puncture was not found to be necessary. Results of the other investigations were as follows:—

Urine: nothing abnormal was detected.

Blood pressure: systolic 125 mm. Hg., and diastolic 80 mm. Hg.

Nasal smears before and after a strong dose of potassium iodide: negative for Hansen's bacillus.

Blood smear: nothing abnormal detected.

Wassermann reaction of blood: negative.

The following clinical conditions were looked for and excluded:—

Peripheral neuritis.—There was no tingling or numbness. Calves were not painful. All tendon-jerks were normal.

Diabetes mellitus.—Urine never showed any sugar. There were no symptoms of the condition. Blood sugar of a fasting sample was 80 mg. per 100 c.cm.

Gonorrhœa.—No history, and no evidence on examination.

Leprosy.—Nasal smears were negative repeatedly for Hansen's bacillus. There was no hyperæsthetic, anæsthetic or depigmented patches on the body. No thickening of nerves was noticed.

Tabes dorsalis and subacute combined degeneration.—There was lack of any evidence on examination of nervous system.

Erythromelalgia, Raynaud's disease, endarteritis obliterans.—Absence of trophic changes. No change in the colour and temperature of the skin. Pulsation of vessels was normal.

Neurasthenia.—The patient was in real distress and woke up even from deep sleep when his feet were handled.

Pellagra.—No evidence of pigmentation, dermatitis or other symptoms.

Treatment.—In the absence of any definite diagnosis, it was decided to put the patient on intensive vitamin therapy on the evidence that he showed a little congestion of his gums and some dryness of the skin. He was given a diet rich in vitamins, supplemented by adexolin, and intravenous injections of vitamins B and C. Lead lotion compresses were given to his feet which were protected by a cradle. He also required repeated and strong hypnotics in the beginning to bring on sleep, which was greatly disturbed by the burning sensation.

He was re-examined after about ten days of treatment, and though the patient complained that he had only little and temporary relief by treatment, it was observed that his trouble was definitely much less. It was noticed during examination that, though the patient felt the agony of touch by the examining hand, he did not feel anything when he was engaged in conversation or was kept busy otherwise. This observation lead to the possibility of a neurosis, or a touch-phobia appearing on the top of his original trouble. To assess the part played by neurosis in the remaining trouble, the patient was ordered to walk in spite of his complaint. On his refusing to do so, he was taken out of his bed and forced to walk along the floor for a few feet with the help of two persons. As he gained confidence, he was gradually left to himself and it was found that he could walk alone briskly in the ward and along the corridor, the same day. From that moment his symptoms greatly ameliorated, appearing only in the early morning at about 4 a.m. for an hour or two. His remaining symptoms disappeared completely on the same line of treatment during the next week and he was able to run about like a normal man before his discharge. Though we believed that his improvement was due to intensive vitamin therapy, he used to say that it was due to the 'German *hikmat*' (trick) of forced walking.

Discussion.—The complaint of the patient was very peculiar and no reference to such a condition could be obtained in any of the usual text- or reference books on medicine. As the patient was about to be discharged, I came across an answer to a query about a similar case in the *Journal of the American Medical Association* of 28th September, 1940, page 1120, where such a condition was diagnosed as dermatalgia. I extract below a few lines for the information of readers :—

'. . . there is no change in the appearance of the skin during attacks, thus justifying the diagnosis of dermatalgia, a disturbance of the nerves supplying the skin of the part affected, supposedly the nerves of the vegetative system. The pain varies in different cases, burning as in the case cited, or a sensation of hot or cold water running over the skin, of stabbing, cutting, rubbing of the skin, or the sensation of an electric current. The attacks come usually at night, affect middle aged women most often and are commonly associated with hyperæsthesia so that the contact of clothing or other objects adds to the distress. Hairy parts or the extremities are most often involved. . . . As possible ætiological factors, tabes dorsalis, malaria, rheumatism, diabetes mellitus, leucæmia and other members of the lymphoblastoma group and leprosy were mentioned. In addition chlorosis, hysteria and any cause of neuritis are mentioned in the literature. Exposure to cold is also mentioned, probably the reason for the mention of rheumatism. It might be well to examine for anæmia and the possibility of certain forms of avitaminosis, especially those in which elements of the vitamin B complex are concerned. . . . In the considerable proportion of the cases in which no such basis can be found, acetyl-salicylic acid, salicin, quinine and arsenic are recommended and the local use of alternating hot and cold applications, galvanic or faradic electricity or counter irritation over the nerves supplying the part. Langeron and Desplats are quoted as having suggested roentgen therapy over the sympathetic centres for the relief of the pain of dermatalgia. . . . A small dose of roentgen rays, from 40 to 80 roentgens filtered through 2 mm. of aluminum, may be effective. This can be repeated at weekly intervals. . . . The skin should be protected as far as possible from the irritation of clothing.'

It will be realized that the case had improved as a result of our investigation and treatment before we came across the reference quoted above.

The interest of the case lies in the following :—

(1) The case presents a rare condition known as dermatalgia.

(2) The disease occurred in a middle aged man, while it is believed to be more common in females.

(3) The condition was amenable to intensive vitamin therapy.

(4) The case well exemplifies the necessity of recognizing the fact that neurosis or a phobia may in the course of time supervene on a real complaint. Later, the complaint may gradually disappear and neurosis take its place, the latter requiring treating with a firm hand.

I wish to thank Dr. M. S. H. Mody, honorary physician, for helping me in the investigation of the case and Major H. S. Waters, I.M.S., for giving me permission to report it.

