

the latter in several cases with marked beneficial results. Of the Potash salts the nitrate has been found more useful than either the citrate or the acetate. I have seen good results produced by oil of turpentine in drop doses, and the beneficial effect ascribed to Treak Farook depends, I believe, on the turpentine present in it. The following mixture with or without Tincture of steel, as the case may be, has been used by me with success in a great many cases: Vin colchici ℞v., Tr Digitalis ℞v., Ipecac. Pulvis gr. ½, Potas nitras gr. xv., Spt. Ether. nit, ℞xx., Aquæ one ounce, 4 times daily. Ammonia with bark, as also a small allowance of brandy, have been found useful at the later stages with constant cough, great respiratory difficulty and growing exhaustion. Dry cupping over the base of the lungs gives great relief to the sufferers, but the application of blisters has been observed to produce most troublesome ulcers, the vitality of the skin being almost lost. I should mention here the efficacy of two native medicines observed by me while in Madras. Both of them are small plants growing in marshy places, the one named *Belliavaram* and the other *Azarevaram*, both belonging to the natural order Leguminosæ, brought to my notice by a non-professional native who has got a considerable experience of the disease. I have used the powder of the bark of the root and the tincture made from it with gratifying results in several cases. As regards food, I have found light nourishing diet better suited to the majority of the cases. In those cases in which there was any taint of scurvy present I have often given limes at the rate of 2 to 3 a day with benefit.

9th March 1880.

CHOLERA FEVER.

BY SURGEON J. A. GREENE, M. D.,

Civil Medical Officer.

Mr. J. T., a resident of Serampore, and subject to periodical attacks of intermittent fever, was seized with ague on the morning of the 22nd October 1877; simultaneously with the ague fit severe vomiting set in, the vomited matters at first consisted of bile, afterwards of watery fluid. The ague fit lasted about one hour, then fever set in; about 3 P. M. purging commenced with severe griping, the first evacuations were watery and of brownish colour; later on they became copious and of the colour of rice water; at 5 P. M. whilst on the commode, passing a copious watery motion, he fainted. I was then called in and found him lying with his eyes half closed; extremities cold; pulse thready and at times almost imperceptible; breathing regular though quickened; voice husky; lips and nails livid; features livid, pinched and shrivelled; tongue covered with a white fur, red at tip and edges, and cold to the touch; temperature in axilla 100°. The motion just passed consisted of bloody serum with white flakes: passed no urine since 2 P. M. An acid mixture with chloric ether was prescribed every two hours; alternately with this iced jug soup was given, a mustard poultice was applied to the epigastrium, and he was allowed to suck ice as the thirst was incessant, and the

recumbent position was strictly enjoined. Next morning I found him better; temperature in axilla 99°; pulse 100, soft; passed urine once and had two scanty stools during the night, the stools consisted of bloody serum. The same treatment was continued at longer intervals; the next day he was able to sit up, and the bowels had not been moved, though he had passed urine freely; quinine was given and repeated daily with plain and nourishing diet; in a week he was able to resume his duties as a police officer.

On the 23rd November following he had a relapse: this attack was also ushered in with a severe fit of ague, followed by heat of skin, vomiting and purging; the evacuations consisted of bloody serum with white flakes; thirst was very urgent; pulse thready; prostration rapid; cramps of the extremities; voice husky; features shrivelled and livid; eyes half closed; urine suppressed. Under the treatment employed in the first attack he gradually recovered, though he was so weakened that he could not resume his duties, and left the station for change to the North-Western Provinces.

On the 15th October 1877 I was called to see a lady residing on the river bank 5 miles from Serampore, she had a severe fit of ague accompanied with incessant vomiting, fever followed with copious motions of bloody serum mixed with white flakes; thirst was urgent; voice husky; pulse thready; features livid and pinched; urine suppressed; cramps of the extremities, whilst the temperature in the axilla was 101°: the hands and feet were icy cold and clammy. The same treatment was adopted as in the last case, and she recovered. In the middle of the following November she had a relapse with a repetition of the same symptoms, and recovered under similar treatment. After this attack she removed to Calcutta, where the attacks recurred periodically, ultimately ending in death.

During the latter part of October 1877 there was an outbreak of cholera in the village of Connagur 4 miles down the river from Serampore; several of these cholera patients were admitted into the Serampore Charitable Hospital, and in all of them I noticed bloody stools, but I could not ascertain whether the attacks were ushered in with ague and fever.

Whilst Medical Officer of Tipperah, I saw two cases of this disease. The first was a prisoner in the jail, who was admitted to hospital one morning suffering from strong fever, headache, costive bowels, tongue thickly coated with a creamy fur. I ordered him 2 ounces of Senna mixture to be followed by simple diaphoretic mixture; on my evening visit to the hospital I was astonished to find the man sinking, passing motions involuntarily, consisting of a brownish, watery and highly offensive fluid; muttering delirium, body warm, covered with profuse perspiration, extremities icy cold, no pulse perceptible at wrists: this case terminated fatally. A few days after the above a Constable of the Police force was admitted into the Police Hospital, suffering with strong ague, followed by fever and accompanied with vomiting and purging of rice-water fluid: this man was treated for cholera and recovered.

