fever. For all these financial difficulties they committed suicide.

3. *Remorse and shame* (2 *cases*).—Both the cases have got the same story; they were prosecuted in the Magistrates' Courts on charges of theft and for this they put an end to their lives.

4. *Incurable and painful disease* (5 *cases*).—One of this series of cases was suffering from paralysis for a long time and had hysteric fits off and on; another was suffering from bubo; third one from leucoderma and the remaining two from chronic fevers.

N.B.—In 15 cases of this series, letters or pocket books were left intimating that they died of their own accord, but they did not disclose their reasons for the same. In 34 cases, no causes of suicide could be determined. They were diagnosed as cases of suicide from information supplied by relatives and neighbours of the victims and by coroner's inquest.

ERRATUM

SEROLOGICAL TECHNIQUE

By S. D. S. GREVAL

and

A. B. ROY CHOWDHURY

Page 355, column 1, paragraph 4. Instead of 'Serum o comes from sub-group AB' read 'Serum o comes from group AB'.

A Mirror of Hospital Practice

A CASE OF CARCINOMA OF THE COLON WITH AMŒBIC INFECTION

By R. N. CHAUDHURI, M.B. (Cal.), M.R.C.P. (Edin.), T.D.D. (Wales), F.S.M.F.

and

H. CHAKRAVARTY, M.B. (Cal.)

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In the diagnosis of tropical diseases the laboratory findings are often of greater importance than in that of non-tropical diseases, but great care must be taken that one's clinical judgment is not outweighed by laboratory findings which may be as misleading in some cases as they may be useful in others. In this connection, the following case report will be of interest.

Case report

A man, aged 60 years, was admitted to the Carmichael Hospital for Tropical Diseases on 1st April, 1946, for dysentery. The history was that he was not keeping well for the past six months during which he had been suffering from 'dyspepsia' (constipation and flatulence being the main symptoms) with occasional bouts of fever, and had lost about four stones in weight. The dysenteric symptoms—frequent loose motions with passage of mucus and occasionally blood—were of six weeks' duration. He had been given a course of emetine injections as well as sulphaguanidine but with little or no effect.

On admission he appeared prostrated. The liver was enlarged one inch below the costal margin with normal consistency. A small ill-defined somewhat irregular mass was palpable in the left hypochondrium which could be easily pushed under the costal margin like a palpable spleen. The abdomen was soft, and there was no tenderness. Digital examination of the rectum showed no abnormality.

Laboratory findings.—The blood examination showed a white cell count of 9,100 per c.mm. The red cells were 4.2 million per c.mm. and hæmoglobin was 8.8 gm. (64 per cent). Stools : *E. histolytica* trophozoites were found once in a serial examination for four consecutive days. The test for occult blood was positive. Gastric analysis showed a low acid curve.

X-*ray examination.*—A barium meal series were taken and the radiologist's opinion was 'colitis and appendicitis'. But there were certain other peculiarities which could be distinguished : The ten-hour picture (*see* figure 1, plate XXIV) showed a distended transverse colon with horizontal fluid level of the meal. The 24-hour picture (*see* figure 2, plate XXIV) revealed a segment of 'defective filling' beyond the distended transverse colon while the meal had passed distal to this segment into the large gut of more or less normal calibre. After 48 hours an irregular residual shadow of the meal was seen held up in the segment where there was the 'filling defect' (*see* figure 3, plate XXIV).

Diagnosis.—Considering the age of the patient, the history of the case, the clinical findings and the unusual radiological findings, we suspected a neoplastic condition of the transverse colon and transferred the patient to the Medical College Hospital where he was operated on by Major Andreasen. The tumour was found to be cancer involving a segment of the transverse colon and was adherent to the stomach wall. It was removed along with a portion of the stomach. Histologically the tumour was found to be adenocarcinoma of the colon.

The patient died of congestive cardiac failure a few days after the operation.

Discussion.—The case is of considerable interest as it presented the combined features of amœbic infection and cancer of the large bowel. In the practice of tropical medicine it is common to encounter multiple infections in the same patient, and it is therefore not always safe to attempt and trace all the signs and symptoms to a single infection or pathological process. A diagnosis of 'amœboma' of the colon might have explained practically all the features of this case, but the history of the case and of failure to respond to emetine injections led us to think of a neoplastic condition. The case also illustrates the fact how the true diagnosis may be missed if one depends only on

