I remained still very sceptical; indeed, his results appeared to me to be altogether too good to be true, but resolved to give this treatment a trial. I used it first in a native patient in the Berhampur Hospital, an extremely acute case of hepatitis with well-marked enlargement of the liver in a rather elderly broken down individual. In spite of my scepticism I was obliged to admit the result was extremely satisfactory, better than could be expected from any other treatment. During the last 18 months in private, and in the wards, both European and native, of the Howrah General Hospital, I have used Ipecacuanha in practically every case of hepatitis of all degrees of severity, and have become absolutely convinced of its value, which, I believe, has been little if at all exaggerated.

It would be absurd to assert that the majority of the cases I have treated would not have recovered under more ordinary treatment, even with dietary treatment alone, though I am convinced the cure would not have been so satisfactory, but amongst the cases, there have certainly been three or four which it is reasonable to consider would, untreated, have gone on to suppuration.

This is a general statement and may not be convincing. I think, therefore, that an abstract of the notes, taken by Military Assistant Surgeon S. J. V. Fox, of one of the cases, will be of more value; it is upon this case alone that in reality my own belief in the value of Ipecacuanha in the presuppurative stage of hepatitis is founded.

P. E. L., an European gentleman, was seen by me in his home on June 7th, 1909. There was a history of severe dysentery 18 months previously and of some disorder of the bowels a few weeks before. He had been attacked in the previous night, after feeling unwell for a day or two, with severe pains in the epigastrium, vomiting, etc. His temperature was 103° Fahr. No improvement took place the next day, and he was admitted on the third day into the Howrah General Hospital. He then had a temperature of 102°; the pain had now concentrated itself to a spot below the costal margins internal to the right nipple line. Liver dulness was almost three fingers' breadth below the costal margins, and extended above to the upper border of the 6th rib in the nipple line.

During the fourth and fifth days the liver rapidly enlarged downwards and, on the latter day, presented a distinct rounded tumour extending to the middle line of the epigastrium. This swelling was quite evident by inspection from the foot of the bed. The skin also over this tumour was already slightly œdematous. Distinct fine crepitations were detected at the base of the right lung and a blood-examination showed a high degree of leucocytosis. My previous practice would have been with these symptoms to aspirate the tumour, but, as Ipecacuanha had been commenced on the third night and already there had been some fall in the temperature, I decided to wait for two days. On the seventh day, the day appointed for operation, already such improvement, especially in the decrease of pain and tenderness, had taken place, and there had been such a fall in the temperature, which now ranged between 99·5° and 101°, that all thought of operation was abandoned. The tumour from this day rapidly disappeared and all symptoms subsided, until finally on the 14th day of the disease the temperature remained normal throughout the day, and the liver had retracted to almost its normal dimensions. Ipecacuanha, grs. 20 was given on the fourth night and increased on the seventh night to 25 grs.; afterwards 30 grs. was given daily until it had been given continuously for 10 days. During the remainder of his stay in hospital it was given for two or three nights consecutively with intervals. Altogether 415 grains was taken.

The patient left the hospital on the 25th day for a sea trip. I have learnt recently that he has remained in good health since. (See Temperature Chart.)

I have had, during the last year, three or four striking instances of the value of Ipecacuanha in the treatment of liver abscess after aspiration and the injection of quinine solution without drainage. One of these cases developed in a hospital under my control, but was not under my immediate notice; the case was of a very acute character and was not recognized until suppuration had occurred, and Ipecacuanha was not given before operation. In this case some 17 or 18 ounces of pus were withdrawn by aspiration and quinine solution injected, and Ipecacuanha, which at first was badly taken, was given in large doses. Two further aspirations were made at intervals of 10 days, although the temperature was mostly normal, and further quantities of pus withdrawn. Eventually, after taking Ipecacuanha for a long period, recovery took place, the patient, a constable, went on leave and recently returned in robust health.

REPORT FOR 1909 OF MEDICAL COLLEGE HOSPITAL, CALCUTTA.

BY F. J. DRURY, M.B. (Dub.),

LIEUT.-COL., I.M.S.,

Principal.

FIRST PHYSICIAN'S WARDS.

DURING the year under review a number of interesting cases of aneurysm came into the hospital for treatment.

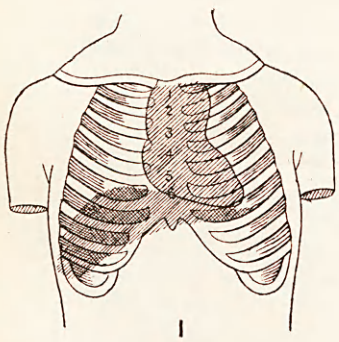
Three of these cases ended fatally, the rest were discharged relieved. The majority of the patients were Europeans and Eurasians.

Case 1.—G H., E. M., 44, by occupation a hotel manager, was first examined in February, 1907, when he came to hospital for the treatment of hepatitis, brought on by a chill caught during a drinking bout.

REPORT FOR 1909 OF MEDICAL COLLEGE HOSPITAL, CALCUTTA.

By Lieut.-Colonel F. J. DRURY, M.B. (Dub.), I.M.S.,
Principal.

CASE II.



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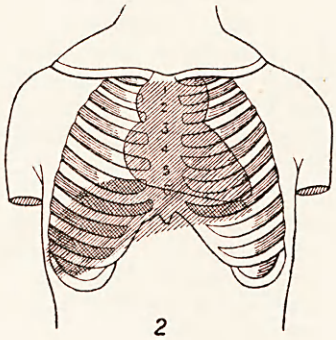

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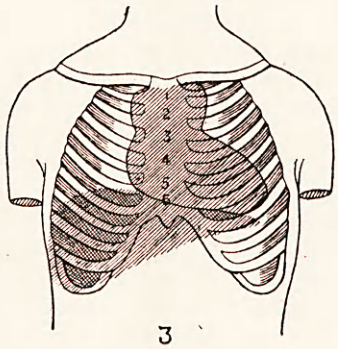

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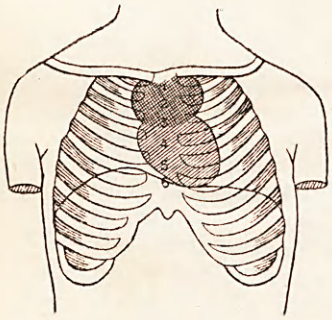
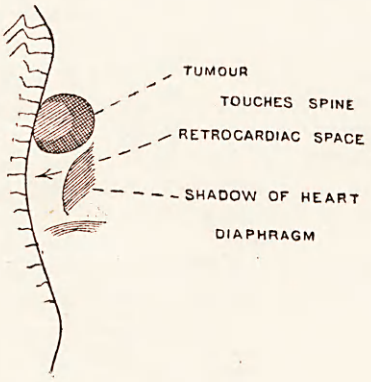
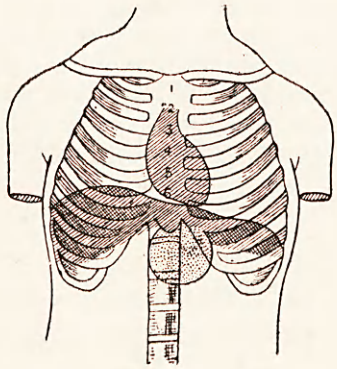
CASE IV.



