fairly advanced, epilation is easy as the hairs, not being brittle, come out with scutula when these are removed.

A good method of removing the scutulum is to soak the scalp overnight with the following:—

℞ Phenol	.. ..	15 minims
Mercuric oleate	..	10 grains
Olive oil ..	..	½ ounce
Vaseline ..	..	½ ounce

In the morning, wash the scalp with spirit soap shampoo (soft soap 1 oz., spiritus rectificatus 2 oz.) and water. During the washing, remove the scutula with the hair, as much as possible. After the shampoo wipe the part dry, apply dilute ammoniated mercury ointment, 1 per cent to 2 per cent, to the ulcerated parts and repeat this process for 3 or 4 successive days until the scalp is fairly clear. In the case of an acute inflammatory condition, warm compress with 1/200 phenol, changed every 3 hours, will be of great benefit. When the inflammatory condition subsides, the scalp is fairly clean, and the ulcers have healed, in mild cases without any inflammation, Whitfield's ointment or thymol iodine paint may be applied.

In refractory cases, there need not be any hesitation in advising the patient *x*-ray treatment by an expert radiologist. The chances of baldness resulting from the disease are much greater than from faulty *x*-ray treatment.

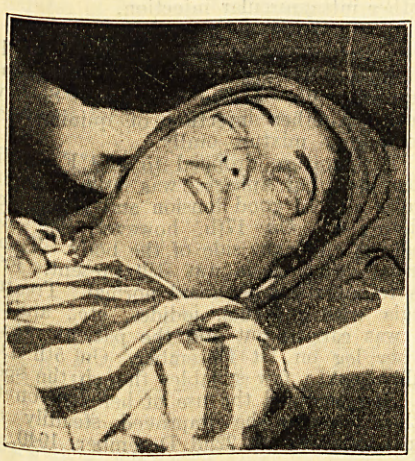
A Mirror of Hospital Practice

A CASE OF CAVERNOUS SINUS THROMBOSIS COMPLICATING MENINGOCOCCAL MENINGITIS WITH RECOVERY

By C. J. HASSETT
CAPTAIN, I.M.S.
Agency Surgeon, North Waziristan

RASHA DIN, aged 19 years, was admitted into hospital on 13th October, 1940, with a history of headache for the past three days. Twelve hours prior to admission he had noticed that his left eye began to bulge and that the lids became swollen and œdematous with constant lachrymation; up to this he had been in excellent health, the temperature was 100°F. and the pulse rate 84 per minute.

Physical examination.—He was conscious but somewhat apathetic. There was exophthalmos of the left eye (*see* figure), the upper and lower lids were swollen and œdematous; the conjunctiva was chemosed; movements of the eye-ball were absent and the pupil failed to react to light. There was absence of vision;



Photograph taken on second day of admission.

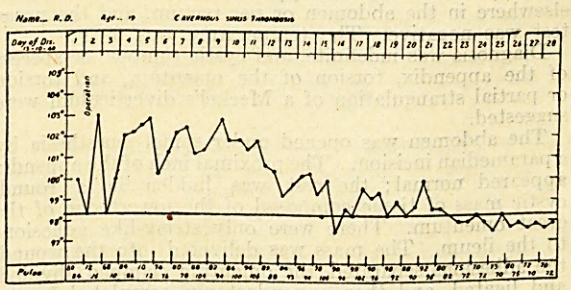
ophthalmoscopic examination revealed choked disc and retinal hæmorrhages. The right eye was normal; the throat, teeth and sinuses were normal; there were no signs of sepsis on the face; the other cranial nerves were normal; the knee and ankle jerks were exaggerated; the plantar reflexes were normal; there was no clonus; the abdominal reflexes were brisk; Kernig's sign was negative; there was no rigidity of the neck muscles; there was no impairment of sensation. The spine and cranium showed no abnormality. The visceral reflexes were normal. There was no rash. Examination of other systems was negative.

Laboratory findings.—13th October. Blood: malarial parasites—negative, red cells 4,550,000 per c.cm., leucocytes 25,312 per c.cm. Differential count—polymorphonuclears 85 per cent, lymphocytes 12 per cent, large mononuclears 3 per cent. Culture—sterile.

Cerebrospinal fluid: 1,109 cells per c.cm., meningococci positive. Nonne-Apelt test positive. Urine and stools normal.

14th October. The right eye now showed exophthalmos though not so severe as in the left eye. There was some chemosis of the conjunctiva, movements were restricted, vision was normal. Ophthalmoscopic examination revealed no abnormality. General examination revealed a positive Kernig's sign and rigidity of the neck muscles.

Treatment.—Lumbar puncture was performed on the day of admission when 30 c.cm. of purulent fluid were removed. He was put on sulphapyridine, 2 grammes four hourly by mouth, and 2.5 grammes by intramuscular injection. In all a total of 67 grammes was given. As



remarked the right eye showed involvement. The left eye was more proptosed and swollen and showed signs of irido-cyclitis. The discharge was now purulent; normal saline washes were given to the right eye and liquid paraffin drops were instilled. Owing to the onset of suppuration in the left eye and with a view to preserving the vision in the right eye, it was decided to enucleate it. This was done under ether anæsthesia on the second day after admission. After the removal of the eye, the patient stated that he felt more comfortable and there was no further protrusion of the right

eye-ball. Recession began to take place though slowly. It was complete in two months; at present there is slight hypertrophy of the lower tarsal conjunctiva; movements and vision are now normal. A daily check was also kept on the white cell count to avoid the possible toxic effects of the sulphapyridine. Lumbar puncture was carried out daily for six days, when it was discontinued as there was no further indications for its employment.

