The patient was advised complete enucleation of the tonsils. Evidently the tonsils were secondarily infected from the posterior group of sinuses, which remained in the latent infective condition with active foci in the former.

Thus obscure and doubtful cases of painful affections of parts of body without any obvious cause should remind one of focal sepsis somewhere. Next to sepsis in the teeth, and the tonsils, one's attention should be drawn to the nasal fossæ and an examination should be made of the sinuses. As in some of the cases cited above there may be very few signs relating of sinus infection, though this may really be the focus from which toxic or septic absorption occurs. E. R. Falkner(3) says, "The remote effects of focal sinusitis which may properly be classed as complications include all that great category of ills, the causation of which is now ascribed to focal infection anywhere. It includes many of the diseases which were formerly attributed to syphilis, and in fact many of the degenerative results supposed to be peculiar to syphilis can be duplicated by a pus focus with absorption going on for a long period of years. Even the gumma or syphilitic granuloma is occasionally found associated with a pus focus infected with streptococci or staphylococci. The arterial changes in the small thin-coated vessels, such as the choroid and the retina with hæmorrhages are often found associated with a pyogenic infection in the nasal sinuses. The chronic inflammatory processes due to a pus focus may be enumerated: inflammatory process in all the tissues of the eye; labyrinthitis; bronchitis and pulmonary abscess; gastric ulcer; cholecystitis and cholangytis; appendicitis; nephritis in its various forms; pyelitis and cystitis; arteritis, myocarditis and endocarditis; simple and malignant arthritis; myositis; bursitis and neuritis. Whenever and wherever in the body a chronic inflammatory process has been initiated and the origin from a primary focus is suspected, but not obvious, it is well to have a thorough examination of the paranasal sinuses."

REFERENCES.

(1) Bana, F. D. (1930). A Simple Method of Dealing with Glandular Swellings. *Indian Med. Gaz.*, Vol. LXV, April, p. 208.

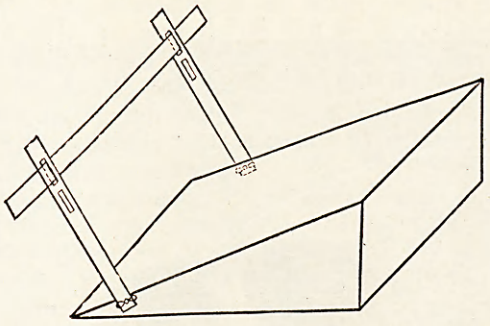
(2) MacCullan (1929). Toxic Absorption due to Focal Septic Lesions. *Brit. Med. Journ.*, 23rd November, p. 943.

(3) "Inflammatory Affections of Sinuses" in Jackson and Coates' "The Ear, Nose and Throat Diseases," 1929.

A MYOPIA-PREVENTING DEVICE.

By R. K. WADIA, L.O., M.B., B.SC.

STOOPING over books and close reading is admitted to be a potent cause of myopia, and in consequence the schools have adopted the "hygienic" combined sloping table and chair with a straight back; yet I have not heard of any device for the direct prevention of myopia. With this intention in view, I have devised a "chin bar," illustrated in the following sketch.



The apparatus consists of a horizontal wooden strip, the ends of which pass lengthwise through two strips fixed at an angle to the sides of the sloping desk by a bolt screw and nut. The horizontal bar passes through different slots at different heights to suit the child's height.

The "chin bar" is tightened in such a position that the chin rests lightly on it and cannot come closer to the desk than 30 to 33 cms. The horizontal bar also prevents the child from trying to look under it at the book. When not in use, the side bars can be folded down by the sides of the sloping desk.

I have had this apparatus in use now for about a year, and in some cases have noted that rapidly developing myopia has been arrested. A few local schools have approved the idea, and state that they intend adopting it. If made of ply wood, the cost of such an apparatus is only 4 annas, or even less if ordered in considerable numbers.

CORRIGENDUM.

In Sub-Assistant Surgeon N. C. Dey's article "A Study of Yaws in Khetri Area, Kamrup, Assam" in our issue for August 1930, the following corrections should be made:—

(1) P. 423, left hand column, in place of "(Plate I, fig. 2)" please *read* "(Plate III, fig. 11)."

(2) P. 424, left hand column, in place of "(Plate II, fig. 10)" please *read* "(Plate IV, fig. 10)."

(3) In Plate II, fig. 6, in place of "scar over the right knee cap" please *read* "scar over the left knee cap."

(The first two mistakes are due to the fact that the arrangement of the illustrations had to be altered to fit the pages after the paged proofs had been returned to press; hence the irregular order in which they are numbered.—EDITOR, *I. M. G.*)

A Mirror of Hospital Practice.

REPORT OF A SECOND CASE OF "DERMAL LEISHMANOID" FROM MADRAS.

By CAPTAIN N. SESHADRINATHAN, M.B., B.S., D.T.M., *Bacteriology Department, Medical College, Madras.*

"DERMAL LEISHMANOID" cases do not seem to have been reported so far from Madras.

The following case with illustrations may be of interest therefore.

