examined for the Wassermann reaction which was absolutely negative; the urine was also found to be normal. No other septic focus, *e.g.*, in the teeth or tonsils, could be found. After a few days' rest in bed the bleeding spot seemed to be a little smaller. He was then put on an iodide mixture. For the first three or four days, he did not note any change in the vision of his affected eye but later on he complained of a further loss of vision. On ophthalmological examination, it was practically impossible to see the fundus owing to a darkish haze in front, caused no doubt by an accumulation of blood in the vitreous. Thinking that a further bleeding had taken place, I gave him a few calcium injections. In addition he was given subconjunctival saline (normal) on every alternate day in doses of 0.2 c.cm., 0.4 c.cm., 0.5 c.cm., 0.5 c.cm., 0.5 c.cm., and 0.5 c.cm. After this course of subconjunctival saline was over, his right eye was again examined by the ophthalmoscope and it was found that the haze in the vitreous was much reduced but another small speck of hæmorrhage (as shown in figure 2) and some opacity

Fig. 2.

in the lower portion and in front of the fundus was seen. The patient was again given subconjunctival saline (double strength of normal saline), put on an iodide mixture of thirty grains of potassium iodide per dose, twice daily after food, and calcium injections in the form of collosal calcium with vitamin D (Glaxo) twice weekly. The patient gradually noted an improvement in his sight. His vision in the right eye is at present 6/9. But on movement of his eyes up and to the sides, he complains of seeing some screen-like shifting opacity in front of the right eye. On ophthalmological examination, I found the fundus to be absolutely clear except that in the lower portion a small area of a glistening fibrous band of tissue, probably retinitis proliferans, extended into the vitreous.

Recurrent hæmorrhages in the vitreous, known as Eales' disease, usually affects both eyes and is commonly due to deficiency of some blood constituent or to the changes in the endothelium of the retinal vessels due to some toxic products. The condition has also been thought to be of a tuberculous or tuberculo-allergic nature.

A CASE OF STRANGULATED HERNIA

By A. F. W. DA COSTA, F.R.C.S.E., D.T.M., L.M.S., V.D.
MAJOR, I.M.D.
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MR. H. K., aged 30 years, well built, an athlete, was admitted into the hospital for vomiting and unbearable pain in the right pubic and scrotal regions which began at 3 a.m. the same morning. On admission the pulse was 86 per minute, temperature 98°F., respiration—21 per minute, tongue—dry and thickly coated.

The complaint about a swelling appearing and disappearing in the right pubo-inguinal and scrotal area had been of twelve years' duration. The swelling, which used to descend into the scrotum from the abdomen, appeared almost invariably after exertion in the gymnasium and occasionally used to be painful, but after rest the pain and swelling used to subside completely.

At about 2-45 a.m. on the day of his admission to hospital he had a severe fit of coughing, which brought on the swelling in the scrotum and along with it pain which gradually increased and became intense.

I examined him carefully and found the hernia to be of a direct type and irreducible and the man was in agony. The hernial swelling was of the size of a big coconut, resonant, but without a gurgle; in fact with all the signs and symptoms of a strangulation. At 1 p.m. the same day after an injection of stovaine into the spinal theca and a subcutaneous injection of 1 c.cm. adrenalin, a three-inch incision immediately above the base of Hesselbach's triangle was made and the hernial sac, which looked blackish, identified. On opening the sac a purplish black fluid welled out and a fifteen-inch-long loop of gut near the ileo-cæcal valve was found to be almost gangrenous. It was rigid, purplish black, along with its mesentery which looked and felt the same. There was no visible or palpable sign of pulsation in the arteries. An enterectomy looked obvious but I tried and succeeded in resuscitating the gut, after removing the constriction, with very hot saline for fully eighty minutes. To my surprise and also that of my assistants the gut began very gradually to revive until the whole coil of intestine with its mesentery became active, excepting a patch one and a quarter inches long and three-quarter inch wide on the side of the gut and a triangular patch of mesentery about one and a half inches long and an inch and a quarter wide at its base which remained purple and hard. Further efforts to revive these patches failed, so I decided to return the coil to the abdomen with the big gangrenous patch on the bowel and mesentery, although it was against all the canons and rules of surgery.

In the evening as the general condition was bad (the abdomen was tympanitic, no flatus had been passed even with a flatus tube) I decided to administer pitressin.

I commenced giving it every four hours and applied turpentine stupes to the abdomen four-hourly. Next morning he passed urine by himself to my great satisfaction and within forty-eight hours the tympanites started diminishing and some flatus was passed through a flatus tube.

He was kept on continuous glucose 5 per cent per rectum (not glucose saline), one pint every hour for six hours and then one pint four-hourly until ten pints were administered in the twenty-four hours; glucose water alone by mouth was given for four days after the operation. This was followed by barley water and glucose-D and fruit juice (of grapes, oranges, sweet limes and pomegranates) until the end of the first week. By the end of two weeks a normal diet was allowed.

He was discharged cured on the twenty-second day after operation.

He could have been discharged on the fourteenth day without danger, but I was anxious to observe the behaviour of his intestinal mechanism. As a matter of fact, it is always wise to keep an operated hernia case in bed for three weeks. I saw him two months later when he told me he was so fit that he had already begun his gymnastics as he could not resist the temptation, despite my telling

him to go easy for three months at the very least.