CASE V.





He was discharged cured. He came in again in October, 1908, with a history of obstinate brassy cough and hæmoptysis. Nothing special was found on physical examination and no T. B. or liver pus was found in the sputum. X-rays failed to reveal anything special, save that the base of the aorta was elongated, but no obvious pulsation was present. The retro-cardiac space was not quite clear. The brassy nature of the cough, coupled with a history of hard drinking and antecedent syphilis, raised a suspicion of aneurysm which was confirmed by the sudden death of the patient during a fit of hæmoptysis and by the subsequent *post-mortem* examination. At the P. M., it was found that the aorta was atheromatous and dilated. There was an aneurysm of the innominate artery, about half inch in diameter. It opened into the trachea two inches below the cricoid. The wall of the trachea for half an inch was thinned and almost ulcerated through in two places, the cartilages being absorbed. The bases of the lungs were infiltrated with blood, and clots were present in the bronchi.

Case 2.—Ahmed, M. M., 40, was admitted in December, 1908, for the treatment of morbus cordis. He was a rice merchant by occupation, and had to work very hard in his business. He had had syphilis seven years before and used to take alcohol occasionally. He was subject to chronic constipation and piles. His symptoms started about a year ago with a sudden pain in the præcordium followed by an attack of difficulty of breathing. He had been subject to these fits since then. He had a dull boring pain over the præcordium and in the left scapula. The heart was hypertrophied the apex being at the sixth space, and the aortic second sound had a peculiar low-pitched booming character. There was some difference in the rhythm of the pulses, the right being somewhat delayed, and the pressure in it being rather low, 80 mm. compared to 110 mm. in the left.

Fluoroscopic examination on the 22nd December, 1908, showed the bases of the great vessels to be dilated, particularly to the right, obscuring the posterior mediastinum, but it was not obviously pulsatile.

A diagnosis of aneurysm was made. The patient's condition became worse. While in hospital mitral regurgitation with cardiac dilatation set in, and he died in September, 1909. On P.M., examination, it was found that the first part of the aorta was considerably dilated and formed a sac of the size of an orange, bulging to the right. The vessels of the arch of the aorta was extremely atheromatous throughout. The left pleural cavity contained a large quantity of yellow thin fluid containing lymph, and a gangrenous cavity about 1½ inch in diameter was present at about the middle of the posterior border, coming to the surface of the left lung.

Case 3.—J. M., West Indian Male, aged 45, was admitted for the treatment of bronchitis in September, 1909. His symptoms were cough, pain in the chest, shortness of breath and hoarseness of voice. He had all these in July, 1909. His father died of a similar disease twelve years previously. He was a cook by occupation, and stated that he was a strict abstainer from all liquors and denied syphilis.

There was a certain amount of difference in the character of the radial pulse of both sides, the right one being rather jerky and abrupt. Slight tracheal tugging was present. He was treated with big doses of potassium iodide. This combined with rest in bed improved his condition a great deal. He left hospital in January 1910.

The interesting points about this case are the singular absence of the classical predisposing causes and the strong hereditary element.

Case 4.—Abdul Rahaman, M. M., 40, came into hospital in June, 1909, for the treatment of cough and difficulty of breathing, from which he had been suffering for one year and-a-half; he was a cook by occupation, and was addicted to alcohol from the age of 15, and had had syphilis at 18. His symptoms began about 18 months before with fits of cough and dyspnœa. This went on for about a year, at the end of which time his voice became hoarse.

Condition on admission.—The patient was rather emaciated. There was a well marked swelling over and to the left of the sternum. This was dull on percussion, and rather tender, but no pulsation was visible. There was also a slight bulging in the interscapular region to the left of the vertebræ. Well-marked tracheal tugging was present. There was present a double murmur over the base of the heart. The pulse was of a "water hammer" character, and the left radial pulse was a little delayed. The left vocal cord was paralysed.

X-ray examination showed a very large shadow at the aortic base bulging to the left. The left border was seen to pulsate. The antero-posterior diameter of the tumour was nearly equal to the diameter from right to left. The retrocardiac space was clear save at the level of the tumour where the latter was seen to press on the spine.

He was put to bed and given big doses of potassium iodide and morphia, gr. ¼, to secure rest at night. His condition greatly improved while in hospital. The fits of cough were less and he could sleep comfortably in bed. There was no appreciable increase in the size of the swelling. He left hospital in November, 1909.

Case 5.—S. J. D., E. I. M., 38, a fitter in a rifle factory, was admitted on May, 1909, for the treatment of pain in loins. He was a widower, a heavy drinker of spirits, and had syphilis 8 years before. His troubles began about two months before admission with pain in the left side of the abdomen, and this gradually extended to his back. On careful examination an ill-defined pulsating tumour was palpated in the epigastrium, the pulsation persisted in the knee-chest position and a definite thrill was present. On auscultation a loud blowing systolic murmur and a soft diastolic murmur was heard over the tumour. Fluoroscopic examination showed a dark mass over the vertebral column and projecting to the left.

A diagnosis of an aneurysm of the abdominal aorta was made. He was put on large doses of iodide. Three months later when he left the hospital, the pain was less and the pulsation markedly diminished.

NOTES ON A CASE OF MYASTHENIA GRAVIS.

Mrs. R., aged 48, a resident of Allahabad, was admitted into this hospital on the 28th August 1909, with the following complaints:—(1) Palpitation, (2) sweating of the whole body especially the left side, (3) tightness of the chest when she was lying down, (4) pain in the back of the neck, (5) general weakness and difficulty of deglutition, (6) feeling of impending collapse especially at times when trying to do anything.