A CASE OF ABDOMINAL PREGNANCY AND DELIVERY PER RECTUM

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

Medical Officer, Government Hospital, Kasaragod

A WOMAN, aged about 30 years, wife of a forester, was admitted into the Queen Alexandra Hospital for

women in Salem town in the month of September 1932. She was said to have been pregnant for 18 months and was admitted for colicky pains which were mistaken for labour pains.

On examination, the abdomen was found to be of the size of a full-term pregnant woman. It was tympanitic all over. A round globular swelling was present in the middle line of the lower abdomen and extending up to 3 inches above the umbilicus. She had no difficulty in passing urine or stools. Frequency of micturition was a very distressing symptom. She had colicky pain with passage of blood and mucus simulating dysentery. One early morning, two days after admission, while she was passing a stool a small hand appeared at the anus; this frightened her. While examining the patient I pulled out the protruding hand and the whole of the right forearm from the elbow downwards came out easily. I had the patient taken to the Headquarters Hospital and put her on the table and examined her under chloroform. On rectal examination I felt the head 3 inches from the anus and also the stump of the remaining portion of the right arm. On pulling this down by gentle traction, the whole macerated fœtus aged about six months came out followed by the placenta, all in one mass. The woman was in the hospital for eight days. Her recovery was uneventful.

I met her again in February 1939 after seven years. She was hale and hearty. She had had no more pregnancies.

Evidently this was a case of tubal rupture into the peritoneum. It could not be verified as no abdominal section was done. Her history was that she had some sort of pain about a year prior to her admission in the hospital and was treated at home by a quack.

The rupture must have taken place at six months, and the fœtus was extruded into the peritoneum. Nature came to her rescue. Adhesions were formed around the fœtus enclosing it in a sac and it remained there for a year after rupture. Latterly, the fœtus ulcerated through the wall of the rectum and came out.

A CASE OF ECLAMPSIA*

By JIWANLATA

Medical Superintendent, Lady Butler Hospital, Khandwa

A HINDU FEMALE, aged 17 years, primipara, was admitted on the 4th November, 1940, with a history of fever and rigors for 3 to 4 days and fits since the morning.

Family history.—She was a pampered child of the family; her mother had hysterical fits during one of her pregnancies and eclampsia during two of her confinements.

Present history.—The patient was attending the out-patients' department, and had a trace of albumin while three months' pregnant, which cleared up completely with treatment. She was constipated and her bowels had to be moved daily with laxatives. She kept well for 4 to 5 months but subsequently she started getting shivering attacks 2 to 3 times a day. She complained of pain in the left loin about 2 days before admission.

Condition on admission.—Healthy looking woman, temperature 90°F., pulse 92 per minute, tongue red and exfoliated due to large doses of alkalis. Uterus: full term size; L. O. A.; fœtal heart sounds good; head not fixed. Urine: scanty, acid, albumin, pus cells and micro-organisms present. Blood pressure was within normal limits, the systolic being 116. Fits appeared to be hysterical.

Alkalis were continued in large doses and bowels kept moved. She got no more rise of temperature or pain in the loin, and by the 15th the urine was completely free from albumin, pus cells and micro-organisms. She had no fits for 11 days and was therefore discharged on request to come back for delivery when pain started.

On 30th November, I was called again at 10-15 a.m., and found the patient suffering from a severe type of eclampsia, fits having started at about 8 a.m. She was getting fits one after another, and was completely unconscious. She had also become cyanosed and had bitten her tongue. She was given an injection of morphia and atropine immediately; this brought the fits under control but she remained unconscious. She was removed to the hospital and given an enema which had no effect. The catheter specimen of urine was high coloured and contained a fairly large quantity of albumin. Systolic pressure 116. Patient was not in labour as there was no uterine contraction; head was above the pelvis and no show was seen. Pelvic examination was not done in view of the contemplated Cæsarean section which was done at 1 p.m. A cyanosed female child was delivered. She got no more eclamptic fits after the operation and became conscious after about 7 hours. She behaved like a mental patient on the second day and got a temperature of 100°F. accompanied by shivering. The urine showed pus cells again. She was put on alkalis. Mother and baby are now both doing well.

Points of interest.—The case is of interest because the patient was kept under observation; urine was free from albumin till 8 days before the attack; bowels were kept moved and blood pressure was normal yet she developed severe eclampsia. Bowels had moved well that morning also and the patient was feeling quite well.

This is the second case under my care who developed eclampsia while the urine was kept free from albumin till a few days before the attack.

* Rearranged by Editor.

VESICAL CALCULUS IN A VAGINAL CYSTOCOELE

By R. D. MACRAE, F.R.C.S.E.
CAPTAIN, I.M.S.
Agency Surgeon, Gilgit, via Kashmir

A MOHAMMEDAN multipara was admitted in the second stage of labour. There was delay in the advance of the head through the lower canal.

Examination revealed that a normal labour was taking place, but a hard mass was felt in the anterior vaginal wall, and a cystocoele was seen to bulge below the pubic arch obstructing the progress of the head.

A no. 10 male silver catheter was passed per urethrem, with the tip pointing posteriorly, and, after taking a specimen of urine, the catheter was felt to grate against a stone in the cystocoele.

The bladder was incised through the anterior vaginal wall, and a stone about the size of a walnut removed. The fistula so formed was carefully sutured in two layers, and delivery completed by forceps so as to avoid prolonged pressure on the sutured wound.

Recovery was uneventful except for some cystitis, and no fistula resulted.

CORRIGENDUM

IN the paper on 'Tuberculosis of the Female Genital Tract' by M. N. Sarkar *et al.*, published in our May 1941 issue, on page 259, under the heading *Summary and Conclusions*, para (2), line 3 should read 'From the post-mortem figures the incidence was 1.1 per cent in unselected deaths in females, and where death occurred from tuberculosis the percentage was found to be 8.9'.

The mistake originated in the authors' typescript.