body except the trunk where there were a few very small depigmented spots.

(2) Discrete nodules on the lips, inner side of the elbow joints and on the anterior aspects of the knee joints.

A confluent diffuse type on the dorsal aspects of the wrist joints, extending from about 1 inch above the wrists to the tips of the fingers and also on the similar aspects of the ankle joints, extending from about 2 inches above the ankles to the tips of the toes.

Family History.—One brother died of kala-azar.

Previous Illness.—Suffered from kala-azar and was cured after a course of injections of sodium antimony tartrate.

Previous Treatment.—Received three injections of sodium hydnocarpate: case was diagnosed as leprosy.

Duration of the Disease.—About four years.

Nature of onset.—Four months after being discharged cured of kala-azar the patient noticed very small depigmented spots on the lips, chin, arms and forearms, thighs and legs and last of all on the trunk. These spots grew larger. Subsequently these patches were replaced by nodules on the lips, backs of the wrists, dorsum of the feet, anterior aspects of the knee joints and inner aspects of the elbow joints.

Spleen.—Not palpable.

Liver.—1 inch below the right costal arch.

Aldehyde test.—Negative.

Urea Stibamine test.—Positive in 5 and 10 dilutions of serum with 4 per cent. solution.

Total W. B. C. count.—8,600.

Different W. B. C. count.

Polymorphonuclears	..	62 per cent.
Small lymphocyte	..	18 „ „
Large mononuclears	..	12 „ „
Eosinophiles	..	8 „ „

He had goitre before the attack of kala-azar.

Now I suspected the case to be one of dermal leishmanoid. I next prepared six slides from the cut surface of a nodule and after staining with Leishman's stain, I found Leishman-Donovan bodies on examination in large numbers in various forms. I was struck by the fact that the first slide which contained numerous blood cells was the one in which Leishman-Donovan bodies showed up best and were plentiful.

On examination the characteristics of the parasite were as follows:—

1. They were all extra-cellular.
2. The parasite was often seen in clusters of 8 and 9 lying between cellular tissues.
3. Many of them were almost at the point of complete division. (Two cells connected by a bridge of cytoplasm.)
4. Some were at the beginning of division (double nucleus and double kinetoplasts).
5. The nuclei were spongy in appearance in lightly stained specimens.

Treatment.—The boy was discharged clinically cured after receiving 2.4 grms. of urea stibamine (Brahmachari). All the nodules and depigmented spots disappeared and the general health of the patient improved very much.

My thanks are due to Dr. P. K. Das, Sub-Assistant Surgeon, Jajari K. A. Dispensary, for kindly communicating the result of treatment.

Note.—This case is of special interest in view of the apparent rarity of the disease in Assam. At the Calcutta School of Tropical Medicine we have notes on well over 100 cases collected during the last 3 years.—EDITOR, *I. M. G.*

A HEART CASE—FOR DIAGNOSIS.

By PROVAT CHANDRA BAGCHI, L.M.F.,
Madaripur Charitable Dispensary, Malsara P. O., Dist. Rajshahi, Bengal.

I SEND the following notes of a case for diagnosis, and I believe it will certainly provide some interest to readers of this paper.

The patient, a fair-skinned Hindu girl, age 11 years, not well-nourished. Height 4 ft. 3½ inches, chest 1 ft. 11½ inches. Forehead prominent, lips thick, nose flat, eyes prominent and congested. A peculiar ashy pigmentation of the skin over the alæ of the nose, lobules of the ear and external canthi of the eyes can be noticed. The face is cyanosed and the venules are distinct. The fingers and toes are abnormally long, clubbed and cyanosed. There is overgrowth of nails present.

Endocrine deficiency and the other causes of osteo-arthopathy being eliminated, her present condition could be referred to one due to heart disease—chronic or congenital.

Past History.—She has never been a subject of rheumatism—acute or chronic, nor of congenital syphilis. Her parents—as they say—are absolutely free from either of the diseases.

Present Complaints.—Dyspnœa and palpitation on slight exertion, sometimes paroxysmal. Aching pain of the bases of the ungual phalanges occurs in pyrexia from any cause.

CHEST.

Lungs.—Are resonant throughout except at their bases where there is moderate dullness and the vesicular murmur cannot be heard.

Heart.—The apex-beat is visible in the 5th interspace—left, 1 inch lateral to the mid-clavicular line. The cardiac dullness extends from the mid-sternal line to the apex = 4 inches. Auscultation reveals a systolic bruit all over the præcordium except the apical region. This bruit is of rough, grating character and is loudest over the pulmonary area. Pulmonary second sound is loud and distinct. At the apex and over a very small area a pre-systolic bruit can be distinctly heard—the systolic sound is neither replaced nor is the bruit present with it. The systolic bruit can be heard throughout the left

half of the chest in front and is conducted through the carotids and the subclavian arteries.