Family history.—Nothing particular.

Present illness.—Had an attack of double pneumonia in December 1908, with which she was laid up for two and-a-half months. Had rheumatism in 1897.

Personal history.—Nothing particular.

History of present illness.—In April 1909, the patient began to feel weak and tired, had a disinclination for food and had pain in the stomach. These came on after a long walk at Asansol, during which she felt as if she would fall down and the shoulders felt heavier and painful. Since then she had been feeling weaker. About the same month she lost control over the right eyelid, though after a fortnight she regained some power over it. The left lid also dropped and she had not recovered full power over it. They remained half closed when she looked straight, but if she looked at anything for any length of time they gradually dropped more and more. Palpitation was increasing in frequency every month.

Alimentary system.—Tongue coated, no deviation to any side, fibrillary twitchings marked. She felt the tongue getting twisted and inactive. She became very tired in speaking too. She could not keep up a

conversation for any length of time. She felt very tired though her speech did not become incoherent.

Circulatory system.—The pulse is not regular, varying from 66 to 56 per minute.

A systolic murmur could be heard over the mitral region and over the left border of the scapula, gradually disappearing when traced up and not conducted to the axilla. The second sound was accentuated especially over the pulmonary area.

Respiratory system.—Nothing abnormal.

Nervous system.—She was unable to do any work for any length of time. She could not keep the arms raised for more than a few seconds and could not walk more than a few paces. She felt as if she were falling.

Reflexes.—Knee jerk—brisk. Ankle clonus and Babinsky—absent. Eyes—ptosis present. Pupils—normal. The eyes followed the movements of the finger in every direction except upwards. Ears—rather deaf in the left ear, due as she said to an abscess in that year twenty years previously.

A CASE OF DILATATION OF HEART FOLLOWING SECONDARY EXTENSIVE FIBROUS ENDOCARDITIS.

Subdha, M. F, aged 35 was admitted on the 15th May, 1909 for the treatment of dyspnœa and general anasarca. She was in a very bad condition and no satisfactory history could be obtained.

Present condition.—Patient had a bloated appearance, very much cyanosed and was gasping for breath. Marked orthopnœa was present. The heart was dilated, a prolonged systolic bruit could be heard at the apex conducted towards the axilla. Moist râles were present all over the chest.

Liver.—Enlarged and very tender.

Urine.—Scanty, high coloured, no albumen present.

Her condition did not improve much in hospital. She was treated with digitalis and purgatives, and though somewhat relieved by the application of leeches over the liver (after which she bled rather freely) she again became worse and died on the 23rd May.

On *post-mortem* examination it was found that the heart weighed 10 ozs. and presented an extensive raised white thickening of the pericardium at the apex and smooth thickening over the rest of the surface. Tricuspid valves admitted tips of 3 fingers. On the anterior cusp of the valve there were marked thickenings of fibrous tissue. The posterior cusp was adherent to the wall of the ventricle. The apex of the cavity was largely obliterated by adhesions of endocardium which presented extensive yellow patches of thickening. There was slight thickening of the posterior cusp of the mitral valve. Endocardium presented extensive yellow patches of thickening at the apex.

The wall of the right ventricle was somewhat thin except at the apex where there was marked sclerotic thickening. Wall of the left ventricle also thin, measured about $\frac{1}{3}$" in thickness, sclerosed at the apex. The cavity was dilated. There was a patch of thickening in the arch of the aorta.

Liver enlarged, of a pale yellow colour, cuts firmly. There were similar mettled yellow patches on section.

Cause of death.—Dilatation of the heart, secondary extensive fibrous endocarditis and myocarditis and cirrhosis of liver probably syphilitic.

The interest of the case lies in the rarity of such a condition and the difficulty of diagnosing it.

NOTES ON TWO CASES OF POLYARTHRITIS OF OBSCURE ORIGIN IN CHILDREN.

B, a Hindu male child, aged 8, a resident of Gwalior, was admitted into the Medical College Hospital for the treatment of polyarthritis.

For two years the patient was suffering from irregular febrile attacks, pain in all the large joints—the range of movements in these joints being very much limited. The affected joints (both knees and elbows especially) were swollen and the skin over these had a peculiar glossy appearance. The spleen was not enlarged. There were no signs of lung trouble, nor any tubercular history in the family. Salicylates had no effect on the rises of temperature and the pain in the joints. There was no cardiac trouble.

Nothing especial was obtained by Fluoroscopic examination of the affected joints.

The temperature was very irregular. For days the child was free from fever, then suddenly he would have a temperature ranging between 97° to 100° or 101°.

Major Rogers wanted to treat the child with a vaccine prepared from a micro-organism which he found in the blood of a patient with a similar complaint, but the patient's parents insisted on taking the child away.

Ram Charan, H. M., 12, a resident of Garden Reach, was admitted on the 31st August and is still in the hospital. He was admitted for the treatment of pain and swelling in several large joints (both knees, both wrists, both elbows and both ankles). He used to live in a damp house. Three weeks before his admission he had pain and swelling in the right knee-joint which was followed by fever after two days. He never had acid sweats.

He was admitted into the hospital in a crippled condition.

There was a systolic bruit over the mitral region which was not conducted towards the axilla and which varied very much from time to time, disappearing altogether after a few days.

The lungs were quite healthy, and the spleen was not appreciably enlarged. The child was put on salicylates which had no effect on the temperature and on the joints affected. Alkaline fomentation and alkaline drinks were given with the same result. At about this time the patient had an attack of keratoiritis of both eyes, of which he was cured with some difficulty. About the end of September Major Rogers took some blood from one of the affected joints and cultivated a minute staphylococcus. The characteristic point about it was that it grew in colonies resembling colonies of streptococcus. For about a month and-a-half the boy was treated with injection of a vaccine prepared from the staphylococci. The condition slightly improved at first, but as soon as the dose of vaccine was increased, the pain in the joints and the fever increased. The vaccine treatment was stopped and the child was put on arsenic and cod liver oil. On the 22nd December the patient was put on ammoniated tincture of guiaicum, and he began to show signs of gradual improvement. The fever left him altogether in six or seven days and he never had any rise of temperature after that. Gentle passive movements were tried in the affected joints, but any attempt in stretching them forcibly caused a rise of temperature and pain in the joints. The patient was taught to move his limbs gently every day, and about the end of March he was given a pair of crutches. All his joints have regained normal movement and contour except the right knee which is still swollen and stiff

A CASE OF XERODERMIA PIGMENTOSA.