Commentary.—I am of opinion that this case teaches one not to be so cautious in replacing into the abdomen intestine which has been strangulated and which has revived almost completely. In due course of time with wise and appropriate after-treatment the patches of bowel, which does not appear normal before being returned to the coeliac cavity, will ultimately recover without any untoward symptoms. [On the other hand the 'canons of surgery' are based on the long experience of many surgeons and cannot be upset by a single experience of one surgeon.—EDITOR, *I. M. G.*]

A CASE OF SURGICAL EMPHYSEMA*

By S. N. SEN, L.M.P.
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IN February last on returning to my native village I was called in to see a patient—a breast-fed male child about four months old—with the following symptoms, namely, restlessness, œdema from the chest upwards and dyspnœa.

Previous history.—No definite history could be obtained from the parents. They stated that about ten days ago the child had cried for a whole day and night, after which the above symptoms had gradually developed. A local physician suspecting diphtheria had given an injection of the anti-serum, which however had failed to produce any improvement. On thorough examination of the child, I came to the conclusion that it could not be a case of diphtheria. There was no patch, congestion nor œdema inside the throat; salivation was absent; there was no difficulty in swallowing or sucking; the expression was anxious, respiration hurried and there was movement of the alæ nasi. On palpation the liver was felt rather more than an inch below the right costal arch; the spleen was not enlarged. On the right side from the head down to the chest emphysema could be noted under the skin; this was particularly noticeable over a spot between the sixth and seventh ribs which was tender to pressure. The abdomen was slightly tympanitic and a slight degree of emphysema was present over the upper right quadrant. The knee jerks were normal, the pulse was 90 per minute, tension fair, respiration—60 per minute and shallow; the temperature was 97.8°F. and never exceeded 98°F.

From the emphysema and pain it struck me that there must be some injury to the lungs. I enquired thoroughly to find out if the child had had a fall or any injury to the chest; this however was denied until finally an old woman attendant admitted that the child had accidently fallen over a verandah about ten days previously. This fact had been suppressed as her negligence was responsible for the accident.

No medicine was prescribed for internal use except a few drops of brandy every four hours. The œdematous parts were bandaged and after two days the emphysema commenced to disappear. The child recovered completely a fortnight later.

A history of a fall from a height, the presence of emphysema, the negative signs of diphtheria and the failure to respond to the anti-serum proved clearly that the symptoms could not be due to that disease. It was purely a case of injury to the lungs following a fracture of the ribs although no signs of fracture could be detected. The œdema was probably secondary to the emphysema.

* Rearranged by Editor.

A CASE OF ABSCESS OF THE SPLEEN IN MALARIA

By N. S. PILLAI, L.M.P.
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MA K. S., a Burmese female, thirty-nine years of age, was admitted to the Civil Hospital, Kyauktan, on the 12th March, 1934, suffering from an attack of fever with chills of twenty days' duration. She hailed from one of the villages of this township which was heavily infected with malaria. Her anæmic and emaciated condition showed that she must have been suffering for a longer period than she was aware of. Benign tertian parasites were found in the blood. The spleen which was enlarged (two finger-breadths) was bulging below the costal margin; the anterior margin was rounded and the notch was obliterated. The organ was freely movable, heavy, tense and gave a feeling of fluid contents. Although deep-seated pain was complained of there was no tenderness over the spleen. Under a course of quinine treatment her temperature became normal after six days. The condition of the spleen remained the same although the pain was said to have been slightly relieved. She was discharged from the hospital on the 31st March with instructions to come back if the splenic swelling increased or grew painful. Accordingly she came back on the 14th April with fever complaining of increased pain in, and swelling of the spleen. On examination it was found to have grown larger in size extending three inches inwards and downwards. It was immovable and the skin over the part was stretched, hyperæmic and œdematous, showing that adhesions had formed. It was thereupon decided to open it. The swelling was first explored with a hypodermic needle when pus was found. Under novocain adrenalin infiltration, a vertical incision one and a half inches long was made over the area just below the costal margin in the anterior axillary line dividing the skin and muscles and the swelling was opened with the blades of a sinus forceps. Nearly a pint and a half of thick dusky-white pus of a peculiar odour (not that of *Bacillus coli* infection) was evacuated without exerting much pressure. A rubber tube four inches long was introduced into the abscess cavity and stitched to the skin. The skin incision was closed above and below. The patient was immediately relieved of the pain and her temperature which was 101°F. on admission came down to normal on the fourth day. The abscess drained well and the cavity rapidly closed up. The patient began to move about on the tenth day. She had, however, another attack of fever with chills on the 6th May and again benign tertian parasites were demonstrable in her blood. Another course of quinine treatment was given. The fever lasted only one day. Thereafter, the patient improved steadily in health and her weight increased. She was discharged from the hospital completely cured on the 20th May. I saw her again on the 12th June. She looked quite well and cheerful. The spleen was felt just below the costal margin and was fairly movable. The anterior margin was thickened and the notch was not felt.

The inflammatory enlargement of the spleen being a marked feature in malaria, may it not safely be assumed that malaria was the cause in this case of the enlargement and suppuration which is one of the usual terminations of all inflammatory phenomena? I regret very much that I did not take a smear of the pus as soon as the abscess was opened and thus valuable