involvements of cochlear and vestibular divisions of 8th nerve, causing deafness, tinnitus, vertigo, vomiting, imbalance, etc., and herpes of tongue, palate, etc., in some cases. This shows the wide range of variation of nervous lesion in this disease for which Denny Brown rightly suggested that it may conveniently be described as 'The Ramsay Hunt Syndrome', until a better term than geneculate herpes is forthcoming, based upon exact knowledge of morbid anatomy.

TWO CASES OF TROPICAL EOSINOPHILIA IN TEA ESTATE PRACTICE

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A MALE tea garden labourer, aged 36 years, occupation chowkidar, was admitted in the Central Hospital on 25th May, 1948, from a neighbouring garden for the following chief complaints : (*i*) Irritating cough, (*ii*) irregular rise of temperature, (*iii*) loss of weight, and (*iv*) emaciation. Duration of illness—4 months.

Previous history.—An attack of similar illness 2½ years back which gradually improved on symptomatic treatment.

Present history.—A detailed history is not easily available from this class of labourers : he had been suffering from irritating cough which was persistent and exacerbated at times with occasional rise of temperature and nocturnal dyspnœa. History of hæmoptysis on one or two occasions is also available.

On examination.—The patient was well built but emaciated and slightly anæmic. Temperature was 99°F., pulse 90, respiration 20, appetite poor, spleen palpable, gland not enlarged, cough dry and hacking in nature. Inspiratory dyspnœa was more marked at night. He also complained of substernal pain.

On auscultation.—A good number of rhonchi and medium râles were heard at the bases of the lungs.

Blood showed no malarial parasites. Sputum —Repeated examination revealed no acid-fast bacilli.

Skiagram of the chest could not be taken but it was thought that the case might be one of tropical eosinophilia and as such total and differential counts were done with the following results : Differential count—Neutrophiles 16 per cent, lymphocytes 13 per cent, monocytes 1 per cent, eosinophiles 70 per cent. Total W.B.C. count 32,000 per c.mm.

Stool showed no helminthic ova : W.R. could not be done. No other cause of such high rise of eosinophiles was apparent.

The case was provisionally diagnosed as tropical eosinophilia.

Treatment.—A sedative cough mixture was prescribed and acetylarsan 3 cc. was given every 4th day on 6 occasions. The patient felt better after the 2nd injection except that he had an exacerbation of symptoms due to exposure to cold while out of the ward on a few hours' leave : otherwise he was free from symptoms after the 3rd injection and was completely cured. He became cheerful, gained in weight and was discharged on 24th June. W.B.C. count at that time was 8,000 per c.mm. Differential count—Neutrophiles 35 per cent, lymphocytes 25 per cent, monocytes 2 per cent, eosinophiles 38 per cent.

2nd case.—A female labourer, aged 40 years, from the same garden was admitted on 10th June, 1948, for the following complaints : (*i*) Evening rise of temperature, (*ii*) dry hacking cough, (*iii*) emaciation, and (*iv*) dyspnœa at night. Duration—5 months.

On investigation.—Temperature 99.2°F., pulse 86, respiration 20, spleen not palpable. In the lungs were heard a few rhonchi and many râles at the bases. Sputum—No acid-fast bacilli. M.P. not found. Differential count—Neutrophiles 28 per cent, lymphocytes 23 per cent, monocytes 1 per cent, eosinophiles 48 per cent. Total W.B.C. 10,000 per c.mm. Stool showed a few ova of ascaris and hookworm. The case was provisionally diagnosed as tropical eosinophilia and responded dramatically even after a single injection of acetylarsan 3 cc. She was discharged at her own request after the 3rd injection to continue the treatment in the garden dispensary.

Although a thorough investigation was not possible, these cases could be safely diagnosed as tropical eosinophilia owing to signs and symptoms suggestive of pulmonary tuberculosis, absence of acid-fast bacilli in sputum and high eosinophile count. Löffler syndrome* could be excluded by its transient character, rapid and spontaneous recovery in contrast to the chronic nature of tropical eosinophilia and dramatic response to arsenic.

Comments.—In this connection it may be pointed out here that quite often these cases are not correctly diagnosed due to lack of proper facilities for investigation in mofussil places and stamped as pulmonary tuberculosis or bronchial asthma and treated as such for a long time without beneficial results, when the disease, if properly diagnosed, is so rapidly amenable to simple treatment.

I am indebted to my chief Dr. A. B. Mitra, M.B., for his valuable suggestions in conducting the cases and kind permission to publish this note and also thankful to Dr. S. Chakravarty, D.T.M., for his laboratory investigations.

*'It is uncertain at present whether tropical eosinophilia or the eosinophilic lung is the same condition as Löffler syndrome.'—EDITOR, *I.M.G.*

ERRATUM

UNWANTED MEDICAL RELIEF

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In the above article published in the *Indian Med. Gaz.*, **83**, page 323, column 2, last but one para, line 5, *for* " injured ' murdered '," *read* " injured, ' murdered ',".