During his illness he developed a mild parotitis on the left side which cleared up with an intravenous injection of calcium gluconate, and he was given chewing gum to promote the flow of saliva. The temperature chart of the case is given.

Discussion.—Such a complication of meningococcal meningitis appears to be very rare. It is not an uncommon complication of septic processes on the face, suppuration in the sphenoidal air cells, inflammation of the jaw or teeth sockets. In the well-known textbooks of medicine such a complication of meningococcal meningitis is not mentioned nor have I been able to trace such a complication in the literature at my disposal. When the case was first seen, discussion arose as to whether the thrombosis was the primary cause of the meningitis following on a possible source of sepsis in the orbit, or whether the meningitis was primary and the thrombosis of the cavernous sinus secondary. This was settled by the lumbar puncture and the demonstration of meningococci in the fluid.

A MOBILE APPENDICAL ABSCESS

By R. D. MACRAE, F.R.C.S.E.
CAPTAIN, I.M.S.
Agency Surgeon, Gilgit, via Kashmir

A YOUNG Mohammedan male was admitted with a history of recurring mild attacks of pain in the right iliac fossa. There had been nausea but no vomiting. After an unusually distinct attack of the pain had come and gone, he sought advice, and an explanation of his symptoms. He walked to the out-patient department.

Examination revealed a furred tongue, a slightly increased leucocyte count, and a tender mass in the right iliac fossa about the size of an egg. The mass was so mobile that it could be depressed towards the pelvic brim, when it could no longer be felt. It moved vertically more easily than laterally. There was no rigidity, no cutaneous hyperæsthesia, no tenderness elsewhere in the abdomen or per rectum, and the psoas test was negative. The temperature was 99°F.

Diagnosis was indefinite, and cystic tumour, or abscess of the appendix, torsion of the omentum, and torsion or partial strangulation of a Meckel's diverticulum were suggested.

The abdomen was opened under spinal anæsthesia by a paramedian incision. The proximal inch of the appendix appeared normal; the rest was hidden in a round, cystic mass of tissue composed of the lower edge of the great omentum. There were only string-like adhesions to the ileum. The mass was delivered into the wound, the adhesions separated, the omentum clamped, divided, and ligated, and then appendectomy completed in the usual way.

The specimen was incised and showed a perforated appendix, surrounded by omentum, which everywhere formed the wall of an abscess containing homogeneous, odourless pus. Recovery was uneventful.

It is surmised that an appendical mucocele became infected by organisms of low virulence, and complete omental adhesion formed before perforation occurred.

A CASE OF CEREBRAL MALARIA WITH RARE COMPLICATIONS AND COMPLETE RECOVERY

By R. M. LLOYD STILL
MAJOR, I.M.S.
Medical Officer, Burma Frontier Force Hospital, Myitkyina

and

RAI SAHIB T. N. LAL, L.M.P.
Burma Frontier Force Hospital, Myitkyina

ON 12th November, 1940, at 7-30 a.m., a Punjabi Mohammedan woman, aged 18 years, was admitted into Family Line Hospital, Burma Frontier Force, Myitkyina, with fever and in a semi-conscious condition.

History.—The patient was reported to have had fever with rigor at 3 p.m. on the previous day.

Temperature on admission 102°F. Pulse—rapid but regular and strong. Respiration—28 per minute.

Examination.—Though the temperature was not very high, patient was rapidly becoming unconscious.

Lungs—clear. Heart—nothing abnormal detected. Liver—not enlarged. Spleen—not enlarged. Urine—catheter specimen revealed nothing abnormal.

Nervous system.—Knee jerks—present but sluggish. Kernig's and Babinski's signs absent. There was no rigidity of the neck. Pupils were equal and reacted both to light and accommodation.

Examination of blood for malaria parasites showed malignant tertian rings and marked mononucleosis.

Patient was given an intravenous injection of quinine gr. x and placed on usual treatment for malaria. At 8 p.m. the same day temperature went up to 104°F. and she became deeply comatose. Pulse was very rapid and weak. She was given four-hourly injections of gr. 1/100 digitalin. Intramuscular injection gr. x of quinine was also given at night.

13th. Temperature fell to 102.2°F. Pulse—110 per minute, weak but regular.

Lumbar puncture was done and cerebrospinal fluid was clear and not under pressure. Blood for Kahn test was negative.

In the evening the patient regained consciousness partially, and began to take notice of her surroundings but was unable to speak. Quinine was given orally and also another intramuscular injection.

14th. In the morning the temperature was 100.8°F. Patient was fully conscious but aphasia was still present. Patient showed by signs that she had headache and also expressed her wishes by signs. She was not incontinent. Another injection of quinine was given and also quinine mixture orally.

15th. Temperature dropped to 99.4°F. Patient was fully conscious, but aphasia was still present. Pulse was regular and of good tension and general condition much improved. On 17th, however, she developed hemiplegia of the right side of the body. Temperature was normal and aphasia was still present. From 17th onwards temperature remained normal. Treatment for hemiplegia with massage, iodides, etc., and also for malaria was carried out and the patient regained the use of her leg on 1st December. On 5th December, she could speak a few syllables though the speech was slurred. She regained the use of her arm on the 10th. From then onwards she improved steadily and was discharged as cured on 22nd December, 1940.

Notes.—(1) This case is reported as it had some unusual and interesting features. Although hemiplegia and aphasia are reported as rare complications of cerebral malaria the two together are very unusual, especially as the aphasis occurred 3 days before the hemiplegia,