for one and a half years, by which time the patient was reduced very much. He used to weep most of the time. Treatment for insanity was given without any appreciable effect. The patient was a government servant so he had to appear before a medical board for invalid pension, but a member of the board, an eye-surgeon, finding the condition of his teeth and gums very bad suggested complete dental treatment. The patient was referred to me when the following conditions were noted :—

Teeth.—Lower left third molar badly decayed and not in good position. Lower right third molar impacted and the *x*-ray examination showed it badly pressing against the second molar, but the patient had no complaint.

Gums.—Spongy, bled easily and in upper right 1 and 2, and upper left 1 and 2 badly pyoratic with receding gums.

Lymphatic glands were not enlarged, thyroid normal in size, both lobes symmetrical.

Smears from gums showed numerous pus cells, many epithelial cells, considerable mucus, Vincent's spirilla and fusiform bacilli.

Blood picture.—R.B.C. 4,110,000; W.B.C. 11,800; hæmoglobin 78.

Urine.—Acid reaction; specific gravity 1.009; no sugar or albumin, a few cells of squamous and round epithelium.

The clinical examination and laboratory data indicated Vincent's infection of teeth.

Following recommendations were made :—

1. Increase in caloric and vitamin content of his dietary.
2. Increase in consumption of water to 8 to 10 tumblers (for 2 to 3 he used to consume).
3. A tonic in the form of nux vomica x before meal.

One and a half months later another culture from the gum was done and the following was the additional report :—

Upper gums.—Practically a pure culture of *Streptococcus viridans* with a few colonies of *Staphylococcus albus.*

Lower gums.—*Streptococcus viridans* in pure culture.

Final diagnosis was streptococcal stomatitis.

Routine treatment for the above disease was given for 3 weeks, then the impacted tooth was extracted under nitrous oxide gas, so also the upper 4 teeth and the decayed lower left third molar (2 teeth at a time). During the course of the treatment the patient was improving and after the completion of the whole dental treatment was practically normal. Four weeks after this the patient became absolutely normal and joined the service again.

Oral sepsis is one of the most prevalent sources of nervous disorders although it does not always produce disturbances of this nature until the resistance of the patient is lowered by age, malnutrition, pregnancy, influenza, exposure, grief, worry or fear.

ERRATA

PENICILLIN THERAPY COMPARED WITH SULPHONAMIDE THERAPY IN CEREBRO-SPINAL FEVER

By S. G. VENGSARKAR, V. C. MANKODI and D. D. VAIDYA

(*I.M.G.*, **81**, 1946)

On page 113, column 2, line 39, substitute 'for' by 'in'.

On page 114, column 1, lines 46-47, substitute 'sodium sulfadiazine 50 c.c. of 25 per cent strength' by 'solution of 2.5 gm. of sodium sulfadiazine diluted to 50 c.c. with distilled water or glucose solution (50 c.c. of 25 per cent strength)'.

On page 114, column 1, lines 58-59, after '2.5 gm. after 24 hours' add 'and repeated as required thereafter'.

On page 115, column 2, lines 25-26, substitute 'in the group' by 'in the penicillin group'.

TREATMENT OF ORIENTAL SORE BY *X*-RAYS

By G. PANJA

(*I.M.G.*, **81**, 1946)

On page 251, column 2, line 20, for 'an inch' read 'a millimetre'.

A Mirror of Hospital Practice

A CASE OF NEUROMYELITIS OPTICA

By M. N. DE, M.B., M.R.C.P. (Lond.), F.S.M.F., F.N.I.
Professor of Medicine and First Physician, Medical College Hospitals, Calcutta
and
JYOTSNA RANJAN CHATTERJEE, M.B.
Research Assistant under the Professor of Medicine, Medical College Hospitals, Calcutta

A YOUNG, married Hindu lady, 22 years old, came to the out-patients department of the Eye Hospital, Medical College, Calcutta, on 27th February, 1946, with the following complaints : Since 20th February, 1946, she noticed dimness of vision in the right eye which rapidly became completely blind. Two days later, the left eye was affected which also became blind within two days. On enquiry she said that she had been suffering from slight intermittent fever with frontal headache since 18th February, 1946.

Past history.—Malaria one year ago, kala-azar 6 months ago for which she took one course of antimony injections. No history of syphilis. Married seven years. Two healthy children, the last child being two years old. No history of abortion.

Subsequent course.—She complained of a dull ache in the lumbar region and felt difficulty in emptying the bladder. For this reason she was admitted into the hospital. On the day of admission she complained of extreme weakness of the right lower extremity and moderate weakness in the left.

Examination of the eyes revealed the following : No perception of light. Pupils widely dilated and not reacting to light. Papillitis both eyes but more extensive in the right. Other cranial nerves normal. Motor power : complete loss of power in the right lower limb and paresis in the left. Power in the upper limbs normal. The muscles of both lower limbs hypotonic. No atrophy, fibrillation or tremors.