Pulse.—Regular, volume—small, tension—moderate.

Now the majority of the above clinical signs and symptoms refer to the presence of congenital pulmonary stenosis, but I should be glad if any reader of this paper can account for the presence of:—

(*i*) Pre-systolic murmur at the apical area.

(*ii*) Conduction of the murmur through the carotids and subclavian arteries.

(*iii*) Loud and distinct pulmonary second sound.

(*iv*) Aching pain at the bases of ungual phalanges occurring in pyrexia from any cause.

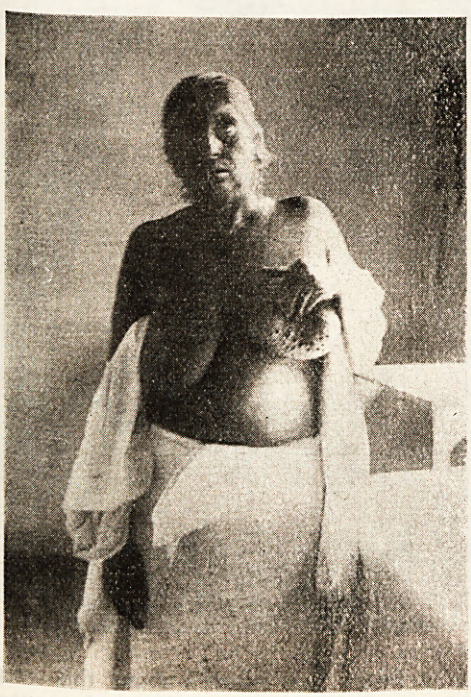
[*Note.*—Some of the signs and symptoms suggest patent *ductus arteriosus.*—EDITOR, *I. M. G.*]

A CASE OF BLEEDING FROM THE BREAST.

By D. N. SINHA, M.B.,
and
R. K. MUKHERJEE, S.A.S.,
Suri Sadar Hospital, Birbhum.

ON the 11th October, 1928, an old out-door patient Khudan Bibi, Mohammedan female, aged 50, came to the out-door with the following complaints:—

(1) She has been bleeding almost continually from the venous blebs on the surface of the left breast for the last one year.



(2) The left breast feels tense and slightly tender.

(3) There are venous blebs on the surface of the breast.

Past History.—She used to menstruate regularly but it stopped 12 years ago. During the last 4 years she has had bleeding from the left breast. For the first 3 years she bled regularly 4 days a month. For one year she has been bleeding continually.

Personal History.—She has only one child, still living. Her husband died 35 years ago. She denies gonorrhœa and syphilis. She has been fairly healthy throughout her life.

Local Examination.—The left breast looks enlarged, tense and a little tender. There are angiomatic venous blebs present. These disappear on pressure. There is no ulcerous area nearby. The breast is not hard to the touch and there are no enlarged glands present anywhere throughout the body.

The patient again came on the 28th of October with fever. Her blood was examined and malaria parasites (B. T.) were found. She was treated by quinine. Her fever was cured in a few days but to our surprise we learnt she has stopped bleeding from the breast.

In conclusion, we beg to thank our chief colleague, Dr. W. A. Browne, Civil Surgeon, for kindly allowing us to publish the case.

A CASE OF UNUSUALLY LARGE CYSTIC GOITRE.

By G. M. IRVINE,
CAPTAIN, I.M.S.,
Indian Military Hospital, Bakloh.

THE following case may prove of interest as an example of unusually large cystic goitre.

The patient was an elderly "pahari" whom I met casually when on a shooting expedition outside the cantonment. Being interested in the unusual appearances of the tumour, I persuaded him for a small consideration to come to be examined and photographed.

He was unable to give a very intelligible account of himself. He thought he was about 50 years old and stated that he had had a swelling in his neck from boyhood, since which time it had increased imperceptibly to its present dimensions.

A large tense cystic tumour of regular outline, about the size and shape of a fœtal head projected forward from the left side of the neck. It was extremely vascular, the skin over it being covered by a network of tortuous and dilated veins, to a greater extent even than that suggested by the photograph. In the normal position of the head it extended from the lower border of the body of the mandible above to the level of the 2nd intercostal space below. A definite thrill was elicited.

The tumour was found to have its origin in the left lobe of the thyroid gland and followed the movement of the larynx in deglutition as far as its bulk would permit it. The larynx was displaced to the right but not