of the serous discharge.—EDITOR, *Indian Medical Gazette*.)

INTRAVENOUS IODINE INJECTIONS IN PLAGUE.

By R. D. PAL, M.B.,
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HAVING read Colonel Jeurwine's paper on iodine injections, I decided to try them on my plague patients.

The first plague patient I had this season was a Burmese lady about fifty years old. She was taken ill early in the morning and I was sent for shortly before 6 p.m. I injected 10 m. of iodine solution immediately. Her temperature at the time was 105.8°F, and she was delirious.

At about 10 p.m., just as I had gone to bed, I was sent for with the alarming information that the patient was about to die, and was lying cold and motionless. I hurried to her house, but while yet a quarter of a mile away, I heard terrible moaning sounds issuing from the direction of the house. On my arrival, the patient was having severe tetanic convulsions, and shouting and struggling for breath. Her shrieks were inhuman, and the sight of several yellow-robed priests sitting round her gave the whole scene a ghostly effect to my sleepy eyes. Probably the iodine had set up a transient œdema of the glottis. After about ten minutes she was calm, but perspired profusely. Her pulse and respiration were

uncountable, and I retired, thinking she would die. I gave her a tablet of morphia and atropine orally, as her relatives were afraid of further injections.

The next morning I was surprised to find the patient sitting up in bed with a temperature of 101°F. Subsequently at the request of the same relatives she was given four more intravenous injections (one injection every evening) with no untoward results.

On the fifth day her temperature had come down to 100°F and the pulse was fairly good, but on the sixth morning she died suddenly of heart failure.

My object in reporting this case is to draw the attention of those using these injections to the serious danger of setting up œdema of the glottis at the first injection. Since then, I begin with a m. v. dose, and continue up to m.xv. It is safer to give a hypodermic injection of adrenalin (5 to 10 m.) along with the iodine injection to prevent iodism. None of my other patients had any trouble with these injections.

If an initial intravenous injection of m.v. to x. of iodine solution does not produce a considerable fall of temperature, the prognosis may be regarded as bad.

Dr. Sheldon, M. D. (Lond.) whom I called in for consultation, noticed slight jaundice in this case, and regarded it as possibly due to the iodine injection.

Another patient, a Chinaman, whom I injected with the same solution, developed severe jaundice a few days after the injection. Later on, he had a severe attack of hæmatemesis and melæna. I am not sure whether the latter symptoms were due to the iodine or to the malignancy of the attack of plague. This patient is so far progressing well. There is no doubt that iodine does reduce the temperature of plague patients even in bad septicæmic cases, but as regards cures the results are as disappointing as with any other form of drug treatment of this dreaded disease.

A CASE OF DOUBLE HERNIA.

By K. MADHAVA NAYAK, L.M. & S.,
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CHENNAKA, aged 12 years, a Hindu female, dull and apathetic in appearance, was admitted to the Government Pentland Hospital, Vellore, on 31st August, 1923, with a large pendulous reducible tumour of the size of a cocoanut in the right groin and a sausage shaped tumour, also reducible, in the left inguinal region.

General condition.—A very ill-nourished and anæmic girl with slight rises of temperature ranging from 99 to 101°F. Had many hookworm ova in her stools. The daily rise of temperature could not be accounted for clinically unless due to intestinal toxæmia and