Kanai Lal, H. M., 17 years, student, inhabitant of Howrah, was admitted to hospital on 8-12-09

Family history.—He is the eldest and only survivor of a family of eleven, none of whom were suckled by the mother. Of these children two died before attaining the age of 12 months, six died of "infantile biliary cirrhosis" and two (girls), one at the age of 8 and the other at 9 years, died apparently of xerodermia pigmentosa. At the age of ten months they developed a pigmented disease of the skin which progressed, was later followed by the appearance of wart-like indurated growths on the cheek which ultimately broke down leaving an ulcer characterised by thickened everted

edges and which, gradually spreading, involved the jaws, leading to necrosis of bone and death from cachexia. These two patients were the fourth and fifth children of the family.

Previous history of patient.—When a baby of 11 months, his parents noticed that he suffered from a persistent flushing with local heat of the left cheek. This was followed by local pigmentation of the skin and desquamation. From the left cheek the pigmentation spread over the nose to the right cheek and thence on to the extremities When 13 years old the tip of the nose became ulcerated and later healed leaving a scar. Pigmented spots increasing in size developed on his chest. The wart-like growth on the lower lip was noticed 8 months ago. It increases in size, falls off and begins to grow again.

Present condition.—In appearance the boy's skin is the colour of a plover's egg. There are numerous patches of pigmentation, varying in colour from light brown to black and in size from pins' heads to a patch on the right breast $\frac{1}{2}'' \times \frac{1}{3}''$ in size. In places the eruption appears scaly. Interspersed betweeen these black spots are numerous white atrophic patches. There is a white atrophic scar on the bridge and on both sides of the nose. The lower lip is cracked and scarred. His scalp is covered with numerous scaly patches. There are vascular telangiectasus on the sternum. There is conjunctivitis in both eyes On the nasal side of the right eye is a well-marked vascular pterygium, and a commencing one in a similar situation on the left eye; at the left angle of the lower lip is a small wart-like tumour resembling a commencing epithelioma.

Note.—This disease is very rare—only one hundred cases having been recorded according to Radcliffe Crocker. An excellent colour drawing has been made by the College artist for the Pathological Museum. The patient refused to stay in hospital. Quite the most interesting part of this case is the family history.

A CASE OF ABDOMINAL ANEURISM.

P. S., 38, Bengalee Male, Sweetmeat maker, was admitted on 31-11-09 and discharged relieved on 13-12-09.

Previous history.—Syphilis 12 years ago, gonorrhœa 10 years ago, smokes tobacco to excess.

About a fortnight prior to admission owing to the holidays and heavy demand for sweets, he had to do 13 hours hard work daily in front of a fire. His illness dates from that time and began with a feeling of heaviness and pain in his stomach, which was later followed by a burning pain in the epigastrium accompanied by vomiting. On the 6th day he complained of a gnawing pain in the spine and extending down into the loins.

On admission.—He was a well developed moderately muscular man. Heart second sound at base abrupt and accentuated. Pulse 90, moderately high tension, can be felt equal in both femorals.

Abdomen.—On inspection distinct epigastric pulsation was seen. On palpation an elastic tolerably hard mass was felt slightly to left of mid line. It was pulsatile and expansile, dull on percussion, whilst on auscultation a harsh systolic bruit was heard all over it. With rest in bed and under large doses of pot. iod. slight reduction in the size of the tumour took place and some relief to the gnawing pain, worse at night and which on admission were sufficiently severe to give rise to insomnia. Obtaining some relief he declined to stay longer in hospital.

A CASE OF ROUND-CELLED SARCOMA OF LESSER CURVATURE OF STOMACH.

G. F., 48, Native Christian, ship's steward, was admitted on 24-8-09 and died on 7-9-09.

Previous history.—Syphilis 20 years ago—alcoholism. States he had excellent health till a month and-a-half previous to admission. Three weeks ago he felt a tumour in the abdomen. He had anorexia, nausea and constipation.

On admission.—A fairly well-nourished man, not emaciated but markedly anæmic, complaining of nausea, anorexia, constipation and an abdominal tumour. He never vomited during his illness or noticed any tarry motions.

On examination.—There was a rounded smooth tumour in the left hypochondrium as large as a cricket ball which apparently moved with respiration. It was slightly moveable and could be pushed upwards. The abdominal wall moved freely over it. There was apparently a coil of intestine in front of it; it could be separated from the left lobe of the liver on percussion but not from the area of splenic dullness. It was tender on palpation and at one spot on the inner border the palpating finger could be passed into a rather rounded softened depression (splenic notch?).

X ray examination showed a shadow continuous with that of the spleen descending lower than the umbilicus. The heart was dilated, a systolic bruit was heard at the apex, not conducted; the pulmonary second sound was accentuated. The arteries were thickened and tortuous. Liver and lungs nothing abnormal. Urine contained a trace of albumen. A blood-count gave R B C., 2,900,000; Leucocytes, 7,680; no abnormal cells.

Diagnosis.—The rounded nature of the tumour with distended intestine in front of it suggested a renal tumour. The X ray examination showing a shadow continuous with the spleen suggested a splenic origin, and it was thought to be a tumour or gumma of the spleen.

The patient suddenly developed a local peritonitis over the tumour. The assistance of a surgeon was sought who, suggesting abscess of the left lobe of the liver, passed an exploring needle into the tumour and drew off clear fluid. The grave condition of the patient forbade any further interference and death rapidly followed.

Post-Mortem.—Stomach showed a large caseous tumour affecting the lesser curvature, having a diameter of 4" and weighing 2 lbs. 3 ozs. There was a round ulcer $2\frac{1}{2}''$ in diameter, extending from the cavity of the stomach into the growth; the edges of this were raised and the margin was slightly overhanging. The cardiac and pyloric orifices were healthy. The liver showed numerous scars of old gummata. On the anterior border of the left lobe was a white capsulated nodule about $\frac{1}{3}''$ in diameter, and a similar nodule was seen in the under-surface of the liver. The anterior $\frac{3}{4}$, of the pancreas was involved in the growth The spleen was small $2\frac{1}{2}$ ozs. In the kidneys the cortex of both was narrowed to $\frac{3}{8}''$. The heart was dilated, lungs healthy, microscopical examination showed round-celled sarcoma.

