The condition of phlegmasia alba dolens is known to take several weeks and sometimes months to clear. In this case it took only 20 days. Though the associated measures (nursing, campolon, tonics, etc.) must have done their respective parts, the effect produced by salyrgan in draining the œdema was definite and it appears was a useful factor in accelerating the cure.

Summary.—A case is recorded of phlegmasia alba dolens in which salyrgan was administered parenterally and orally with benefit.

REFERENCE

Fleckseder, R. (1931). *Wiener Klin. Woch.*, Vol. XLIV, p. 672.

A CASE OF SCARLET FEVER

By BALKRISHNA N. MEHTA, M.B., B.S.

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ON the tenth day of illness I was called in consultation to see a female patient aged about 20 years.

Previous history.—Ten days ago she felt ill and had pain in the throat and was feverish. Next day an eruption was noticed on the face. It was red, punctate and then confluent and spread all over the body within four days. Desquamation started on the eighth day.

She was in bed with a temperature of 101°F. and pulse 120 per minute. The rash spread from head to foot and desquamation had already started. For the most part it consisted of fine scales, while on the palms and soles large flakes—complete glove-like casts—were about to be thrown off. The pharynx was very congested. The tongue was thickly furred and flabby, but not typical of scarlet fever. The lymphatic glands under the right jaw were enlarged and tender; they had been enlarged on both sides, but the left ones had subsided. No enlargement of the liver or spleen was felt. There was no respiratory complication. Cough was slight and pharyngeal in character. There was a great deal of itching all over the body. The maximum temperature was 104°F. The patient was delirious at night. There was a history of passing blood in the urine. The bowels were constipated.

The urine which was examined on the twentieth day contained no albumin or casts. The temperature gradually came down to normal on the twenty-second day; however, it remained fluctuating between 98°F. to 99°F. for about eight days more. Prontosil by mouth was given from the fifteenth day.

The patient had had measles in her youth. The diagnosis of scarlet fever was made from the character of the onset, the type of rash and its desquamation.

During twenty-four years' practice I have only seen three cases of scarlet fever; all were females. The first one, a Parsi woman, was seen ten years ago and survived. The second one, which proved fatal, was seen last year.

[*Note.*—Although very suggestive it is possible that this disease was not scarlet fever because it is atypical in several of its manifestations. It may have been a toxic erythema induced by a septic infection of the throat. If other similar cases had been noted in the district at the time the diagnosis of scarlet fever would have been rendered much more likely. It is difficult to understand how a single case of a very infectious disease could arise without a history of contact with earlier cases and how it was not followed by others, especially in a community that would almost certainly be highly susceptible.—Editor, *I. M. G.*]

PROBABLE RING CARCINOMA OF THE DESCENDING COLON; MANGO FIBRES OBSTRUCTING THE RING AND CAUSING COMPLETE OBSTRUCTION

By S. R. GORE, L.M. & S.

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N. N. P., age 45, was admitted into the hospital on 16th June, 1937, for intestinal obstruction.

History.—She had pain in the left iliac region on 12th June, 1937. The pain was attended with vomiting and constipation. Since 14th June she had absolute constipation. She was given a soap-and-water enema by the sub-assistant surgeon of the nearest dispensary when she passed a little hard stool; after this there was no further stool or passage of flatus.

Her abdomen was distended but not tense when she was admitted. Temperature—98.4°F., pulse—98, and respiration—30 per minute. Soap-and-water enema given in the hospital had no effect.

Immediate laparotomy was done under spinal anæsthesia and the cause of the obstruction was found to be a hard ring carcinoma at the junction of the descending colon and the sigmoid. The constriction was band-like and hard and it was found to be connected with some enlarged glands adjacent to the mesentery. The gut proximal to the stricture was enormously distended. As it was found impossible to do a side-to-side anastomosis a resection of the tumour with the glands *en masse* and an end-to-end anastomosis were done, after making an incision on the antimesenteric border of the collapsed sigmoid to make it fit the distended gut above the stricture.

The patient made an uninterrupted recovery and was discharged on the 9th July, 1937. She has had no more trouble up to the present and she attends the out-patient department occasionally for inspection.

The specimen is preserved. On inspection, it was found that a mass of mango fibres was blocking the constricted lumen of the gut which was just large enough to admit a lead pencil. There was no history of any pain or other symptoms previously and the patient considered herself quite normal up to 12th June, 1937, when pain started. The inner surface of the ring is not ulcerated. The general condition of the patient was quite good, there was not the least trace of cachexia. I have diagnosed this as cancer on account of its hardness and the hard associated glands. There being no means for making a section, microscopic pathological investigation could not be carried out*.

*It should be an easy matter to send the whole or part of the tumour to a pathological laboratory for confirmation of the diagnosis.—EDITOR, *I. M. G.*