of temperature after the operation. In all eleven injections, each of 1 grain of emetine, were given.

The patient made an uninterrupted recovery. The swelling in the right hypochondriac region disappeared altogether and also the œdema of the feet. The patient became plump and healthy looking and was discharged cured from the hospital on 5th July 1925.

A CASE OF ACUTE HÆMORRHAGIC PANCREATITIS.

By K. M. NAYAK, L.M.S.,

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THE patient, aged about 50 years, when in quite sound health suddenly took very ill on the morning of the 31st of October last. He was slightly adipose. The illness had a fatal termination and lasted for only 24 hours. He took very ill one morning and died the next. On the day of illness he got up as usual and had his early breakfast at 7-30 a.m. Since his bowels did not move satisfactory the previous day, he had taken a dose of Eno's "Fruit Salts" overnight and his bowels acted well that morning. At about 8 a.m., exactly half an hour after his meal, he felt acute excruciating pain in the epigastrium and vomited everything that he had taken. The pain was so severe and overwhelming that he was completely doubled up in 5 minutes and the pain kept coming and going every 15 minutes in severe paroxysms lasting for 5 minutes each time. The intensity was so severe as to distinguish it from that of appendicitis. The appendicular region and practically the whole of the right iliac and umbilical regions did not reveal any tender spots even on deep palpation, and the rectus muscle was not rigid. The abdomen was not board-like but tolerably soft in the beginning, but all the same, palpation was difficult as the patient was inclined to be fat and had a respectable paunch.

A perforated ulcer and passage of a gall-stone or a kidney-stone are the only common diseases giving such severe pains. The radiating character and the paroxysmal nature of the pain suggested either a gall-stone or kidney-stone. Absence of any previous similar attacks and absence of any crystals of urinary salts in the centrifugalised urine led to the elimination of renal calculus. The fact that even gentle palpation elicited tenderness over the tip of the right 9th costal cartilage and that the radiating character of the pain was referred to the right shoulder blade and lumbar region, led to a tentative diagnosis of gall-stone being made. But even here there was absolutely no history of any previous attacks and he was not jaundiced. Gall-stones are said to be "tombstones erected to the memory of typhoid bacilli" but the most careful enquiry did not elicit that he had ever suffered from typhoid fever.

General Condition.—The patient was very ill from the commencement. The pain was very acute, excruciating and exhausting. Vomiting, which was sudden and profuse in the beginning, continued for some time. His stomach was so intolerant as not to retain a teaspoonful of water or medicine. Ultimately it was limited to retching and bringing-up of only mucus mixed with saliva. His pulse was full, regular, bounding, 70 per minute, and remained like that till 4 a.m. on the morning of the 1st November, when it began to flag and became soft, small and thready. So much so that by 6 a.m. in the morning it was imperceptible and was sustained only by the administration of stimulants. In other words it was a *combined pulse,* hæmorrhagic and peritonitic. His abdomen, which was soft in the beginning, gradually became more and more distended and very tender all over. Though rigidity was not marked in the early stages, his abdomen became very rigid and tender all over later on, and was as hard as a solid block of wood. Though the abdominal tenderness was universal all over, gradual deep pressure in the epigastrium brought on excruciating pain. His temperature was normal throughout, or to be more accurate it was 98°F. In the later stages it was sub-normal and it never rose above the normal even by half a degree throughout the illness.

Treatment.—Though his bowels had moved satisfactorily that morning a soap and water enema was given straight off and was returned satisfactorily. Since appendicitis was ruled out of court from the very beginning morphia and atropine were given hypodermically and were repeated four times in the 24 hours, but had no effect on the pains at all beyond making the patient drowsy. The pain continued in the same intensity and was paroxysmal. The stomach was washed out at about 6 p.m. to stop the retching and this had some effect. Benzyl benzoate was administered thrice in 12 hours but had not the desired effect. Not being blessed with an *x*-ray installation in Vellore, a photograph could not be taken to clinch the tentative diagnosis of gall-stones. The nearest place where one was available was Madras, but the patient's condition at the end of 24 hours was such as to utterly prevent his removal to Madras either by train or motor. He would certainly have died on the way. Hence, after consulting another doctor and having obtained the patient's and his wife's consent, it was decided to operate on him immediately. He was put on the table at 9 a.m. He was practically dying, completely collapsed and slightly cyanosed in the face. The anæsthetist was