The specimen is in the College Museum.

A CASE OF EPIDEMIC DROPSY WITH *POST-MORTEM* NOTES.

Basanta, H. M., aged 30, compositor, was admitted on 6th September 1909, and died of exhaustion on 27th September 1909.

Family history.—Three members (two male and one female) of the family who live with him are suffering from fever, slight, and œdema of feet.

Personal history.—Nothing of importance; has previously enjoyed good health.

Present illness.—Began 26 days ago with pain in the spine and legs followed by slight fever, constipation, loss of appetite, and 6 days later by swelling beginning at the feet and ankles. The swelling extended to the legs, thighs, scrotum, back and abdomen. Later he was attacked with dyspnœa on the slightest exertion and hence sought admission to hospital.

On admission.—He was found to be a young man of good physique, somewhat anæmic, complaining of dyspnœa, etc.; temperature 101°. On examination there was swelling of the feet, legs, thighs, scrotum, abdomen and

back. The œdema was hard, brawny, indurated, pitted slightly on firm pressure and the skin over it was hard and dry. The skin over the legs felt hot, and intense itching was complained of. It was as if the patient was gradually being enveloped in a cuirass. The heart was slightly dilated with a soft systolic murmur at the apex and accentuation of the second sound at the base. Moist râles were audible in both lungs, and there was cough with some expectoration. The urine was scanty, sp. gra. 1016 and contained no albumen or sugar. The liver and spleen were normal in size. Knee-jerks were present and considering the œdema of the legs active. There was no food drop and no paralysis.

The subsequent course of the disease was a steady progress to a fatal termination in spite of all treatment, which consisted chiefly in the administration of various cardiac stimulants, digitalis, strychnine, caffein, etc., and later hypnotics to overcome the sleeplessness which was exhausting him and which was most intractable to treatment. He complained greatly of the heaviness and stiffness of the legs. He began to pass bright-coloured blood with his motions, which at no time were dysenteric in character. On passing the finger into the rectum the mucous membrane was found to be so swollen and œdematous and in consequence the entering finger was so compressed that it felt as if the finger was passing into the inner tube of an intussusception. Later on the œdema extended upwards the bleeding from the rectum ceased and was replaced by bloody expectoration from the lungs. Bronchitis became general and a patch of broncho-pneumonia was found in the left upper lobe. He developed a measly rash on his face; the œdema of the legs subsided somewhat, leaving the skin harsh, thickened, wrinkled and inelastic. The œdema at the same extended over the chest and down the arms; his belly was like a board and his chest wall became rigid, leading to great difficulty in breathing. The solid œdema of hands and arms became so great as to prevent them being moved except with difficulty. As the œdema extended upwards, the dyspnœa increased and he passed his time propped up in bed, but in no position could he find relief, for his troubles chiefly arose from this brawny, indurated thickened and œdematous skin which compressed him like a moulded vice. The broncho-pneumonia cleared up the temperature which had risen between 98° and 100°, became subnormal and the patient slowly died of exhaustion, the closing scenes being most distressing from the absolute inefficacy of any treatment to relieve the hide-bound condition of which he complained so bitterly. The result of a blood-examination was:—

H. B.	... 14%
R. B. C.	... 2,100,000
W. B. C.	... 6,700

Poikilocytosis, polychromatophilia and a few normoblast, megaloblasts and myelocytes present.

Up to a few days before death when examinations were discontinued, there were no signs of effusion into peritoneal cavity, pleura or pericardium. P.-M. examination by Major Rogers, I.M.S.

Brawny œdematous condition all over body including tissues of neck. Over abdomen subcutaneous tissues were 1 in. thick. Abdominal cavity nearly free from fluid, pericardial cavity contained ½ oz. serum, right pleura contained 16 ozs. and left 14 ozs. of serum. *Heart* weighed 8 ozs., valves healthy. Slightly raised yellow patch ¼ in. thin on tricuspid, musculature pale, no tabby-cat striæ. *Larynx*, aryteno-epiglottidian fold œdematous. *Left lung*, crepitant throughout, except a patch at apex. On section upper lobe firm and somewhat œdematous. Lower lobe slightly œdematous. *Right lung*, also showed firm patches of œdema scattered throughout; bronchial glands pigmented. *Liver*, pale yellow in colour, œdematous. *Kidneys*, healthy. *Stomach*, healthy, a few patches of petechial hæmorrhage in sigmoid flexure. No ankylostomes. *Brain cortex*, slightly œdematous. *Basal ganglia*, slightly œdematous. *Bacteriological examination*—Samples of fluid were taken from the different parts of body and also from yellow patch on heart; on cultivation innumerable staphylococci were seen.

This case has been reported in full owing to the fact that a P.-M. examination was obtained, and the belief held by some that epidemic dropsy is merely the wet form of beri beri.

CASES FROM MAJOR BIRD'S WARDS.

The following cases are worthy of record from Major R. Bird's wards. Cases of surgical interest, done during the six months Major F. O'Kinealy officiated for Major Bird, have not been collected and recorded by him.

SEPTIC PHLEBITIS OF THE SPERMATIC CORD.

W., age 30, pure European, formerly a soldier, came much debilitated by fever into hospital, with a history of having four days ago a sharp attack of "ague" which was followed in a few hours by swelling of the right side of the scrotum. The fever was continuous and caused much prostration. The scrotum increased in size, with a cord-like swelling in the inguinal ring continuous with the testes.

On admission, the scrotum was found much swollen, the surface being red, œdematous, and painful acute hydrocele. The spermatic cord was swollen to the size of the ball of the thumb, painful and tender, the swelling extending from the testes up to the canal, and ending obscurely at the brim of the pelvis on deep palpation. The patient kept his thigh somewhat flexed, and rotated out, and had the facies of one clearly in a gravely septic condition. Operation was performed by Major Bird four days from the initial rigor; a long incision was made from the bottom of the scrotum extending up the groin till opposite the anterior and superior iliac spine; tunica was found full of turbid, yellow fluid, its reddened surface being covered with a yellow lymph deposit. The testes were found moderately swollen. The cord was very much swollen, of 1 in. diameter, its veins being dilated and thrombosed. The increase in size was mainly due to yellow jelly-like infiltration of the cellular tissue of the the cord. On section, the surface was yellow, with the plugged ends of the out veins protruding. The muscles of the abdomen were freely divided, and the cord ligatured as high as possible. Streptococci were found in the yellow exudate. With the removal of the cause of sepsis, the patient made a good recovery.