I have often thought over these cases; were they cases

of cholera or fever, or a mixture of the two diseases which may be called cholera fever? I believe them to have been cases of cholera fever, the two poisons being mixed up, but that of cholera predominating. Dr. E. Goodeve, in his able article on Cholera in Reynolds' System of Medicine, 1st edition, describes a disease called cholera fever, he says: "In Calcutta one frequently meets with fevers which begin with diarrhœa. I have elsewhere mentioned this as frequently ushering in the red fevers sometimes prevailing there, and it is not unusual for some of the common fevers of children to begin in this way. It is probable that some of these happening to prevail during cholera times, are influenced by the epidemic constitution of the atmosphere. It is not likely that the fever is a variety of cholera."

Sir Ranald Martin, in his work on "The Influence of Tropical Climates on European Constitutions," describes an epidemic of cholera fever which occurred in Calcutta in 1834, he gives the symptoms as heat and dryness of skin, frequent pulse, clammy white tongue, and generally a slight diarrhœa. Further he says, "So mild a fever I seldom recollect to have seen, yet it was most dangerous to treat, the irritable condition of the bowels which formed so prominent a symptom of the epidemic, being readily aggravated into fatal cholera whenever purgatives of a saline nature were exhibited."

Surgeon-Major Curran, A.M.D., in his exhaustive and interesting account of Peshawur Fever, published in the *Indian Annals of Medical Science* for July 1876, defines Peshawur fever as "a specific paroxysmal fever, which begins with a feeling of superficial chilliness or general rigors, and lasts from one to twenty-four hours, or more. Its outset induces great constitutional anxiety and depression, and its progress is characterised by much gastric irritability, frequent watery, bilious or blood-stained stools, cold clammy surface, cramps of the extremities, and other symptoms that simulate cholera. Its termination is by resolution or collapse, and recovery from it is generally rapid, and almost always without febrile reaction. The cerebral sensibility though often diminished, is rarely suppressed, and the most striking pathological features disclosed by death are congestion of the brain, lungs and, to a lesser degree, of the liver and other abdominal viscera."

In a foot-note of the same article, page 273, Dr. Curran remarks, "a friend to whom I had applied for aid in this investigation, after pleading his inexperience and want of literary culture, adds, 'but I must tell you one thing, and it is my firm opinion that cholera and Peshawur fever are identical, they are one and the same thing, and the number of cases decides which one it is pronounced to be; should a few cases only occur, it is called Peshawur fever, but should twenty or thirty cases occur, medical officers call it cholera.' Since leaving Peshawur, I have thought a good deal about it, and last summer at Dinapore I saw cholera cases, and I compared them in my mind; and I feel sure if these cases had occurred in Peshawur, they would have been called Peshawur fever, for the symptoms were exactly the same."

In comparing the symptoms of Peshawur fever with

the symptoms of the two cases I saw at Serampore, the disease will be found identically the same. I treated three of my cases for the graver disease, cholera, and they recovered; the one I treated as a case of fever, died. It will be seen from Dr. Curran's paper that in Peshawur the disease is treated as fever, and the mortality is unusually high, would it not be therefore advisable to try the other tack (to use a nautical phrase) and treat the so-called Peshawur fever as cholera? for cholera or its twin brother I consider it to be undoubtedly.

Serampore, 31st January 1880.

PRECIS OF OPERATIONS PERFORMED IN THE WARDS OF THE SECOND SURGEON, MEDICAL COLLEGE HOSPITAL, DURING THE YEAR 1879.

By SURGEON-MAJOR K. McLEOD, A.M., M.D.,
Professor of Surgery, Calcutta Medical College.

[Concluded from page 96.]

Amputations for disease.

7. *For malignant disease of the arm.*—Hindu male, æt. 42. Severe burn of left arm and forearm at 6 years of age; epithelioma commenced two years ago, involved periosteum of inner condyle and fascia covering origins of muscles. Amputation antiseptically of lower third of arm by modified circular plan. Healed by primary adhesion. Discharged in 18 days. This amputation pursued a typical antiseptic course notwithstanding that, owing to tight bandaging, the stump cavity became distended with venous blood, and it was necessary, on the third day, to open the wound and remove the clots which were creating tension and some constitutional disturbance; these disappeared immediately on removal of the tension.

8. *For malignant disease of the forearm.*—Hindu male, æt. 50. Epithelioma of wrist following injury sustained one year ago. Amputation by modified circular plan at upper third of forearm; antiseptic; primary union. Discharged in 25 days.

9. *For caries of the tarsus.*—Hindu male, æt. 40; 2 years' duration: health bad. Extensive caries of tarsus and lower end of tibia and fibula. Syme's amputation; died of pleurisy in six days.

Of the four fatal cases of amputation two died of the combined effects of the injuries sustained and operation performed. In the third, the operation was performed as a last resort in a man whose health had been shattered by dissipation, and who was suffering from delirium when the amputation was done. The fourth was also a bad subject, exhausted by long-continued disease. In none of the amputations did septicæmic symptoms arise, and those which were treated under strict antiseptic precautions recovered as rapidly as it is possible for amputations to recover.

VI. A. 1. *Scirrhus of mamma.*—Hindu female, æt. 40. One year's duration; left axillary glands extensively diseased. Breast removed and glands extirpated. Died of pleurisy in five days. Antiseptically performed, but became putrid.