tenth and eleventh ribs, both of which were partially cut.

Force of impact sent it on, and it passed through the left buttock of the rider, emerging behind, and ultimately coming to rest with the blade in a position behind the left axilla and shoulder joint.

Only the buttock wound was made, the point of entrance being near the middle of the thigh, 1 (one) inch below the fold of the buttock, the point of exit being 3 (three) inches behind and on a level with left trochanter major, and the distance between being six and-a-half inches.

The wound was superficial, missed everything of importance, and is healing well. It was treated with carbolic oil at the time.

Only some $1\frac{1}{2}$ inches of shaft were visible between the point of exit from the pony and the entrance buttock wound. The pony stopped dead still, and was held, while the shaft was cut through below the entrance wound. It was then pulled straight through.

Nine and-a-quarter inches of blade, and 1 foot $9\frac{3}{4}$ inches of shaft passed through the rider, and 1 foot 9 inches of solid shaft and 3 feet of torn bamboo passed through the pony. The pony developed pneumonia and died one week afterwards; but the *post-mortem* revealed no lung perforation.

The case is interesting, I think, first as illustrating the vagaries of a spear in a very few moments, once control over it has been lost by the rider; second, also as showing that such a wound need not become septic if first aid appliances are at hand.

APPENDICITIS WITH ABSCESS.

By J. G. MURRAY, M.B.,
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As cases of appendicitis are not frequently reported in the *Indian Medical Gazette* the following may perhaps be of interest. I see it is mentioned by Major Calvert in the October Number, 1901; "that in his experience of mofussil practice cases of appendicitis of so severe a nature or recurring character as to require operation are rarely met with."

The following case, which permitted of little doubt on admission, was subsequently verified by *post-mortem* examination.

Asaruddi, aged about 15 or 16, was admitted to hospital on 12th July 1903, with a history of a fall about sixteen days ago. On being questioned, he complained of very severe pain in the "belly," chiefly on the right side.

On examination he was found to be very emaciated and looked exceedingly ill. Temperature 100°F., tongue furred and dry; unable to extend the right leg which was kept in a flexed position. Examining the abdomen there was no distension, a firm hard swelling was found in the right iliac fossa, and fluctuation could not be obtained.

On the following day he was operated upon, and a large abscess was opened in the right iliac fossa which was shut off from the general peritoneal cavity by adhesions; on this account and because of the patient's general condition no further examination was made, a drainage tube was inserted, dressing applied and the boy sent back to bed. Next morning, the 14th, the temperature was 99°, pulse very fair, and he had passed a good night, the dressings were changed, a good quantity of discharge was present.

For the next seven days the patient improved considerably, temperature practically normal, morning and evening, till the 21st, when a decided change for the worse occurred. The temperature rose again, herpes broke out on the lips, and in the chest pneumonic consolidation rapidly developed, first on the left side, then to a slight extent on the right. From the abscess cavity pus still discharged freely, but there were no bad symptoms in the abdomen till 27th July, the day before his death, when signs of peritonitis set in.

Post-mortem on 29th, eighteen hours after death. On opening the abdominal cavity purulent peritonitis was found, the coils of intestines being matted together by thick semi-purulent lymph. Round the abscess cavity in the right iliac fossa the coils of intestines showed old adhesions, and, after a little search, the appendix was found towards the posterior part ulcerated and perforated. In the chest the greater part of the left lung was consolidated, also the base of the right lung; and, on opening the pericardium, the heart was covered with semi-purulent lymph.

A CASE OF COLLOID CARCINOMA OF THE MESENTERY.

By W. J. WANLESS, M.D.,
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The fact that colloid carcinoma of the mesentery at the age of fourteen is of such infrequent occurrence, is the author's excuse for the publication of the following case:—

Krishna Tatya, a Mahratta boy of fourteen, was admitted to the Presbyterian Mission Hospital, Miraj, June 4, 1902, complaining of an enlargement of the abdomen.

History.—Six months ago a nodular swelling appeared in the epigastrium. When first noticed it was the size of a small child's fist and has since increased in size very rapidly.