PLATE XXIV

A CASE OF CARCINOMA OF THE COLON WITH AMŒBIC INFECTION : R. N. CHAUDHURI AND H. CHAKRAVARTY.
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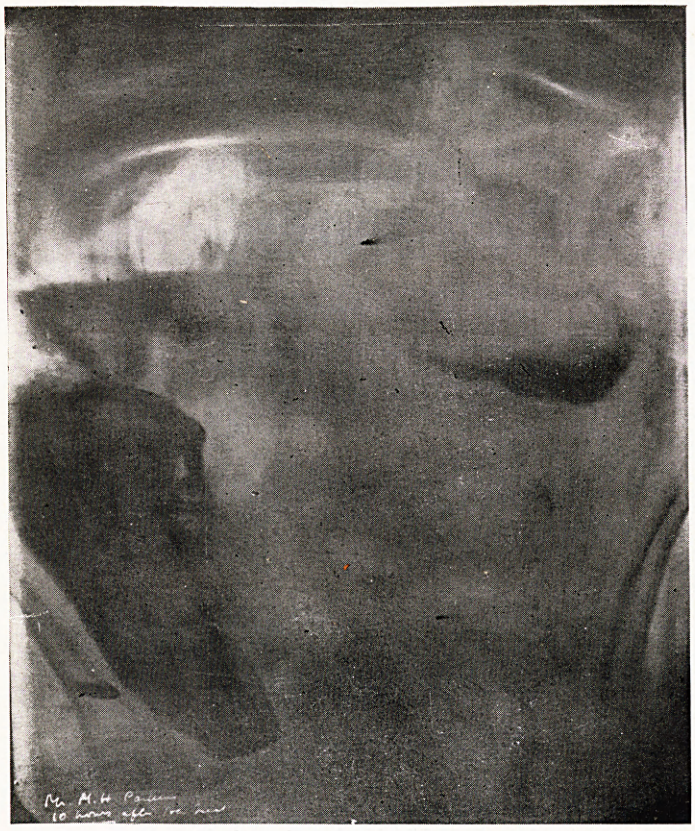

Fig. 1.

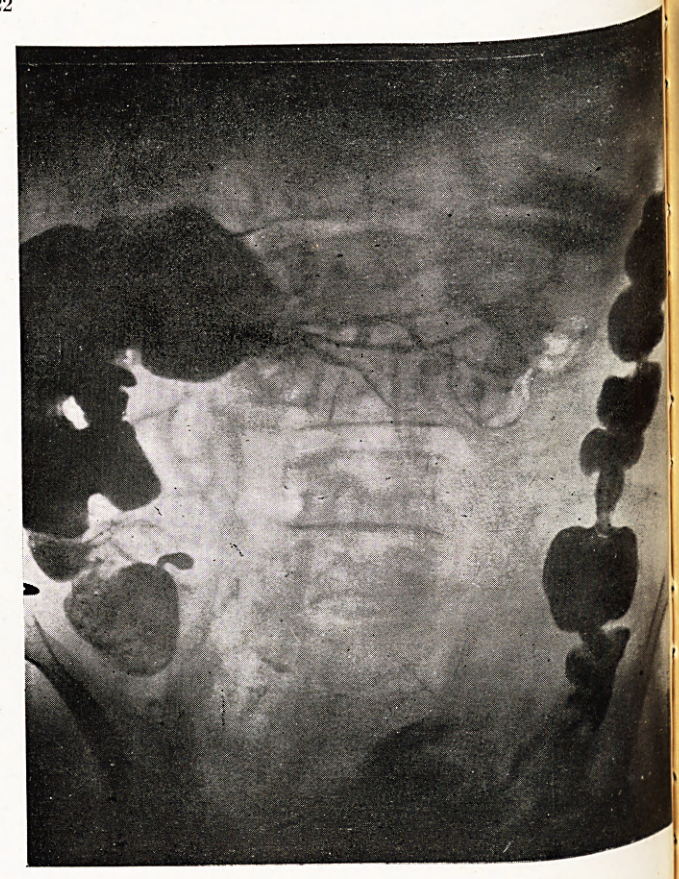

Fig. 2.

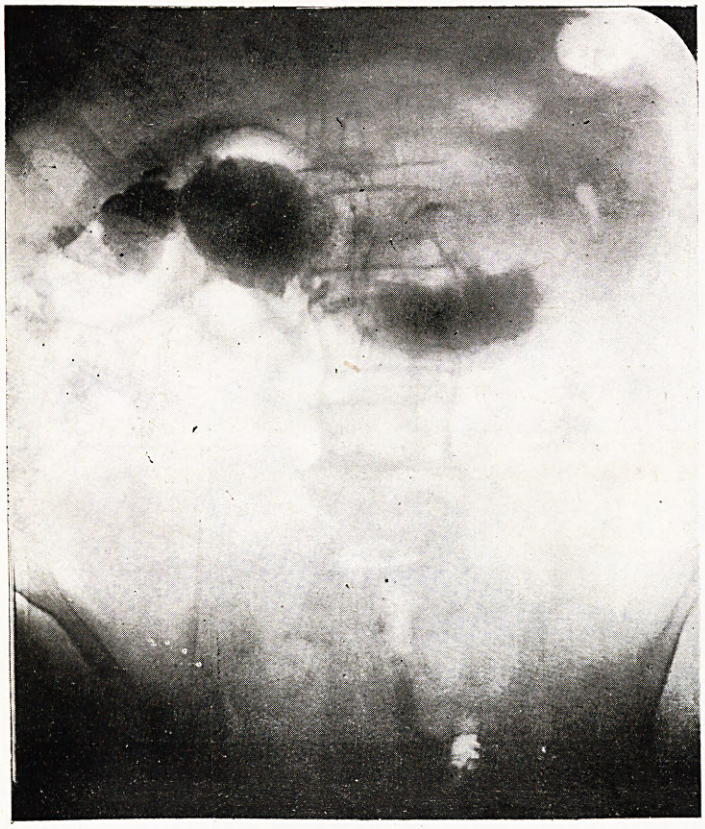

Fig. 3.

