A CASE OF LOCOMOTOR ATAXIA IN AN INDIAN

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J. P., aged 42, Hindu, male, came under my treatment for ataxia which he had had for the last 4 years. There was a history of syphilis 20 years back. In 1920 the patient felt a mild pain in the lumbar region of his back. This pain was intermittent and mild in character in the beginning, but later the intervals between the attacks of pain became shorter, while the pain became more severe. This pain had become lightning and somewhat shooting in character for the last one and a half years, and for this he had two courses of neosalvarsan injections.

The patient then felt numbness in his great and second toes of his feet and later the soles of both the feet became benumbed and this loss of sensation also spread to the medial side of the legs and thighs.

The patient then began to lose his equilibrium and found that if he were to close his eyes, while standing, he would fall down.

On physical examination the following signs were found :—

Cranial nerves

There was some sensory loss on the tip of the nose. There was no ptosis and the facies was not typical of a tabetic patient. Fundus examination of the eyes showed partial atrophy of the disc on the temporal side. Argyll-Robertson pupil was present on the right side while on the left, the reaction to light was sluggish. Corneal reflex was present and there was no nystagmus.

Spinal nerves

Sensory changes.—Loss of pain and touch on the inner side of the upper arms and forearms; in the lower portion of the chest in a band form, on the inner side of the thighs and legs and on the soles of the feet. Loss of sense of position and weight in both the extremities. Finger nose test showed ataxia of the upper extremity. The heel and shin test showed ataxia of the lower extremity. Tendon and muscle sense was absent. Vibration sense was lost in the lower extremity and partially present in the upper. Romberg's sign was present.

Motor system

Ankle jerk, knee jerk, triceps, biceps and pronator jerks were all absent, superficial reflexes were present and plantar reflex was flexor. There was no atrophy of the muscles and there were no contractures. There was no loss in power. Hypotonicity was present in both the extremities especially in the lower. No history of any crisis. Gait very ataxic and slightly stamping.

Cerebrospinal-fluid

Globulin increased. Cell-count 130 per c.mm. Wassermann reaction strongly positive while in the blood it was negative.

A diagnosis of tabes dorsalis was made. It is a very uncommon condition in India, especially in these provinces where I have seen only this case during the last fifteen years. In this case the lightning and shooting pains have not been a marked feature. Typical tabetic facies was not present indicating that the cervical sympathetic was not involved. The clinical examinations showed the involvement of the sacral and dorsal roots and complete destruction of the posterior columns. This condition combined with the ocular changes completes the diagnosis of tabes dorsalis. Wassermann reaction in blood was negative, probably due to the anti-syphilitic treatment which he had had before.

POST-MORTEM DELIVERY OF A FŒTUS

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The body of a widow, aged 35 years, was sent to the District Hospital, Shimoga (Mysore State), for medico-legal post-mortem examination. She had drowned herself in a tank. At the end of three days the body floated to the surface and was removed by the police for enquiry and examination.

The usual police inquest was held and the body was transported in a bullock cart a distance of thirty miles. A post-mortem examination was held twelve hours after the inquest.

The body was in a state of decomposition. Protruding through the vagina and hanging down was a fœtus, with the cord 13 inches long. The entrance to the vagina was plugged by the placenta. On further examination it was found that the uterus had prolapsed and completely everted, lying in the vaginal canal with the placenta still adherent to the fundus.

As nothing abnormal was found during the inquest and no marks of injury on the genitalia, it is evident that the delivery was affected post-mortem during the transport of the body for examination.

The cause of the post-mortem delivery is pressure exerted by gases of decomposition, assisted in this case by the jolting of the country bullock cart.

It is the custom among Hindus to have a post-mortem Cæsarian section done and to bury the mother and fœtus separately. In circumstances where even a village barber is not available, the custom, I believe, is to allow the body to decompose sufficiently in order to effect a post-mortem delivery via the natural passages.

I express my thanks to Dr. K. Srinivasachar, District Medical Officer, Shimoga, for permitting me to report this case.

TWO INTERESTING CASES OF MALARIA

By AMULYA KUMER BHATTACHARYYA, L.M.P.

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My plea for sending these notes on the following two cases is that they exhibited symptoms not usually met with.

Case 1.—A. H., Mohammedan schoolboy, aged 15 years, was asked by his father to write a letter. While doing this he suddenly fainted. On receipt of the information I hastened to the spot, a distance of three miles, and found the boy in a totally unconscious state. There

was no history of venereal disease, alcohol or narcotics. He had no previous similar attack but had had an attack of fever about a week ago.

Examination.—Restless at times and groaning; froth coming out of the mouth; eyes closed; pupillary reflex lost; temperature 98°F.; plantar and cutaneous reflexes lost; pulse soft, regular but slow—58 per minute; respiration slightly laboured; no abnormalities in the lung and heart sounds; abdomen slightly distended; spleen enlarged; liver not palpable; complete aphasia.