This case is one of a rare condition which has not been described. It simulates strangulated omental hernia in appearance, but has none of its intestinal symptoms. If not operated on early, *i.e.*, by the fourth day at the latest, it is invariably fatal. The following cases have been met with by Major Bird:—

(1) Sixth day. Right side. European soldier. Pus was found forming in cord. Operation. Death from septicæmia. No external wound.

(2) Bengali tradesman. Also sixth day. Right cord affected. Grave septicæmia. Pus in cord. Yellowish brown in colour. No bacteriological examination was made. The man died. The doctor who incised this case infected his hand, and developed a subpectoral abscess containing the same brown pus. Recovered after being opened and drained by Major Bird.

(3) Bengali landowner. Sixth day. Both cords affected. Pus was found in both cords by operation. Death from septicæmia.

(4) E. W., European, age 35, came into hospital with a history of rigor followed by rapid reddened œdematous swelling of the scrotum and cord. Operation was performed on the third day of the disease, grave sepsis being present. The tunica was drained, commencing yellowish jelly-like infiltration of the cord was observed, which was freely incised, section of the veins of the pampiniform plexis being avoided. Antiseptics were freely used. Patient made uninterrupted recovery, temperature dropping down from 105° to 99°, the day after the operation.

No cause of origin has been found for this condition, there being no wound, no previous chronic orchitis. The treatment should be fearless incision, with castration, if the cord is much affected.

MALIGNANT DISEASE OF UNDESCENDED TESTIS.

M., aged 28, has never felt his left testis. A swelling appeared about two years ago in the left inguinal region, and increased rapidly in size during the last two months.

On inspection, a triangular swelling was observed with rounded angle, the base lying above and parallel to Poupart's ligament. The lower angle corresponded to the external ring, the dimensions of the tumour being $3\frac{1}{2}'' \times 2''$. There was no testicle in the left scrotum; no clear impulse on coughing. The swelling was not painful, but rather tender to the touch. It was tense, highly elastic, and dull on percussion. A portion of it was lying beneath the external oblique in the inguinal canal. The remaining portion being beneath the abdominal muscles. The operation was performed by Major Bird. An incision down the inguinal canal showed that it was an enlarged testis with some of the fluid in the tunica vaginalis. It was attached to the tissues over the iliacus and bound down with a mesorchium which had not been lengthened out into a spermatic cord.

Microscopically, it was composed of alveoli containing large epithilioid cells.

The condition is a rare one. Retained testis is often associated with interstitial hernia.

FILARIAL WORM ENCYSTED IN A LYMPHANGEIECTASIS.

A. E. V., aged 33, Eurasian clerk, always an inhabitant of Calcutta, was admitted into hospital under Major Bird for the treatment of double inguinal hernia. On further examination the case was found to be lymphangeiectasis of the cord The swellings could be reduced and were projected downwards on coughing with a clear impulse which has the additional character of a thrill. The tumours were felt to be knotted, vermiform masses, not like the smooth surface of a hernial sac.

On exposing the right tumour, a small clear pellucid cyst $\frac{3}{4}''$ diameter, the walls being a transparent pellicle was found. In it was a living worm rolling and twisting itself into knots. The cyst was removed entire, and placed in formal. It was taken to the Bombay Medical Congress where it was identified as a female F. Bancroftii. The case healed by first intention.

THREE CASES OF PANCREATIC CYST.

Two cases of monolocular pancreatic cyst, and one of the multilocular variety were successfully operated on by Major Bird. In the two former, there was a definite history of blow on the abdomen near the umbilicus previous to the appearance of the swelling. How far this could be deemed causative it is impossible to say. In both cases there was a large, tense, monolocular cyst occupying the epigastrium and central umbilical regions —dull on percussion with a clearly-defined percussion thrill. On exposing them they were found to be retroperitoneal, with a thick wall which seemed to have retractile elements as it increased in thickness when the tension was relieved. The pancreas could be felt at the back of the abdomen. The contents were blood-stained, fluid, with no digestive properties, and in one case containing cholesterine. There was no connection with the receptaculum chyli or posterior abdominal lymphatics. One case (Rakhal Chandra Das, Hindu male, age 16) granulated up, and was discharged cured. The other case (Subal, Hindu male, age 20) acquired small-pox while in hospital and was removed.

In the multilocular case (Rajendra Lal Pal, Hindu male, 21) the patient's condition was complicated by kyphosis of the dorsal spine, and some old rheumatic fixity of the hip-joints in partial flexion. The cyst was clearly multilocular, dull on percussion, occupying most of the anterior abdominal aspect without any free abdominal fluid. The cysts were tense to the feel. On exposure they were found to be retroperitoneal, extending up behind the stomach to the liver over the front of the right kidney. The posterior peritoneum was removed from the cysts fixed to the margin of the incision. There was no communication with the posterior lymph trunk. The fluid was of a palo straw colour and had no digestive properties.

The cavity collapsed, and granulated up. But a similar swelling developed in front of the right kidney which is to be removed later on.

CASES IN WARDS OF MAJOR C. R. STEVENS, I. M. S.

A case of popliteal aneurism.—Patient, named Hari Charan Khan, H. M., 40, admitted into hospital on 10th June 1909.

History of present illness.—About one year ago hi left calf and skin were swollen and painful, which condition lasted for six months. After that he noticed a swelling in the popliteal space.

General history.—A well-developed young man. Had syphilis when he was 16 years old. Had rheumatic pain in his knees when he was 25. Takes alcohol occasionally.

Physical Examination, Inspection.—A pulsating swelling was found occupying the upper part of the left popliteal space and a little to the outer side. The swelling was oval and well defined in outline. The veins were more prominent than in the opposite leg. The left calf was larger than the right.

Palpation.—Tumour $4\frac{1}{2}''$ to $5''$ long and $5''$ wide over the curve. It was pulsatile and expansive in all directions. The pulsation in the tumour followed the open beat. The pulsation was synchronous with the pulse at the wrist. It was uniform throughout the whole swelling. It persisted in all positions of the limb.

