pancreatic fluid passed would digest this and leave the skin alone.

The patient gradually put on weight and eventually took his discharge with still a small sinus left from which fluid oozed away.

I again saw the man in October 1908 and found him quite fit with the sinus completely closed up. In fact, so fit and fat was the man that I should never have recognised him.

Unfortunately the fluid from the cyst was thrown away before it could be examined.

For permission to publish this case and for the pleasure of assisting him at the operation I have to thank Colonel Thompson, I.M.S.

TWO CASES OF STREPTOCOCCAL INFECTION.

BY STEELE HAUGHTON,

LIEUT. I.M.S.,

Officiating M. O., XVth Sikhs, Nowshera.

THE following notes on these two comparatively rare cases may, I think, prove interesting to some of your readers :—

Case I.—Havildar Memha Singh, XVth Sikhs, came to Hospital on 31st October 1908, complaining of acute pain in both eyes.

On 29th October 1908, *i.e.*, two days prior to my seeing him, he had a little pain in the left eye, and the following day the eyelids of both eyes became swollen and painful, but he did not think it necessary to report sick as he had often had slight conjunctivitis before.

CONDITION AT TIME OF ADMISSION.

Left Eye.—Both eyelids very swollen and puffy with a yellowish discharge; on opening the lids conjunctivæ everywhere bright red with a good deal of chemosis.

The cornea had a granular appearance and there were large patches of infiltration and ulceration.

Pupillary opening was only partially visible and patient was unable to see objects, but light was just perceptible.

Right Eye.—Less swelling of lids with chiefly a watery discharge-some pus. No chemosis, but great vascularity of bulbæ conjunctivæ on inner side especially, cornea showed small patches of infiltration all around the periphery with a certain amount of superficial ulceration. Region of pupil free from inflammation. No iritis.

In both eyes.—Great pain, marked photophobia, tension normal.

I thought the case was one of gonorrhœal infection, but the man had no gonorrhœa and a microscopical examination of the discharge revealed streptococci in abundance.

The case differed somewhat in appearance from gonorrhœal ophthalmia, in that the discharge was more watery and the chemosis not nearly so marked as is usually seen.

Treatment.—After prolonged irrigation, I put Calomel gr. 5 into each eye, atropine, cocaine, and placed him in a darkened room.

Following this irrigation with Hg. lotion two or three times a day, painting with Ag No_3 gr. 10 to ℥i daily, atropine and yellow oxide ointment.

At first the pain was very acute, but after this recovery progressed slowly but steadily.

He was discharged after three months, the right eye having completely recovered and with the left perception of light and ability to count fingers at 2 feet.

Case II.—Recruit Ishar Singh, 31st Punjabis. This boy walked to Hospital on morning of 24th January 1909 at 10-30, complaining of fever and headache which only started the previous evening. His temperature was 103·8°.

I did not see the case till 11-30 same morning when he was only semi-conscious, very cyanosed, with great difficulty in breathing which was fast, very loud and noisy; in fact, the case presented all the appearance of acute laryngeal obstruction.

I performed tracheotomy at once, but it gave no relief, indicating obstruction lower down.

Artificial respiration was also of no avail. I then opened the left basilic vein, but not more than ℥i of blood flowed out, which was very thick and dark.

The boy gradually sunk and died at 12 o'clock. The *post-mortem* revealed—

1. *Heart.*—Normal in every respect.

2. *Lungs.*—On both signs of old-standing interlobar pleurisy, very congested, especially lower lobes and a peculiar semi-crepitant feeling on squeezing tissue between the fingers.

On section the lungs were found to be full of fluid (frothy) much mixed with blood; the fluid was so abundant that it trickled away at once from the cut surfaces.

There must have been several pints of fluid in each lung.

No patches of consolidation.

3. *Œsophagus. Larynx.*—Normal.

4. *Trachea.*—From about 2″ below larynx and extending into bronchi and bronchioles the lining membrane was very congested with numerous petechial patches, more extensive the further into the lung one went.

5. *Abdominal organs.*—With exception of spleen which was slightly enlarged all the organs were normal.

6. Smears taken from cut surface of the lungs and examined microscopically showed streptococci in large numbers. In this case the boy died from asphyxia due to being practically drowned by the exudation of fluid from the lung tissues into the air vesicles.