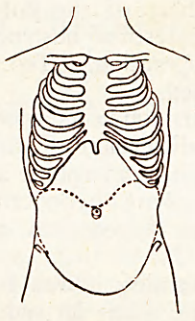
the tubes remained separated up to the level of the cervix, resulting in a condition of uterus bicornis unicollis. The cervix and vagina were single, the two horns uniting at the os uteri.

The patient, a Tamil woman, aged 26, was admitted on 6th November, 1925, at 8 a.m. with labour pains of 16 hours' duration. She was a well developed primipara in the seventh month of pregnancy.

On admission the uterus was one inch above the level of the umbilicus, with a distinct depression in the centre (as in Fig. 1). The girth of

Fig 1.



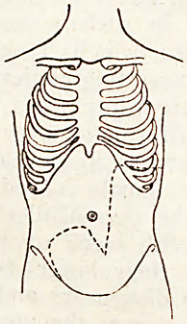
Shape of uterus on admission.

the lower abdomen was larger than one usually sees in a seven-month pregnancy. The various parts of the fœtus could not be palpated.

On vaginal examination the os was three-fifths dilated, and the head fixed in a left occipito-anterior position. She delivered a still-born female child at 9-20 a.m. and a complete placenta at 9-30 a.m.

On examination soon after delivery a hard ball-like mass (the contracted right horn of the uterus) was found in the hypogastric and right iliac regions, simulating a fully distended bladder displaced to the right. The left side of the abdominal cavity was occupied by a cylindrical-shaped body, the upper pole of which, lying under the costal arch, proved to be the left horn of the uterus (as in Fig. 2). Another vaginal examination was done but the presenting parts could not

Fig 2.

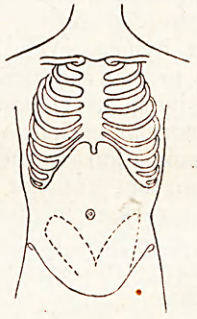


Shape of uterus after the birth of the first child and the placenta.

be reached, and the contracted right horn was displacing the left one up. Under general anæsthesia the whole hand was passed into the vagina and the left scapula and the ribs of a second fœtus were felt. The membranes were ruptured and internal podalic version performed. Another still-born male child was delivered at 11 a.m. followed by the delivery of a second complete placenta. Both the babies were approximately of equal size.

During these manipulations, the bicornuate condition of the uterus was confirmed. The separation extended down to the internal os. The cavity occupied by one child had no connection whatever with the one occupied by the other, except at the internal os. The vagina and the os uteri were single. On abdominal palpation, after the delivery, the two horns of the uterus were distinct and the sulcus between them could with ease be followed into the pelvis, and each horn could be moved independently of the other (as in Fig. 3).

Fig 3.



Shape of uterus after the birth of both children and placentas.

The puerperium was normal and the patient was discharged on the tenth day.

PARESIS FOLLOWING EMETINE INJECTIONS.

By B. D. PAL, M.B., B.S.,

Toungoo, Burma.

Though emetine is known to have a depressant action on the muscular and nervous systems, cases of actual paresis following injections of emetine hydrochloride are rare, and the following may be of interest.

Case 1.—A Chinese lady had six hypodermic injections of emetine hydrochloride in the arm; after the third injection she developed increasing weakness in both upper extremities, and eventually could hardly lift up her hand or anything else. The paresis gradually extended to both lower extremities by the sixth injection, and she could not stand or walk properly. The knee-jerk reflex was diminished. The injections were discontinued and the paresis gradually passed off *in toto*. She also complained of great

depression and weakness during the course of treatment.

Case 2.—A European had paresis of the upper extremity following injections of emetine in the arm; he found difficulty in writing and in lifting up anything.

Case 3.—A Burman rapidly developed paresis in both upper extremities, and after the second injection could not pass his urine which had to be drawn off with a catheter thrice daily. The emetine was discontinued, and all these effects passed off.

Case 4.—An Indian developed paresis after the sixth injection; discontinuance of the treatment relieved him of the trouble.

In all these cases, the hydrochloride of emetine ("Tabloid," B. W. & Co.) was used, and several persons were injected from the same tube; (each tube has a dozen tablets). The dose was one grain daily hypodermically, for the first three injections, and then one every third day.

