six hours. It was 4 a.m. when I completed the plugging and hypodermic injection. Notwithstanding the morphine injection the patient did not sleep. At 7 a.m. her pulse rate was 100 per minute. There was no complaint of abdominal pain or discomfort. At 11 a.m. the patient again discharged blood although the vaginal plugs were in position. There was no pain and the uterus was not contracting. She was placed on the operating table and the plugs removed. She was bleeding profusely, and the os was dilated to admit three fingers. I ruptured the membranes and with my fingers in the uterus managed to draw down one leg and by traction succeeded in delivering a living female child. I divided the cord between two pressure-forceps, kneaded the uterus and with external manual pressure expressed the placenta. The woman had lost a large quantity of blood by now and was in a state of collapse. I gave her 1 c.cm. of pituitrin hypodermically and three pints of saline intravenously. At 3 p.m. the patient had a temperature of 101°F. and her pulse rate was 112 per minute. She complained of thirst. There was no post-partum hæmorrhage, her temperature was normal next morning and continued so throughout her stay in the hospital. Her puerperium was uneventful except that the baby died on the second day after delivery. She walked out of the hospital cured on 11th April, 1935, six days after delivery.

A CASE OF SARCOMA OF THE THIGH

By A. C. DEY, L.M.F.

Senior Resident Medical Officer, Astanga Ayurveda Hospital, Calcutta

T. S., Hindu, male, cultivator by occupation, aged 20 years, an inhabitant of the district of Midnapur, was admitted by the writer in the Astanga Ayurveda Hospital on the 2nd August, 1933, for a tumour on the left thigh.

Previous history.—About a year ago he had a fall and injured the lower third of his left thigh. A few days later he noticed a swelling on the injured part. It was painful to pressure and he had applied liniments

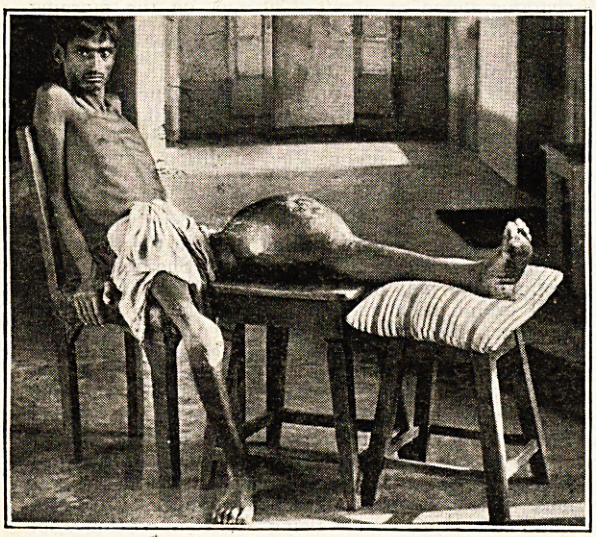

Fig. 1.—Before operation

and embrocations without effect. The swelling gradually increased and attained such a huge size that he was compelled to remain in bed. The patient said that he used to get febrile attacks off and on with occasional pain on the site of the tumour. The huge size of the tumour and his incapacity to do his normal duties compelled him to come down to Calcutta for treatment.

Condition on admission.—The patient was in a very low condition. Pulse—120, and respiration—26 per minute. Temperature—100°F. The heart—apex beat was at the sixth interspace; first and second sounds were feeble. The lungs—a few scattered râles and rhonchi were present in both lungs. The liver—not palpable. The spleen was enlarged 2 inches below the costal arch.

The tumour.—It involved practically the whole of the left thigh extending from the greater trochanter to the knee joint. The length of the tumour was 21 inches and the greatest circumference 27.5 inches.

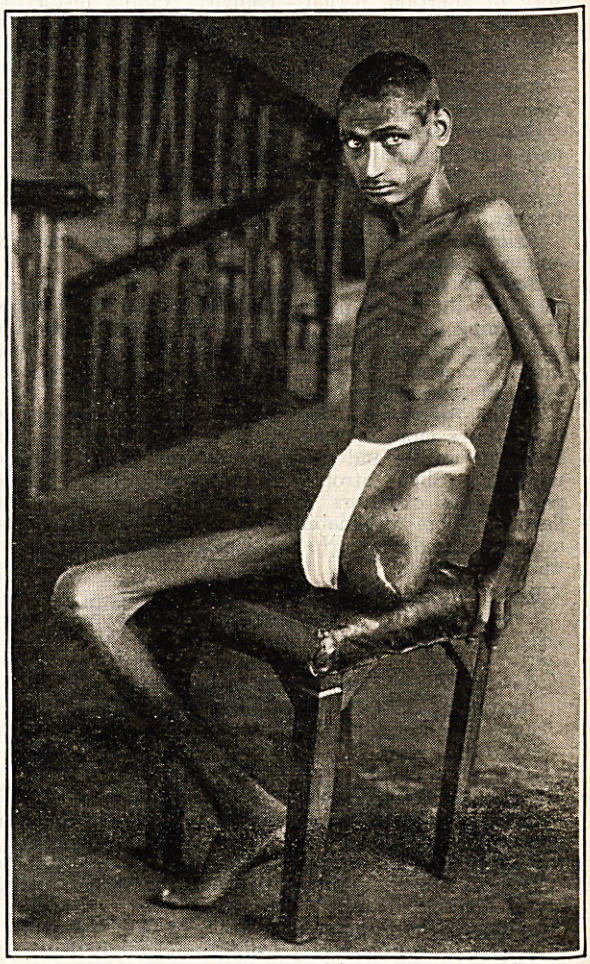

Fig. 2.—After operation

The superficial chain of lymphatic glands of the left groin was enlarged.