Reflexes.—Knee and ankle jerks absent on the right side but present on the left side. Biceps, triceps and supinator jerks normal on both sides. Babinski's sign positive on both sides and superficial abdominal reflexes absent on either side.

Sphincters.—Involved, there being retention with overflow incontinence. Constipation, very marked.

Sensations.—Not impaired.

Her blood pressure was 98/70 mm. of Hg. She had slight fever. She was transferred to the ward of the senior writer on 2nd March, 1946. On examination it was found that in addition to the loss of power in her lower limbs her lower intercostal muscles, specially of the right side, were also affected causing some respiratory distress. Knee jerks were lost on both sides, ankle jerks were absent on the right side but diminished on the left side. Tendon jerks in the upper limbs were normal. Babinski's sign was positive on both sides. Superficial abdominal reflexes were lost on both sides, skin sensations were impaired in the right lower limb and right half of the abdomen extending up to the level of 8th thoracic segment. Joint sense and co-ordination were normal.

She had to be catheterized regularly and constipation was relieved by enema. Spleen was just palpable. Temperature 99°F., P/P 90/22 per minute.

Blood examination :—

W.B.C.	.. ..	8,750 per c.mm.
Polymorphonuclears	..	62 per cent
Lymphocytes	.. ..	26 „
Monocytes	.. ..	2 „
Eosinophils	.. ..	10 „
Blood urea	.. ..	44 mg. per cent
Non-protein nitrogen	..	40 „ „
W.R.	.. ..	Doubtful

Urine examination :—
Albumen present.
Fair number of pus cells.

Lumbar puncture on 5th March, 1946 :—
Clear.
Tension normal.
Total protein 55 mg. per cent.
No increase of cells.
Langes' colloidal reaction paretic type (5555321000).
W.R.—Doubtful.

Subsequent progress of the case.—From 14th March, 1946, her condition began to improve. The motor power of the left lower limb recovered first and then that of the right. The sensation returned earlier in the right lower limb. On 26th March, 1946, she could count fingers; power in the right lower limb returned. Her knee and ankle jerks became exaggerated on both sides. Babinski positive on both sides. During the convalescence period she developed a *B. coli* infection of the urinary tract which however was promptly controlled by hexamine. A slight bed sore developed in the buttocks but healed up very quickly. On 18th April, 1946, she could walk without support and see things of different colours. Fundus showed optic atrophy following optic neuritis on both sides. The patient was discharged on 30th April, 1946, at her request with marked improvement in her nervous system and complete recovery of sphincter control. She however complained of haziness of vision.

In the hospital she was put on heavy doses of vitamin B_1 injection and an iodide mixture.

Although transverse myelitis leading to paralysis of both the lower extremities is fairly common, the simultaneous involvement of the spinal cord and the optic nerves is met with occasionally only. Such a clinical condition develops in an acute demyelinating disease called neuromyelitis optica which is very much akin to disseminated sclerosis in its pathological process but differing from the latter clinically by simultaneous involvement of both the eyes leading to complete and permanent blindness and also the spinal cord followed by complete paraplegia. In the majority of cases the disease is fatal. The blindness is due to the development of bilateral retrobulbar neuritis which may precede the myelitis by a variable period or vice versa. The paraplegia is due to the development of an inflammatory plaque producing demyelinization of the fibres of the spinal cord.

The writers offer their thanks to Captain E. J. Somerset, I.M.S., Professor of Ophthalmology, Medical College, Calcutta, and also to the Superintendent, Medical College Hospitals, Calcutta.

AN ATYPICAL CASE OF MEASLES

By B. B. RAI, M.B., B.S.
Divisional Surgeon, St. John Ambulance, Bareilly

I WAS called in to see a case of a healthy young boy of ten, on the evening of 10th May, 1946, who suddenly started diarrhœa.

There was no particular history except that he had passed a few loose motions. Of course, he complained much of griping. He was on ordinary indigenous drugs and was given *khichri* in diet. The stools contained much of fæcal matter. The temperature of the patient was 100°F. Next morning the frequency of the motion increased, and stools contained blood-tinged mucus. Griping was very agonizing. The temperature shot up to 103°F. and came down to 99°F, next morning. This trend of temperature continued up to the seventh day. He was put on kaolin and bismuth with castor oil. Next day he was put on sulphaguanidine. He did not show any appreciable improvement. On the other hand restlessness and griping increased. The tongue was heavily coated, and was bright red in colour at the edges. Later on, it was suspected to be a case of typhoid fever, diarrhœa being a complication. Tenesmus and frequency of motions (blood-tinged mucus) did not diminish. In view of severe tenesmus, temperature 103°F. and blood-tinged stools consisting of mucus mostly, I suspected the possibility of infective colitis and put him on cibazol with glucose. After two days there was some relief in tenesmus and stools. On the eighth day to my surprise his face disclosed a rash similar to sulphonamide rash. Next day, there was cough, eyes were congested and watery and the rash appeared on the whole body and it was a frank case of measles. On the fourth day the temperature went down, motions and tenesmus stopped. The patient was fed on orange juice and no medicine was given after the appearance of rash.