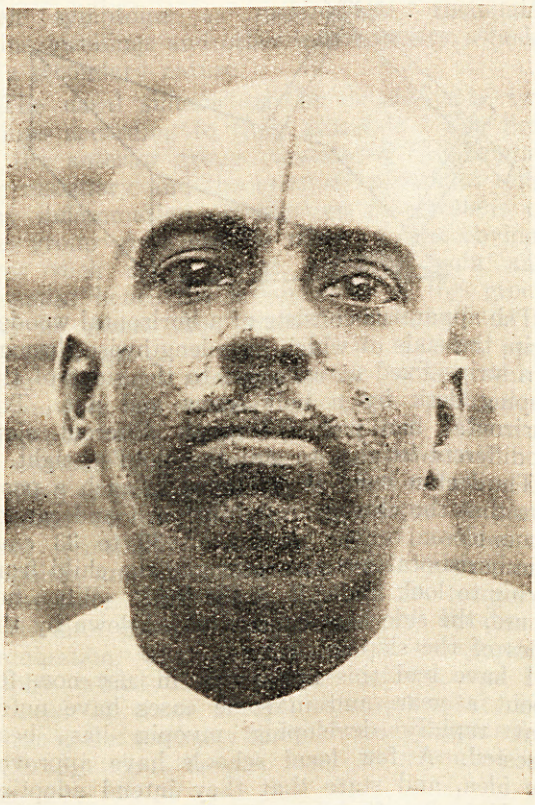


Fig. 1.

The patient, an adult male, is a resident of Wall Tax Road (Park Town), an endemic area for kala-azar, Madras.

History.—First attack of fever of a continuous type in December 1927 lasting about six months. Diagnosed as kala-azar by formolgel test in May 1928 by Dr. Theodore of the King Institute. A course of urea-stibamine brought the fever under control in July 1928. In September of the same year he had a relapse, and was treated at the General Hospital, Madras. Spleen puncture smear showing *Leishmania donovani;* was discharged cured in November.

In December 1929 the patient perceived small discrete papular nodules above the upper lips, spreading gradually over the rest of the face. The forehead and ear lobules were free. The bridge of the nose showed diffuse nodules. They are distributed over the more vascular areas of the face.

Extensive partially depigmented spots about 2 mm. in diameter are seen densely distributed over the back of the trunk and sparsely over the front of the chest and arms. The patches did not extend below the waist.

A smear made with the juice from the nodules showed many leishmania parasites. Smears from the depigmented patches did not show any parasites.

There has been no constitutional disturbance associated with the condition. The spleen and liver are not palpable.

The case is thus definitely one of post kala-azar "dermal leishmanoid," the resistant and non-virulent parasites escaping to the periphery from the internal organs probably by a process of "embolic showers."

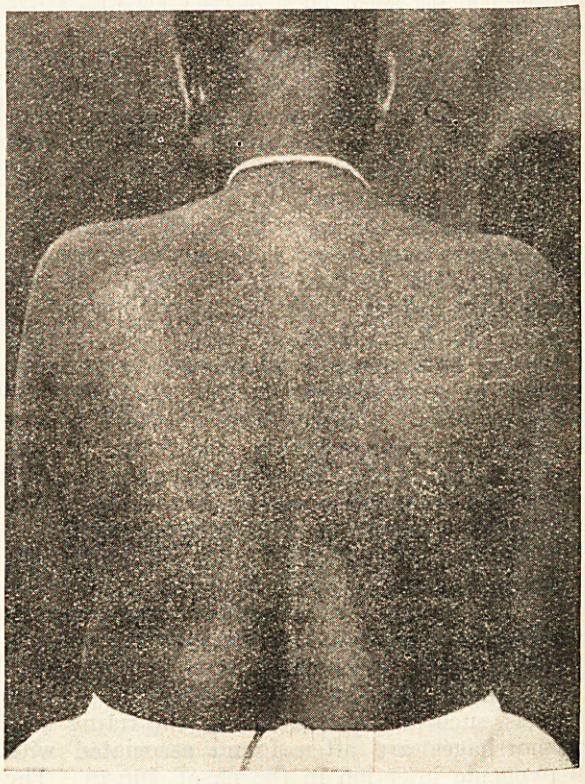


Fig. 2.

A CASE OF CONGENITAL SACRAL TERATOMA.

By G. M. IRVINE, F.R.C.S. (Edin.),
CAPTAIN, I.M.S.,
Medical Officer in-charge, British Military Family Hospital, Quetta.

The following case of a tumour present at birth appears to be rare:—

On November 25th Mrs. A. after a normal labour was delivered of a full term female child. At birth this was found to have a large tumour of the right buttock which on examination presented the following characters:—

The tumour was an elongated oval, almost twice the size of the fist. The vertical extent was from just below the crest of the ilium to 1½ inches below the gluteal fold—the lower pole of the tumour projecting down over the back of the thigh. In the horizontal plane it extended almost from the mid-line of the sacrum to the great trochanter. The surface of the tumour was smooth and regular, and the margin fairly well defined except at the upper limit. The lower and internal aspect encroached on the anal margin and on rectal examination was felt to be in close relation to the wall of the lower part of the rectum. The skin over the tumour was slightly reddened and shiny and showed a network of dilated venules. It was freely movable over the tumour. The tumour was slightly movable on the deeper tissues. It felt tense and cystic and doubtful fluctuation was elicited at the summit. Exploratory puncture yielded a few drops of clear glairy mucoid fluid.

Apart from the tumour the child was otherwise normal. The birth weight was 8½ lbs. and it continued to thrive and put on weight normally. The pelvis and trunk were apparently normal and apart from the fact