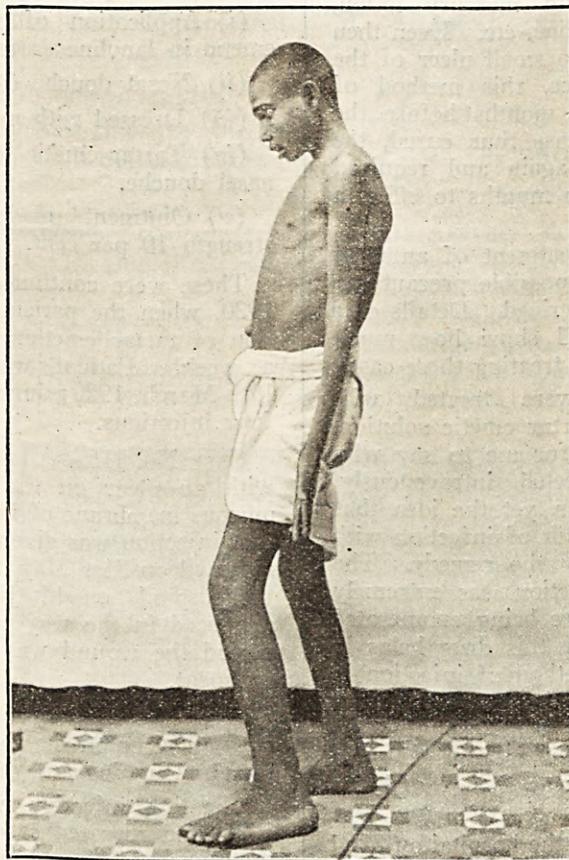


wish to venture further into speculation and discussion on this matter. I think, however, that I am justified in placing on record this remarkable abnormality for what it is worth.

Clinical features.—It starts as a small pimple, which in a day or two is surrounded by an areola. This increases in size rapidly and in a few days breaks out in an ulcer, with profuse discharge and offensive smell, associated with



CACHAR SORE AND ITS TREATMENT.

By J. M. SEN GUPTA,

Silchar.

CACHAR SORE (Assam Sore—locally known as Shantira) is a kind of unyielding ulcer. It appears more or less in epidemic form and affects cultivators and tea garden coolies specially.

Etiology.—The ulcer is very common in the rainy season, but it does not appear in epidemic form every year.

Sex and age have no influence.

In a majority of cases the ulcer affects the leg, probably as a result of contamination by mud, the germ gaining entrance through an abraded skin or a slight wound. In a few cases, however, the upper lip with the mucous membrane of the nose has been found affected.

Bacteriology.—Microscopical examination of the discharge reveals a type of bacillus which is present in enormous numbers. The true nature of this bacillus could not be determined. Excepting this, no other micro-organism could be detected.

acute pain. At this stage the appearance of the ulcer is very characteristic. The shape of the ulcer is very often round in the beginning, but subsequently it takes on an irregular shape and assumes a very large size. In neglected cases affecting the whole of the leg, an edge is raised, slightly everted and very hard. Beyond this, the skin is highly infiltrated particularly in the acute stage. The base is covered with a thick slough which is often adherent. The margin is undermined.

Course.—Extension is very rapid. From an ulcer of a rupee size it has been seen to involve the whole leg in course of a week or ten days. The ulcer has a tendency to affect the deeper layers as well. Several cases have been seen in which the superficial layers of the calf muscle became affected. Once affected, progress is very rapid, proceeding up and down along the course of the muscle. In these cases it is very difficult to check the progress before the whole extent of the muscle has sloughed out.

Treatment.—In this the patience of the physician as well as that of the patient is taxed

to its utmost. It resists all the usual methods of treatment of chronic ulcers, particularly when it is somewhat advanced. In the early condition some good may be achieved by touching the margin and surface of the ulcer with AgNO_3 (silver nitrate) or strong carbolic acid, followed by antiseptic dressings with mercury lotion, picric acid lotion, normal saline, etc. Even then the result is uncertain. In a small ulcer of the size of an eight-anna piece, this method of treatment takes fully three months before the patient is cured. In one case thus cured, the soft cicatrix broke down again and required treatment for a further two months to effect a cure.

All the usual lines of treatment of an ulcer were followed with all the possible precautions, but very little benefit was derived. Details of a few cases noted below will show how much difficulty one experiences in treating these cases.

At last, the patients were treated with intravenous injections of tartar emetic solution. Though it is very difficult for me to say why should tartar emetic, injected intravenously, have any effect on the ulcer, yet the idea that these sores might be the result of infection with L. D. bodies led me to try the remedy. The effect produced by this injection was extremely satisfactory. Some cases are being enumerated below which will show how this drug helps in curing the malady. The method of injection is the same as in kala-azar, but smaller doses usually suffice. A one per cent. solution of tartar emetic in normal saline is injected once a week. The initial dose was 2 c.c., and the maximum quantity given was 4 c.c.