Operation by Major C. R. Stevens on 17th June, 1909. *Mata's operation for obliteration of the sac by internal suture was done.*—Patient was put under chloroform. A tourniquet was tied over a towel over Hunter's canal. An incision about $5''$ long was made on the popliteal space over the tumour. The sac was carefully displayed. It was found to have already begun to rupture On the outside of the sac the internal popliteal nerves were found adherent to it. An incision was made about the whole length of the sac inclined more to the inner side. On opening the sac, fresh blood clot was found in it, which was removed. It was seen that there was a shallow groove in the sac connecting the two openings of the popliteal artery into it, which were $1\frac{3}{4}''$ apart. One row of continuous "Lembert" sutures were applied, beginning $\frac{3}{4}''$ above the upper opening, closing the groove and finishing the same distance below the lower opening. The sac wall was searched for any collateral branches, the tourniquet being gradually loosened. No collateral was found, but the upper opening was leaking. The bleeding point was closed by further silk sutures. Another layer of continuous "Lembert" suture was then applied over the first one, and taking in a larger area of the sac wall. Similarly a third layer of suture was applied thus obliterating the two openings in the sac and the groove connecting them. The tourniquet was then cast loose and kept so during the rest of the operation. Next with each skin suture as much of the sac wall as possible was included tucking in the skin and making a groove. A pad of lint was placed on either side of the groove the limb was dressed, bandaged lightly and put up in a back splint. Tourniquet kept loose round the thigh.

Progress.—Skin stitches were removed on the 8th day. The skin edge was found too much tucked in and the raw edges did not meet having a linear gap $\frac{1}{2}''$ wide. The wound was dressed. There was slight discharge from the wound for the first few days. After six days superficial layer of stitches came away from the wound. The wound then gradually healed by granulation and the patient went away cured, the two deeper layers remaining intact.

II. A case of compound depressed fracture of the Skull with an Abscess of the Brain.—Patient, named Gobinda Charan Mojumdar, H M., 22, was admitted into hospital on 14th December 1909 for the treatment of suspected depressed fracture of the skull. He had an ulcerating wound on the scalp, situated on the right temporal region 2½ inches above and behind the right external auditory meatus. His temperature on admission was 102°, vomited once after admission. He was extremely dull and drowsy and in a semi-comatose condition. No paralysis.

History.—On 21st November 1909 last, he was knocked down by a slowly moving train from behind and remained unconcious for two hours. He was deaf, and could not hear the whistle. The injury was diagnosed locally as a simple cut and the patient dressed and sent home. He had fever for three days. The wound suppurated. He had fever again on the 6th and 7th December. He was seen by another doctor on the 10th December 1909 who suspected depressed fracture of the skull. On the 12th December he had high fever, delirium, vomiting and great pain in the head. Operation was advised. He was admitted into Medical College Hospital on the 14th December 1909.

Operation by Major C.R Stevens on 14th December 1909. – On admission he was taken to operation theatre. Head was shaved and prepared for operation. The wound was examined under chloroform. A depressed fracture was diagnosed. The seat of fracture was exposed by a semi-circular incision about 4" in diameter. After trephining the depressed pieces were removed. The duramater was found bulging and motionless, but apparently intact. A small needle was at first put in, pus was found at about ¾" below the surface. The dura mater was opened and about two drachms of pus et out, the cavity being about the size of a walnut. A fine drainage tube was put in. Scalp wound was stitched, the tube being brought out through a hole in the flap. Patient recovered without incident and went out on 27th January 1910.

III. Elephantiasis of the Leg.—Two cases were treated by embedding silk threads in the subcutaneous tissue from below the ankle to the inguinal region of the abdomen.

Operation.—The whole limb and the inguinal region and buttock were shaved and cleaned for operation. Long thick silk threads were rolled into reels. They were boiled in a saucepan and kept ready for use in it. Patient was chloroformed. The same pan was brought near the foot and held by an assistant, one end of the silk thread was passed through two boiled glass tubes each about a foot long and held mouth to mouth. One tube was held just above the saucepan to prevent the silk from touching its edge.

An incision was made about 1" long on the dorsum of the foot. A long sterile probe about a foot long with a eye at one end was threaded with the silk hanging from the end of the glass tube. It was then pushed through the cut on the dorsum through the subcutaneous tissues and brought out as high as the probe could reach by making an incision on its end when felt through the skin. The end of the glass tube nearest the first incision was placed on the wound and pressed against it to prevent the silk touching the skin, and held so during the rest of the operation. When the silk was brought out at the second incision, a piece of sterilised gauge was placed round it to prevent it from touching the skin. In this way, the silk was passed through the subcutaneous tissue and brought out at successive incisions, with the same antiseptic precautions as far as the inguinal region of the abdomen, where the end of the silk was tied into the subcutaneous tissue. The lower end of the silk was free. By same procedure six silk threads were passed. The wounds were stitched and dressed. Stitches were removed on the 6th day. All the wounds healed by first intention.

Early Case.—The patient had no fever after the operation nor up to the present time, although he suffered from it periodically before the operation. In this case six silk threads were put in all round the limb. His measurements before and after the operation were

	Before Operation.	After Operation.
4in. above tip of ext. malleolus	10"	8½"
4in. below lower border of patella	13½"	12½"

Late Case.—In this case, the swelling was reduced after operation, but it returned again. The patient wrote to say to that she felt easier and lighter. In this case seven silk threads were embedded.

Letters were received from both patients lately They are both doing well. They are both unconscious of the presence of the threads.

IV. Gastrostomy.—In two cases, gastrostomy was done. In both Witzel's operation was done. One was a case of stricture of the œsophagus at the level of the upper margin of the sternum and another a case of new growth near the cardiac end of stomach. Both patients died of inanition.

V. Epithlioma of the Tongue.—Four cases were treated during the year, of which two died and two were cured. In both that were cured almost similar operation was done with this difference that in one preliminary laryngotomy was done and the pharynx plugged with sponge at the time of the operation.

Operation.—Patient was chloroformed and turned on one side with the head slightly lower than the shoulder. An incision was made with the convexity downwards from the chin to the hyoid bone and then to the angle of jaw. The integuments being divided, the lingual artery was brought into view by the usual method, ligatured and divided. The affected submaxillary glands were then removed. The incision was then continued dividing the lower lip into two. After removing the teeth the lower jaw was divided at its middle by a saw. The tongue was removed with scissors as far as the circumvallate papillæ. Similarly the other half was removed. The stump of the tongue which had previously been pierced with stitches was stitched to the floor of the mouth *pari passu* with the removal of the tongue. The jaw was wired with a silver wire. The wound on the chin and lip was stitched as also a part of the wound below the jaw leaving the rest open for drainage. The stitches were sealed with Iodoform varnish and cotton-wool. The open portion was plugged with gauge soaked in iodoform varnish. The wire was subsequently removed, the bone having united in good position. A secondary operation was done later on to remove the glands of the neck. Patients could speak fairly well before they went out.

