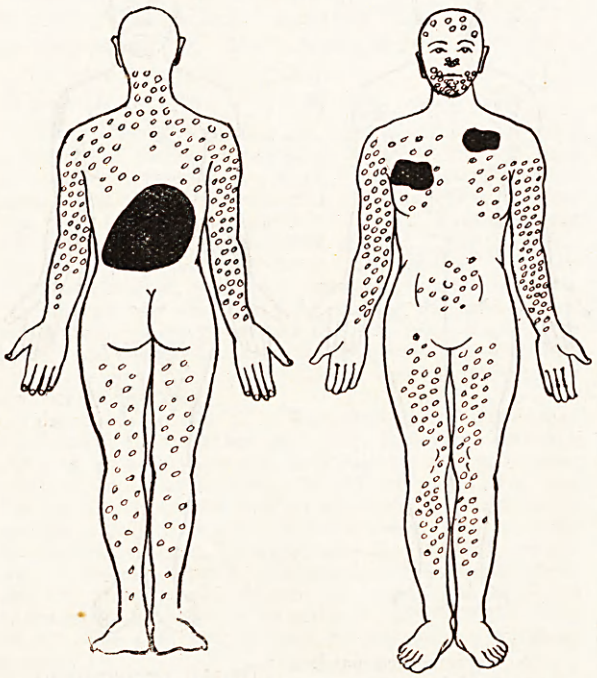
a history of fever and cancrum oris. If this area can be taken as a fair sample of Bengal—and there is no reason to suppose that it is not—we can calculate that there are about

Case 3.



o Depigmented patches
x Nodules
Leprotic lesions black.

Dermal Leishmaniasis.

30,000 cases of this condition in the province. Looking at it from another point of view, about a million patients have been treated for kala-azar in the hospitals and dispensaries in Bengal during the last six years; calculating at the rate of 0.75 per cent. amongst the treated and an equal number amongst the untreated (see Acton and Napier, 1927) by this method we arrive at the figure of 15,000 cases of dermal leishmaniasis in Bengal. In view of the number of cases seen at the School it seems likely that the former figure is nearer the truth. Let us estimate it roughly at 1 in 2,000 of the total population, 46½ millions.

There are probably about half a lakh of lepers, or roughly 1 per 1,000 of the total population, so that were there no ætiological relationship between the two diseases the chances against both diseases appearing in the same person would be about 2,000,000 to 1. This chance is further reduced by the fact that in the districts where leprosy incidence is high, e.g. on the lower slopes of the Bihar plateau, the incidence of kala-azar is extremely low, and *vice versa*.

In view of the fact that three totally unconnected cases were seen in one morning, we must assume that either our calculations are gravely wrong, or that there is some ætiological connection between the two diseases. Our calculations were altogether unscientific and subject to at least a ten-fold error, so that we must admit that the former is the more likely solution.

It is now nearly a year since these patients were seen, and only one other patient with the combined conditions has been encountered. This patient, an obvious leper, was sent by an outside leprosy treatment centre to the kala-azar department for our opinion regarding some nodules on the face; these proved to be due to leishmania infection.

Reference.

Acton, H. W. and Napier, L. E. (1927). Post-Kala-Azar Dermal Leishmaniasis. *Indian Journ. Med. Res.*, Vol. XV, p. 97.

TABES DORSALIS IN AN INDIAN.

By MOHAMMAD YUSUF,

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In view of the fact that tabes dorsalis is extremely rare in India, the following case seems to merit a description.

X., a Hindu male, aged 55, was admitted to the Mayo Hospital on 15th November, 1928.

Complaint.—Loss of the proper use of arms and legs. Duration 3 years.

History.—Contracted syphilis at the age of 20; treatment indifferent. Married 3 years later. Wife had six pregnancies, 3 terminated by abortion and 2 by still-births at full term. One child, aged 8 years, living.

About 3 years ago he noticed a difficulty in carrying out his usual work of weighing heavy articles with an Indian pair of scales. The disability gradually progressed to the present condition when he has difficulty in taking his food even A difficulty was noticed with the use of his legs and it has gradually and steadily progressed. A particular difficulty is felt in walking in the dark.

On interrogation he gives a very clear history of lightning pains of several years' duration.

Examination.—Mental functions normal.

Right Eye.—Disc hazy, pupil smaller than the left and irregular in outline; reaction to accommodation present, to light abolished. Involuntary ptosis of the upper lid, volitional movement being possible.

Left Eye.—Argyl-Robertson pupil *

Upper and Lower extremities.—Motor power fairly good; sensation intact; tone, normal.

Reflexes.—Deep ones abolished. Plantar reflex brisk and flexor in type. Ataxia, very marked. Sense of position of limbs in space defective. Vibration sense intact.

Trunk.—Motor power, nothing special. Sensation: A band of anæsthesia to light touch was noticed in the lower part of the chest and over the scrotum and round about the anus. The glans penis was found to be insensitive to pin pricks. But these features were inconstant and subsequent examinations were negative. Abdominal reflexes brisk. Tone of the back muscles, nothing special.