The slowness of the pulse and the absence of fever made it difficult to arrive at a definite conclusion. However, the enlarged spleen and history of fever about a week before were the only points in favour of malaria and I gave him a dose of quinine bihydrochlor. gr. x with strychnine hydrochlor. gr. 1/60 in the gluteus muscle. Next morning the patient was almost in the same condition except that his temperature was 100°F. I gave him a second dose of quinine. This was followed by partial consciousness and utterance of a few indistinct words—temperature 100°F., retention of urine—bladder relieved by catheter. Two more doses of quinine were given. The patient became fully conscious and the temperature subsided after the third injection.

Case 2.—B. D., Marwari, aged about 40 years, had an attack of fever and pain all over the body for about a fortnight previous to his coming under my treatment. His fever was said to be of a continuous type.

Examination.—A well-built man; no history of venereal disease, alcohol or narcotics. Bowels constipated; spleen enlarged; respiratory system normal; heart dilated with distinct mitral bruit; pulse soft and frequent; œdema of both the lower extremities up to the hip joints; passed urine in my presence—quantity about 4 ounces, high coloured—no albumen—urobilin test strongly positive; temperature about 101°F., could not move his lower extremities without help; plantar reflex lost; knee-jerk on the right slightly exaggerated; could stand with difficulty when supported by others—gait inco-ordinated; fully conscious.

The strongly positive urobilin test, the temperature and the enlarged spleen led me to treat the case as one of malarial infection. Strophanthin subcutaneously and quinine by mouth were ordered and in addition to these he was given digitalis, Arjun and salines. A week's treatment ameliorated the symptoms and he could then freely walk. In a month he was quite well and left for his native district.

A LEECH IN THE NASAL CAVITY

By H. NARASIMHAIAH, L.M.P.

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In the year 1928, a father brought his female child, aged about 2 years, with a history that the child was irritable, sneezing frequently and passing small quantities of blood through the nostril. I examined the nostrils and I could see nothing. Then it occurred to me, that the condition might be due to a leech in the nostril. I applied to the affected nostril, a turpentine swab and a wet cotton plug. The leech came out and I caught it in a tray containing water, in which it lived for a few hours.

Remarks.—Invasion of the nasal cavity and ears is quite common in places near coffee estates, which are infested very heavily with leeches, in this district. I have since come across 2 or 3 more cases of the above nature and the rarity of the condition as reported in the columns of your journal in December last led me to send the above case notes. I find that when leeches become attached to people, the easiest method of removing them is to drop a few drops of lime-juice, chunam, or snuff on the point of attachment when they fall off.

A CASE OF ACUTE ENDOCARDITIS

By R. K. SANYAL, M.B.

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Hasanaddi, M. M., aged about 38 years, was attacked with fever and aphasia, and on the third day I was called in. I found that he could understand me but could not talk in reply. His temperature was 103°F. and pulse rate about 160 per minute and irregular. There was no other physical sign and he denied any history of syphilis, gonorrhœa or rheumatic fever. I prescribed absolute rest, liquid diet and an alkaline mixture. Gradually the temperature came down and on the sixth day it was normal and his speech returned. The patient complained of extreme weakness and I found that his pulse was still irregular and about 130 per minute.

On the eighth day the temperature again rose to 104°F., with a rigor, and the patient started passing highly albuminous bloody urine and complained of pain in the left kidney. The pulse rate was again 150 to 160 per minute and irregular. Next day he complained of pain in the splenic area and the spleen was enlarged. On the tenth day he complained of sudden pain in the left lung and I found a large pneumonic patch in the lower lobe of left lung. Then I thought the hæmaturia with pain in the kidney, the enlarged spleen with severe pain and the sudden appearance of a pneumonic patch suggested emboli from endocarditis. On the twelfth day he complained of sudden pain in the liver and I found the organ enlarged, and his conjunctivæ icteric. All this time there was no endocardial murmur and the temperature varied from 103°F. to 104°F., with only slight sweating and an occasional rigor. On further enquiry, he now admitted that he suffered from swelling and pain in his left knee-joint for about a month, three years back. So I put him on sodium salicylate and iodide with alkalies.

Gradually his urine cleared up, the pains disappeared, the jaundice subsided, and the pneumonic patch resolved.

On the sixth day after beginning salicylate treatment the temperature was normal and the pulse rate came down to 90 per minute. Two days later his pulse settled down to 75 per minute and it was regular and all the other symptoms had disappeared. The patient has now remained well for a month.

Remarks.—Throughout the course of the illness there was no endocardial murmur and all findings in the heart were negative, except that he had an irregular and rapid pulse and with the subsidence of fever on the sixth day the pulse rate did not settle down.