VI. Elephantiasis of the Scrotum and Penis.—Eighteen cases were successfully treated during the year. the biggest tumour weighing 77½lbs. In all the penis was grafted with skin taken from the thigh generally in one piece and sown on at the time of removal of the tumour. In none of the cases was it necessary to make a secondary graft on the penis.

VII. Liver Abscess.—In all thirty-three cases were treated during the year, taking early, late and moribund cases together. Excepting in urgent cases, the patients were first examined under the X-rays, a blood count taken and then operated on. Two methods of treatment were followed. 18 cases were aspirated and treated with injection of quinine bi-hydrochlor solution. Fifteen were opened and drained and irrigated with quinine solution at intervals. All the cases were given Ipecac. by mouth. In those that were aspirated the following technique was followed :—

The patient's skin was first thoroughly sterilised. Instruments were sterilised as usual. Quinine bi-hydrochlor Solution was boiled in a saucepan with a cover on and kept ready for use at the temperature of the body. Four ounces of solution was usually taken and

boiled down to about two ounces. The skin first touched with a Benzene cautery before inserting trocar of the aspirator. Before connecting the trocar with the tube and bottle, pus was collected in a sterilised test tube for bacteriological examination. After evacuating the abscess cavity, as far as possible, the quinine solution was drawn up in a boiled glass syringe with a small rubber tube attached to the nozzle, and the tube of the aspirator was removed from the canula. The rubber tube attached to the nozzle of the syringe was fixed to the canula and the quinine injected. The amount injected depended on the size of the abscess cavity but varied from grs. xx to grs. xxx. After injection of quinine, the canula was removed and a piece of sterilised cottonwool immediately pressed on the hole. After a minute or two the hole was sealed with collodion and cottonwool.

After the first aspiration the cases were watched and aspirated and injected again if a rise of temperature and local signs showed the continuance of an abscess.

Out of 18 cases aspirated, five died. Out of 15 cases opened and drained two died.

VIII. Appendicitis.—Twelve cases were treated of which two died. Both of these arrived late with general peritonitis following gangrenous appendicitis.

IX. Hernia—For Radical Cure—Twenty-eight cases were treated for radical cure with no deaths. A modified Bessini's method without displacement of cord was used.

For Strangulation.—Seventeen cases were treated with no death.

X. Hydrocele.—Eighty-six cases were treated during the year. In all the sac excised. The patients on an average left the hospital about the eighth day after operation.

XI. Removal of Jaw.—There were six cases of removal of one upper jaw with no death.

XII. Litholapaxy.—There were eight cases of litholapaxy. There was no death.

Table of liver abscesses opened and drained.

No.	Name.	Caste & Sex.	Age.	Date of optn.	Result.	Date of discharge or death.	Remarks.
1	Behari	H. M.	30	2-1-09	C.	31-1-09	
2	Purusottam	H. M.	18	4-1-09	C.	31-1-09	Came in moribund.
3	Gobinda	H. M.	38	2-3-09	D.	2-3-09	
4	Nibaran	H. M.	21	14-4-09	C.	12-5-09	
5	Hari Ch. Banerji ...	H. M.	42	11-5-09	C.	7-6-09	
6	Bijoy Gopal Pal ...	H. M.	25	26-5-09	D.	12-6-09	
7	Karim Bux	H. M.	36	11-6-09	C.	15-7-09	
8	Kali Pada Bhatta ...	H. M.	24	16-6-09 21-6-09	C.	22-7-09	Aspirated first and opened and drained at the 2nd optn.
9	Hari Churn	H. M.	25	12-7-09	C.	14-8-09	
10	Fotika	H. M.	45	14-7-09	C.	9-8-09	
11	Sarat Ch.	H. M.	36	15-7-09	C.	25-7-09	
12	Surendra	H. M.	35	27-7-09 31-7-09	D. O.	16-8-09 22-8-09	Aspirated first and opened rib re-seated at the 2nd optn.
13	Nandalal	H. M.	35	10-8-09	C.	24-11-09	
14	Mahabir	M. M.	45	5-11-09	C.	30-12-09	
15	Ranjan	M. M.	37	15-12-09	C.		

Mortality, 13·3%

Table of liver abscesses treated by aspiration and injection of quinine.

No.	Name.	Caste & Sex.	Age.	No. of Aspiration.	Result.	Date of discharge or death.	Remarks.
1	Mofizuddin	M. M.	30	4	C.	4-3-09	
2	Kirti Bosh	H. M.	37	4	D.	22-3-09	
3	Tustu	H. M.	40	3	C.	17-5-09	
4	Pashu	H. M.	45	3	D.	31-3-09	
5	Ram Chandra	H. M.	30	2	D.	18-5-09	Removed by friends; was also suffering from P. P.
6	Judhistir	H. M.	55	3	C.	1-7-09	
7	Mahatab Khan	M. M.	35	1	C.	19-6-09	
8	Dakshina Ch.	H. M.	39	1	C.	1-7-09	
9	Baikanto Nath	H. M.	55	1	D.	10-7-09	Pt. came in moribund.
10	Nishi	H. M.	24	5	C.	15-9-09	
11	Abdulkhan	M. M.	23	1	C.	25-8-09	
12	Amar Chandra	H. M.	40	4	C.	18-10-09	Pt. was extremely emaciated when he came in, improved a good deal before he left hospital.
13	Ibrahim Khan	M. M.	38	1	D.	11-10-09	Came in moribund.
14	G. A. Jenkins	E. M.	29	1	C.	10-12-09	
15	G. M. Seal	H. M.	32	2	D.	22-11-09	Huge abscess going down to pelvis.
16	Bijoy Gopal Roy ...	I. Ch. M.	35	2	C.	10-12-09	Nothing found on aspiration. Had rise of temp. which came down with ipecac. Z-rays show a shadow.
17	Nain Lal	H. M.	37	2	C.	11-12-09	
18	Abinash	H. M.	36	2	C.	15-7-09	Nothing found on asptn. treated with ipecac. Temp. gradually came down.

Mortality, 27·7% including 2 cases of Hepatitis.