General condition.—Previous to the development of the growth the patient had always

enjoyed good health. The patient is pale, anæmic, and his general strength poor, but he can scarcely be called cachectic. The heart is normal, the pulse 100, regular and of fair quality. Examination of the lungs is negative. The tongue is lightly coated, and the bowels are constipated. The urine is high colored, but otherwise normal. The temperature is normal in the evenings, sub-normal in the mornings.

Description.—The abdomen is generally and moderately distended. There is an ill-defined intra-abdominal swelling occupying the right two-thirds of the epigastric region, and extending into and filling most of the right costo-iliac space. By palpation an indistinct tumour mass is made out with a slightly bosselated feel, and at points an indefinite sense of fluctuation. Percussion over the area referred to is dull, and is tympanitic over the remainder of the abdomen.

Diagnosis.—The diagnosis seemed to lie between hydatid cyst of liver, a cyst of the pancreas, and a malignant growth of indefinite origin.

The patient was kept under observation for nine days during which time purgatives were administered at intervals and distension somewhat relieved. Tonics were also administered, and the patient prepared for operation.

June 13, *Operation.*—Three doses of half an ounce each of whisky were given in the morning, and the operation began at 3 P.M. Narcosis, chloroform ʒix. Time, 40 minutes. Assisted by the house staff, an incision 4 inches in length over the right linea semilunaris, subsequently increased to 6 inches and to within one inch of the costal arch. On incising the peritoneum a doughy tumour presented extending in the direction of the stomach, beneath the liver and transverse colon and into the right flank. The wall of the tumour mass was very thin and friable and readily broke down under the fingers; on handling this discharged large quantities of amber-colored fluid and gelatinous material. Approximately a quart of this fluid escaped which was not preserved. The major part of the growth was composed of colloid material. The growth was multilocular and sprang mainly from the mesentery of the transverse and ascending colon; the free portion of the growth was adherent to the omentum which had to be ligated at half a dozen points in order to reach the base of the growth. The growth was then shelled out piecemeal, leaving most of the thin capsule which was ligated in sections with fine celluloid thread close to the mesentery. The growth contained comparatively few vessels in its wall and trabeculæ, and was completely removed without serious loss of blood. The abdominal cavity was freely flushed with several pints of normal salt solution and a couple of pints of the solution, left in the abdomen. To save time the abdominal wound was closed with through and through sutures of silkworm gut, without drainage. Acetanilide was dusted over the wound, and a bichloride gauze dressing and a binder completed the operation. The patient was put to bed in a condition of severe shock. An enema containing 12 ounces of normal salt solution with an ounce of whisky was given before leaving the operating table; 20 minims of liquor strychniæ were given in two doses during the operation.

Subsequent history.—Cardiac stimulants consisting of hypodermic injections of whisky and spirit of camphor were kept up at short intervals during the night, and part of the following day, small doses of morphia and atropia were also administered twice in the first 24 hours to relieve pain and restlessness. The diet consisted of milk and plasmon administered every three hours. The patient reacted to the stimulation, the pulse falling from 130 to 108 within 36 hours. The breathing was observed to have increased in rapidity on the morning of the 3rd day, and on examination dulness was found involving the whole left lung, the patient dying at noon the same day from pneumonia. With the exception of a little pain and considerable restlessness, no abdominal symptoms followed the operation.

The specimen which in addition to the fluid contents which escaped during the operation weighed about two pounds, was unfortunately lost in consequence of the carelessness of a servant.

OLD UNREDUCED POSTERIOR DISLOCATION OF THE BONES OF THE FOREARM: EXCISION OF THE ELBOW JOINT.

By D. M. MOIR, A.M., M.D.,
MAJOR, I.M.S.

R. L. F., European male, aged 25 years, powerful and muscular, fractured the internal condyle of the right humerus and sustained a backward dislocation of the same forearm on the 3rd February 1902, as the result of a fall upon the elbow while playing tennis. The same day his arm was put up under chloroform at Raniganj. Five weeks later the rectangular splint was removed, and the joint was found fixed in a faulty position. At the end of March 1902, he was again anæsthetised, the adhesions were broken down, and violent inflammatory reaction followed.

Early in April 1902, this skiagram was taken with the forearm in pronation, the plate under the elbow and the rays above it. The callus surrounding the internal condyle and the backward dislocation of the bones of the forearm are clearly shown in the skiagram. Between the 9th April and the middle of June 1902, four