A CASE OF SUBCUTANEOUS EMPHYSEMA : L. H. VISSCHE
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Photograph showing the swelling of upper part of the body.

the radiological report disregarding the clinical observations. The tumour in this patient was operable and was removed successfully, but the senile heart ultimately gave way.

Acknowledgments

Our thanks are due to Major A. T. Andreasen, I.M.S., Professor of Surgery, and to Dr. B. P. Tribedi, Professor of Pathology, Medical College, Calcutta, for the operation and the histological report respectively.

A CASE OF SUBCUTANEOUS EMPHYSEMA

By LOIS H. VISSCHER, M.D.

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The patient, a Hindu male aged 18 years, was admitted to the hospital on 10th April, 1945, complaining of a swelling of the upper part of his body, and of difficult breathing. The history was that he had been perfectly well and able to work, free from cough and fever, until six days previously, when he had first noticed symptoms of a 'cold' with slight cough and fever. On the same day he began to complain of mild pain on both sides of the chest; also on that day he first noticed slight swelling of the upper part of his body. In the course of the day the chest pain rapidly increased in severity; two or three days later it subsided. The swelling of the upper part of the body progressed steadily in extent and degree. Two days before admission he began to have difficulty in breathing. On the day of admission, during the ox-cart ride to the hospital, his face became so swollen that his right eye was closed (*see* photograph, plate XXIV). His dyspnœa also became severe.

Past history was not obtainable; the patient was too dyspnœic and his companions were not members of his immediate household.

Physical examination revealed a well-developed, well-nourished young man, acutely ill, with laboured respirations. He was crouching in a frog-like position, trunk bent forward. He spoke in a hoarse voice, with great difficulty. He coughed frequently, raising a thin, frothy, greenish sputum. His face and neck were very swollen, as in severe nephrosis. His arms and upper trunk were also swollen, but the legs and the lower trunk were normal in appearance. Palpation revealed much subcutaneous crepitation in all the swollen areas. Temperature 101.6°F. (oral). Pulse 120. Respiration 28. Blood pressure 120/80. Chest: respirations rapid; expansion appeared equal; no supraclavicular retraction and no use of accessory muscles of respiration; chest resonant throughout, with suggestion of 'crack-pot' resonance on the left side. Vesicular breath sounds were heard throughout, but fainter on the left side. The crepitation of the subcutaneous air beneath the stethoscope prevented auscultation. Heart: apex beat palpable in the sixth interspace, two inches within the nipple line. Right border behind sternum. Rate rapid. Tonus strong. Impossible to auscultate. The rest of the physical examination was negative.

Laboratory report: urine showed one plus albumin, one plus pus cells; otherwise negative. Blood: 70 per cent Hb (Sahli); R.B.C. 2,600,000; W.B.C. 9,000; differential: polymorphonuclears 74 per cent, lymphocytes 15 per cent, large monocytes 11 per cent. Sputum: no acid-fast bacilli found in the one specimen examined.

X-ray of the chest showed many subcutaneous tissue planes outlined by gas; partial left pneumothorax with 20 per cent collapse; diffuse mottling throughout both lung fields, interpreted as advanced bilateral tuberculosis.

A hypodermic needle was put into the distended subcutaneous tissues of the neck, and about 50 c.cm. of air was aspirated with difficulty. The air was not under pressure, and did not seem to be collected in any large pockets. Left thoracentesis was done (with artificial pneumothorax apparatus), and the intrapleural pressure was found to be negative during inspiration, and positive during expiration. After about 1,000 c.cm. of air was withdrawn with difficulty the interpleural pressure became negative during both inspiration and expiration. However, these aspirations did not at all relieve the patient's dyspnœa or discomfort.

The patient remained critically ill with rapid pulse and respiration. He was very apprehensive. He insisted on crouching on his knees, with his trunk bent forward. He was given 25 c.cm. 25 per cent glucose intravenously every eight hours; also 1 per cent ephedrine nose-drops every four hours, in the hope that he might inhale a little. (No spray apparatus available, and no oxygen available.) He received chloral and bromide mixture every four hours, but did not sleep, or get relief from his apprehensiveness. His condition remained unchanged for the first 24 hours; then the pulse rate rose to 130 and the respiratory rate to 34. Again small amounts of air were aspirated from the neck tissues without any relief of symptoms. Since he had had no sleep for at least 48 hours, the patient, 36 hours after admission, was given morphine sulphate grains 1/6. He immediately fell asleep; the respiratory rate dropped to 20; the pulse decreased to 80, and became weak. Caffeine sodium benzoate was injected. Forty-five minutes after receiving the morphine, the pulse rate was 64 and the respiratory rate 12. Fifteen minutes later the patient expired.

Obviously he should not have received the morphine. The question remains, what form of therapy might have offered some chance of saving his life. Tracheotomy was frequently considered, but rejected because there was no supraclavicular retraction, or other evidence of