solution of carbolic acid was injected hypodermically. Chloretone grs. 20 in olive oil was given per rectum.

23-9-25 to 26-9-25. Same treatment. Sedative mixture, chloretone per rectum and carbolic acid injections.

27-9-25. Mouth could be opened a little.

30-9-25. Lockjaw much better. Patient was allowed a little bread. He could sit up. Carbolic acid injections discontinued.

2-10-25. Was put on half diet. Sedative mixture alone continued. Speech clear.

7-10-25. Muscles a little relaxed, particularly the abdominal ones. A blister was again applied over the right mastoid process. Patient was able to walk about with assistance.

13-10-25. Sedative mixture stopped. He was put on to potassium iodide mixture with liquor hydrargyri perchloridi.

18-10-25. Had to be discharged at his own request.

He was cured of tetanus, although he had not regained control over the facial muscles.

A chronic afebrile course, absence of clonic spasms and non-affection of the muscles of deglutition appear to be features of interest in the case. It will be interesting to know whether the facial paralysis is permanent or whether it is likely to be recovered from.

I have to thank Dr. G. O. Pothan, M.B., C.M., District Medical Officer, Ramnad, for permission to publish these notes.

A CASE OF ENDEMIC FUNICULITIS.

By JOHN PHILLIPS, M.B. (Lond.), F.R.C.S. (Eng.),

Nagrakata, Dooars.

ABOUT the middle of January last, a coolie was reported to me as having "something wrong with his testicle." I found that a few days previously a painful swelling had appeared in the region of the left spermatic cord. At the time of my examination, the patient was obviously in considerable pain; his temperature was slightly raised and his pulse was 90. At the onset there had been vomiting and constipation now relieved by aperients, for the giving of which I was not responsible. In the substance of the spermatic cord was a definite, painful, tender swelling, at its maximum about an inch below the external inguinal ring. It did not seem to extend into the inguinal canal, neither did it reach the testicle although this organ was somewhat swollen. The overlying skin was red, but moved freely over the swelling. There was no impulse on coughing and there was no urethral discharge.

The appearances were such as to suggest at first sight a strangulated hernia or possibly, torsion of the cord. I must confess I was at sea, and well adrift forsooth! However, negative facts are not without their value, and, looking at the case as a whole, I realised that I was not dealing with a strangulated hernia, or any hernia for that matter, neither was there any torsion of the cord. In dealing with those and allied conditions, I was sailing more or less on a well-charted sea. Later, in a text-book of surgery, I came across a brief description of a condition referred to as endemic funiculitis, a disease of tropical and subtropical climates. It sounded right; I made it my diagnosis.

The case did not end in suppuration, there was no sloughing of the testis, and frequently applied fomentations resulted in gradual but definite resolution. The patient is now quite fit and presents a rather hard fibrous nodule in the course of the cord—the commemorative record of a painful past.

Will readers who have the advantage of more extensive knowledge please add to mine?

(*Note.*—The case was clearly one of acute funiculitis. The ætiology of this interesting condition, which is occasionally met with in Bengal, is obscure. It is not infrequently fatal. It is possibly due to lymphangitis due to filarial infection plus an acute local or embolic streptococcal super-infection. It would be of interest if any readers who may happen to see cases would investigate the ætiology of the condition.—EDITOR, *Indian Medical Gazette.*)

SOME CASES OF ASTHMA.

By G. RAGHUNATHA RAO, L.M.P.,

Premchand Boral Street, Bow Bazar, Calcutta.

AFTER reading the article entitled "A Note on Some Predisposing Factors in Asthma" appearing in the January 1926 issue of the *Indian Medical Gazette,* I am tempted to bring the following cases to notice:—

In the Ceded Districts of the Madras Presidency cotton-growing areas, a type of asthma which I call "cotton asthma" is very prevalent. I had a number of cases under my observation, of which I give the details of three typical cases; also details of another case which does not belong to the same type, in fact, in this case, as will be seen later, the exciting agent was newly harvested grain and not cotton.

Case 1. Peer Saheb, aged 50, Mahomedan male, a quilter by profession, in the employ of the M. & S. M. Railway. As his profession required handling cotton always, he had very frequent attacks of asthma and consequently he had to leave the service of the Railway Company. He came to me with dyspnœa. He told me that whenever he handled cotton, he was sure to have an attack. I wished to verify his statement and engaged him to stitch a quilt for me. For three days he was put on to Mist. asthmatica after a preliminary mercurial purge and on the fourth day, on my assurance that I would do my best to check the attack, he began to work with cotton.