very nervous about his task. Saline hypodermoclysis was given in both axillæ. The patient was anæsthetised. The bladder was catheterised and as facilities existed on the spot the urine was again centrifugalised and the sediment showed nothing beyond hyaline casts.

Operation.—The operation was performed by Dr. B. Rama Baliga Avl, B.A., M.B., C.M., District Medical Officer, Vellore, assisted by me. The usual gall-bladder incision was made on the right side commencing over the tip of the right 9th costal cartilage and extending downwards for about 3 inches. Not a drop of blood was visible till the peritoneal cavity was reached. When the peritoneal cavity was opened the first object that presented itself was the omentum, loaded with fat. When the structure was pushed aside the fundus of the gall-bladder peeped out and at the same time dark red blood-stained fluid (practically venous blood) began to well up from the wound. On collecting a sample of this fluid in a tablespoon fat globules were seen floating on the surface. Knowing that an acute pancreatitis is one of the causes of "acute abdomen" though rare, the presence of dark venous blood in the peritoneal cavity with fat globules left no doubt as to the fact of the case being one of the acute hæmorrhagic pancreatitis. At this stage of the operation the patient had a convulsion, his breathing became shallow and he expired on the table.

With the consent of his friends and relatives the incision was extended downwards, the appendicular and gall-bladder regions were thoroughly explored and found to present nothing abnormal. The peritoneal cavity was dried as far as possible and the intestines were found to be distended. The visceral peritoneum was inflamed, red and angry-looking and small white opaque spots of fat necrosis were visible in the omentum and mesentery. When the omentum and transverse colon were turned up, the whole of the transverse meso-colon, part of the mesentery and an extensive area of the posterior abdominal wall and the retro-peritoneal tissues were found to be infiltrated with blood. The pancreas itself was swollen and dark red in colour, due to infiltration with blood. The gland was removed for pathological examination which bore out the diagnosis of acute hæmorrhagic pancreatitis.

Discussion.—Acute hæmorrhagic pancreatitis, though rare, is a distinct clinical entity. Rapidly fatal termination of this disease is ample proof of the necessity for very early diagnosis and a wide knowledge of its signs and symptoms is quite essential. In my whole career of 18 years as medical student and as an assistant surgeon I have come across these cases only twice, once when I was a medical student in the year 1911 and now a second time 15 years later. The symptoms make up a clinical picture which is quite clear and the diagnosis can in most cases be made sufficiently early. The image left on my mind by the above clinical picture is now so clear that I would not fail to recognise it a third time. Regarding the ætiology it is doubtless an acute infective process due to the presence of germs. It is said that it is not infrequently found in association with cholangitis and gall-stones which may be found blocking the ampulla of Vater. So our tentative diagnosis of gall-stone was not far from wrong. At any rate it is nearer the truth than to diagnose the condition as appendicitis or appendicular perforation. Unfortunately we could not hold a complete post-mortem.

In conclusion, I wish to express my thanks to Dr. B. Rama Baliga Avl, B.A., M.B., C.M., District Medical Officer, Vellore, for having permitted me to publish these notes.

OPERATIONS ON OLD MEN.

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IN the presence of an accident or other affection threatening life, an urgent surgical operation may become necessary. In such cases the age of the patient may influence the prognosis, but not the necessity for immediate operation. In a patient suffering from strangulated hernia or depressed fracture of the skull or from some tumour of the body one would not hesitate to operate because the patient was aged.

Case.—An old man, some 80 years of age was admitted to the Phagwara Hospital, Kapurthala

State, in February 1922, with the following history. Twenty-five years previously he had noticed