Sexual functions.—Impotent. Bulbo-cavernosus reflex lost. Sphincters, action normal.

Wassermann reaction both in blood and cerebro-spinal fluid strongly positive.

He was put on anti-syphilitic treatment, but made no improvement and left the hospital.

* This report was furnished by the ophthalmologist.

Discussion: The positive features may be summed up thus:

(1) Lightning pains.

(2) Argyll-Robertson pupil; inequality and irregularity of pupils; involuntary ptosis of upper lid and optic atrophy.

(3) Loss of deep reflexes and briskness of the superficial ones.

(4) Ataxia.

(5) Positive Wassermann reaction both in the blood and cerebro-spinal fluid.

However, some of the features which are often present in this disease and were absent in this case may be considered.

(1) *Anæsthesia*: The absence of anæsthesia would not negative the diagnosis, because it is not a part of the essential lesion of the disease. When present it is limited to special areas and it so happens that in this case the lesion was not advanced enough in those areas.

(2) *Involvement of sphincters*: This again does not stand against the diagnosis. It is a sign of a lesion in a particular segment and it is conceivable that in any given case they may be spared, or the disease in them may not have advanced far enough.

(3) *Hypotonia*: Muscular tone depends, among other factors, upon the integrity of the posterior nerve roots and when these are involved there must be some defect in tone. However, minor degrees of defect cannot be definitely elicited, the tests being crude.

(4) Vibration sense is conveyed by fibres in the posterior columns and must be affected. But minute changes in this sense cannot be appreciated.

The absence of both these latter signs would not disprove the conclusion that in this case the posterior columns were the seat of the lesion. And all these negative features put together do not seem to outweigh the positive findings in this case.

I have to thank Major T. A. Hughes, I.M.S., the Visiting Physician, for his kind permission to publish this case and for his kind advice in writing it.

UNUSUAL INTRA-UTERINE TUMOURS.

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T. B., aged about 23 years, a Hindu woman, came to the out-door department on February 27th, 1929, complaining of a general feeling of malaise and pain in the abdomen.

The examination result was as follows:—

Patient appears sick. Abdomen very much distended and tense; appears to be full term.

Palpation of Abdomen: Masses like a fœtal head felt in three places. Head not felt above the symphysis pubis. Limbs could not be felt.

Two fœtal heart sounds, one distinct on the right side below the level of the umbilicus, the other on the left side above the level of the umbilicus, could be heard.

Per vaginam, os one finger, loose.

On March 20th, she attended again with a similar complaint. On this occasion she was having labour pains and so was admitted.

Personal History.—Patient's father died 8 years ago; mother is still living. The latter had one abortion and 10 full term children, of whom 5 died. Now the patient has three brothers and one sister living.

Patient married at the age of 8, menstruated at the age of 16, and had her first child at the age of 17.

The second child was born three years after the first child. Both labours were normal, and both children are living.

Patient gives a vague history of having contracted syphilis from her husband, although there are no signs or symptoms to indicate venereal disease.

Examination *on admission* at 10-30 a.m. on 20th March. Patient looks sick, and seems to be having labour pains.

Pulse 90. Respiration 22, Temperature 98. Albumin in the urine.

Lungs.—Scattered ronchi and râles on both sides.

Abdomen.—Very much distended, reaching right up to xiphisternum. Irregular masses felt in more than two places. One fœtal heart sound on the right side below the level of the umbilicus.

Vaginal Examination.—Os fully dilated. Bag of membranes presenting. Patient is having good labour pains.

Membranes ruptured at 11 o'clock, and a very small head presented. The head was very loose in the vagina, but the midwife could not deliver the fœtus. So it was taken to be a case of interlocking of twins.

I examined the patient 10 minutes after the rupture of the membranes, and found the cervix blocked by a big fœtal abdomen, and so I thought that this was a case of fœtal ascites. Hence the fœtal abdomen was punctured above the umbilicus. No fluid drained out, so the size was not reduced.

The size of the fœtal abdomen was so big that it was impossible to deliver it without using some sort of traction. In order to do version and so deliver it by using traction on the leg, I decapitated the presenting head.

As I pushed the presenting abdomen up and tried to find the leg, I felt a solid head-like mass with a fissure in it. It felt like a hardened brain; this I thought might be the head of another fœtus without a scalp.

This was delivered first. It was found to be attached by a broad gelatinous pedicle. It was a pinkish white oblong tumour, with one longitudinal fissure in the centre on the upper part, and two or three transverse fissures reaching right up to the base. The appearance of it was very much like a hardened brain, without blood vessels.

The pedicle had no blood vessels in it. The circumference of this tumour was about 12 inches.

After this, version of the decapitated fœtus was done; but the legs that were brought out were so tiny and delicate that it was impossible to use traction on them, so I applied forceps to the presenting abdomen and delivered it with considerable difficulty. The circumference of this abdomen was 15 inches.

Next as I tried to find the legs of the other fœtus, I felt another tumour, exactly similar to the first one removed. I delivered it and found its circumference to be 10 inches.