None of the other patients had any trouble. There was no pain or swelling or abscess formation at the site of injection. All the cases were of amœbic dysentery, and were relieved of their complaint by the treatment.

A CASE OF SEVERE SEPSIS ACCOMPANYING DIABETES.

By J. VENKITACHELAM IYER, L.C.P. & S.,
Haripad.

Last November I was called in to see an adult male Hindu patient who had been bedridden from diabetes and under the treatment of local Ayurvedic practitioners for three months. I found him with a subcutaneous abscess of the left leg extending from the hip joint to the knee, discharging pus through an open sinus. The amount of pus discharged daily through this opening was some 16 to 20 ozs. In the groin above the hip joint was a second sinus, some four inches in depth. On the posterior aspect of the thigh was still a third sinus opening into an ulcer some two inches in diameter and with the bared femur lying exposed at the bottom of the sinus. The patient's general condition was extremely unsatisfactory and he could only turn from side to side with assistance. His temperature when first seen was 101°F., pulse rate 100 per minute, and respiration 32.

Treatment.—I gave an intravenous injection of 5 minims of tincture of iodine diluted with distilled water, and a mixture containing codeine, iron and nux vomica by the mouth. The intravenous injections of iodine were continued and the dose increased to 8 minims in the second week, and finally to 20 minims. The patient was kept on a strictly wheat diet, and Sanatogen and other tonics given. In all, ten intravenous injections of iodine were given.

By degrees the sinuses completely cleared up of themselves, without any local application except protective dressings. It is now four months since the patient first came under my treatment and he is able to walk and to carry out his domestic business. The sinuses have completely closed. It would appear to me that the excellent recovery which he has made must be attributed to the intravenous injections of iodine.

THE TREATMENT OF BACILLARY DYSENTERY BY CRESOL.

By Captain C. C. DAS GUPTA, M.B.,
Chief Medical Officer, Hossainabad Group of Tea Estates, P. O. Gopalbagan, Jalpaiguri.

Lieutenant-Colonel F. J. Palmer, in his article on "The treatment of cholera by cresol" published in the *Indian Medical Gazette* for August 1924, mentions that he tried cresol (Sanitol) in a small but severe outbreak of bacillary dysentery with satisfactory results.

In May 1926, I gave cresol a trial in an epidemic of bacillary dysentery at Gopalpur Tea Estate with encouraging results.

The doctor in charge reported that he was treating over 50 cases of dysentery with injections of emetine without any success.

I suspected the outbreak to be due to bacillary infection rather than amœbic. In the absence of a microscope I went round the coolie lines and was shown a number of cases which I clinically diagnosed as bacillary dysentery.

Treatment.

I gave m.i. of cresol in 1 oz. of water three times a day for four days. In the majority of cases, with the sixth dose the stools diminished in frequency, were of yellow colour and pain and tenesmus ceased. All symptoms subsided with three more doses on the third day.

In bad cases I also gave injections of anti-dysentery serum 25 c.c. under the skin of the abdomen with good effect. Sanitary measures, e.g., disinfecting drinking water from the tube well by chlorogen; sprinkling of bleaching powder in the lines to keep down the flies, etc., were undertaken. Now that dysentery has broken out in the Duars I would request the profession to give cresol a fair trial and to report their experiences.

The coolies object to being pricked by the needle. It would be a great boon if oral administration of cresol in bacillary dysentery proves as efficacious as the essential oils' mixture of Dr. Tomb in early cases of cholera.

A CASE OF MEDDLESOME MIDWIFERY.

By A. VISWANATHAN, L.M.P.,
Civil Hospital, Papun Salween, Burma.

E. Kam, a Shan woman, aged 35—a 4th-para, had difficult labour on the 13th June, 1926. She was attended at first by an untrained *dai*, who called in a trained nurse-midwife about 6-30 a.m. The latter found that the head of the fœtus had been born, but that there was no further progress in delivery. I was sent for by the nurse and reached the house about 7-30 a.m.

I found the patient in a condition of collapse, with the pulse feeble and almost imperceptible.