Blood examination.—Hæmoglobin—50 per cent, red blood cells—2,700,000 per cubic millimetre and white blood cell—12,100 per cubic millimetre.

Differential count.—Polymorphonuclears—56 per cent, lymphocytes—23 per cent, large mononuclears—17 per cent, and eosinophils—4 per cent.

Considering the above circumstances, the surgeons hesitated as to whether he would stand an operation. On account of the serious condition of the patient and his repeated requests for removal of the tumour, operation was decided upon and disarticulation of the hip joint was done by Dr. S. C. Das under spinal (spinocaine) anæsthesia on 7th August, 1933.

On examination of the tumour after the operation it was found to be a mixed-celled sarcoma containing

round, oval and spindle cells and involving the soft structures of the thigh.

The patient made an uneventful recovery except for a few post-operative complications and was discharged cured on the 27th September, 1933. As far as information could be obtained by the writer the patient is still alive and is in good health.

Points of interest in this case are :—

1. Huge size.
2. Absence of metastases.
3. The patient is still alive, though the operation was done a year and a half ago.

In conclusion I am grateful to my visiting surgeon Dr. D. P. Ghosh, for permission to publish the notes of this case.

A CLINICAL CASE OF PULMONARY TUBERCULOSIS

(Complete recovery following pneumothorax treatment even in a case with cavitation)

By N. R. NADIG, L.C.P.S. (Bom.)
Hubli, Dharwar District

The patient, a male of thirty-six, had extensive tuberculous infiltration in the left lung; *x*-ray examination suggested the presence of two large cavities in the upper and middle part of the left lung, and also slight tuberculous infiltration of the apex of the right lung which appeared to show a tendency towards fibrosis.

The hilar shadows were enlarged on both sides suggesting the presence of calcified tuberculous glands. The heart and aorta were normal.

On admission the patient had all the usual constitutional symptoms, *viz,* temperature, cough, expectoration, and night sweats.

I decided to induce artificial pneumothorax in his left pleural cavity with the idea of compressing the two large cavities, after giving him complete rest in bed for a fortnight.

The patient came to me on 1st October, 1934, and was given the primary air injection of 350 c.cm. on the 15th. The pleural cavity showed a well-marked negative pressure. A refill of 400 c.cm. was given on the 18th October.

On screening the patient on the same day the picture showed a fairly good collapse of the lung, which appeared like a flattened band, against the hilum. The cavities were also partially compressed.

The refills were given once a week at this stage.

The patient gradually showed alleviation of his symptoms—he had slight expectoration and fever, and he increased about twenty pounds in weight in two months.

In December the patient started walking a little and at present he walks about two miles a day without the least difficulty and without showing any constitutional symptoms.

He is now taking his refills at an interval of a fortnight and has resumed his duties of the management of his factory.

Conclusion.—My reason for describing this case is to show that pneumothorax treatment may be employed not only in early unilateral cases but also in advanced third-stage cases. No doubt there is every possibility of encountering extensive pleural adhesions at this stage, nevertheless it is advisable to try pneumothorax on such a case, and if found unsuccessful to give it up and advise some other treatment such as thoracoplasty operation, with a view to compressing the cavities.

The immediate and remote effects of artificial pneumothorax

The immediate results that we usually see after inducing pneumothorax are often striking. In about a fortnight's time, the patient passes from a state of more-or-less profound illness into one of comparatively good health. The temperature subsides, the cough and sputum diminish, the patient regains his appetite, increases in weight, and his general health improves rapidly.

The more remote results of pneumothorax however have to be considered. These are of course much better when the treatment is given at an early stage of the disease, when the patient has good resisting power than when the disease is of long standing and the resistance has been markedly lowered.

It must be admitted however that many patients at an advanced stage can be relieved of their most distressing and obstinate symptoms and survive longer than would otherwise have been possible.

All medical men with experience of collapse therapy have had good, mediocre and bad results. They have also witnessed complete cures and these cures have been maintained for years after discontinuing the treatment.

There is a reasonable chance that artificial pneumothorax will check the activity of the disease, render the patient more comfortable, and prolong his life.

No doubt this is a therapeutic method which is capable of further improvement as knowledge advances. The indications and contra-indications should be laid down very precisely. The duration of treatment should be better understood than it is at present.

In my small experience, I have treated a sufficient number of cases, to say that the best results of artificial pneumothorax are of course obtained at an early stage of the disease of the lung, when the pleura is free from adhesions there is a sound opposite lung and a patient who is still in a fair state of general health and not totally exhausted. Even under apparently hopeless conditions the results have proved that collapse therapy is worth while.

The method is applied in the early cases in order to bring about a cure and to prevent the disease from spreading. I know of a few cases where the disease, which was unilateral, extended rapidly to the contralateral lung, in spite of open air, rest and nutritious food when efficient treatment by this method (artificial pneumothorax) might have checked the spread of the condition.

The treatment is carried out in advanced cases rather to save life than to effect a cure.

In this case an attempt at artificial pneumothorax was decided upon, only when it became