CASE No. I.—Admitted in the hospital on 22nd June, 1919, with several round ulcers on the right shin, each being a typical Cachar sore. He was given a tonic mixture internally and dressed with the following in succession:—

- (i) Mercury lotion.
- (ii) Methylene blue ointment.
- (iii) Eusol bath, and dusted with eupad.
- (iv) Washed with H_2O_2 .
- (v) The ulcers were touched with strong carbolic acid, and subsequently dressed with methylated spirit.
- (vi) The wound was scraped and dressed with normal saline.
- (vii) Iodoform.
- (viii) Two per cent. solution of picric acid.

These treatments were continued up to 19th March, 1920. At this time, whole of the leg was covered with a big ulcer, very foul and sloughing in character. On 20th March, 1920, the patient was given the first injection of tartar emetic, and subsequently repeated once a week, the last injection being given on 23rd April, 1920. The patient improved very rapidly and was discharged cured on 9th May, 1920. The wound was being dressed with mercury lotion all through this period.

CASE No. II.—Admitted on 29th January, 1920.

The ulcer affected the upper lip and the mucous membrane of the nose. The septum nasi was totally destroyed. The methods of treatment adopted were:—

- (i) Application of ointment made of tartar emetic in lanoline (strength two per cent.).
- (ii) Nasal douche of normal saline.
- (iii) Dressed with mercury lotion.
- (iv) Tartar emetic solution (1 per cent.) for nasal douche.
- (v) Ointment made of pot. bichromate, strength 10 per cent.

These were continued up to 27th February, 1920, when the patient received the first injection of tartar emetic. This was repeated once a week. Patient was discharged cured on 19th March, 1920; during this time he was given four injections.

CASE No. III.—Admitted on 23rd May, 1920, with an ulcer on the upper lip affecting the mucous membrane of nose and septum nasi. The first injection was given on 25th May, 1920, and repeated on 31st May, 1920, but the patient left the hospital on 4th June, 1920, when fairly advanced in the way to recovery. During this period the wound was dressed with zinc oxide ointment.

CASE No. IV.—Admitted on 28th May, 1920, with an ulcer on the right leg, 8 ins. long, 4 ins. broad, sloughing and offensive.

The first injection was given on 29th May, 1920, and repeated at different intervals. (For some unavoidable reasons injections could not be given regularly.) However, the patient got eight injections—the last one on 13th August, 1920—and was discharged cured on 21st August, 1920.

CONCLUSIONS.

The above treatment tends to point out that this affection is a type of Leishmaniasis. Attempts have been made to detect L. D. Bodies in the pus and in the blood of the patients, but all attempts have proved futile. The only micro-organism that could be detected was some bacillus, present in an enormous number in the discharge from the ulcer.

Evidently, the following questions arise at this stage:—

- (i) What is this bacillus?
- (ii) What action has tartar emetic upon the micro-organism.

As regards question (i): For want of laboratory facilities investigation in this direction could not be proceeded with.

In reply to question (ii). Tartar emetic and its action upon an unknown bacillus. The infection may be *Local* and *General*.

A. LOCAL.

(i) *With Leishman-Donovan Bodies.*

It is difficult to conceive this in the affirmative in view of the negative results of microscopical examination as well as failure of tartar emetic ointment applied locally to produce any effect whatsoever, while the same drug administered intravenously produced a marvellous effect.

(ii) *With a certain unknown bacillus.*

What, then, is this bacillus and why should it react to intravenous injection of tartar emetic and resist all local remedies?

B. GENERALISED.

Again it may be with L. D. Bodies as with some other unknown bacillus.

(i) *With L. D. Bodies.*

Are L. D. Bodies capable of producing an ulcer like this without having at the same time

to communicate more about this in future. However, it may interest some of the members of the medical profession in spite of the answer being an incomplete one.

A Mirror of Hospital Practice.

A DOUBLE-HEADED MONSTER.

By SADASHIR KAHAR,

Medical Officer, Hangal.

THE monster depicted in the accompanying photograph was given birth to by a woman called Fakiravva, who is the mother of ten healthy and natural children. It was born by pelvic presentation—a foot appearing first. The heads were born six hours after the body appeared, and came out simultaneously. The child was



a generalised effect upon the system? Positive supposition is difficult to make. In kala-azar cancrum oris is a very late manifestation when prostration has considerably advanced.

(ii) *With a certain unknown bacillus.*

What, then, must be the micro-organism? Whether it be local infection or a generalised one, the reaction of some other micro-organism than L. D. Bodies to intravenous injection of tartar emetic deserves special attention.

At present I am not in a position to deal with the question in any further detail, but will try

born alive and cried once a few minutes after delivery.

The dead foetus has been presented to the museum of the B. J. School, Poona.

A CASE OF FULL TERM PREGNANCY

By Dr. S. N. MISRA,

Civil Surgeon, Sultanpur.

Name: Sajiman. Caste: Mohammadan female.
Age: 29. Residence: Khairabad, Sultanpur.
Occupation: labourer. Previous labours: all