and it may even be necessary to stop giving the undiluted cow's milk and in its stead to give whey, albumen water or peptonised cow's milk and when the conditions become favourable to cautiously return to giving undiluted cow's milk.

In passing I may state that I am of the opinion that unboiled cow's milk is not only more digestible but also more nutritious than boiled cow's milk, and so I prefer to recommend the former undiluted to be given to infants provided of course that the milk is from a good sanitary source.

I have practised the above principles for several years with beneficial results.

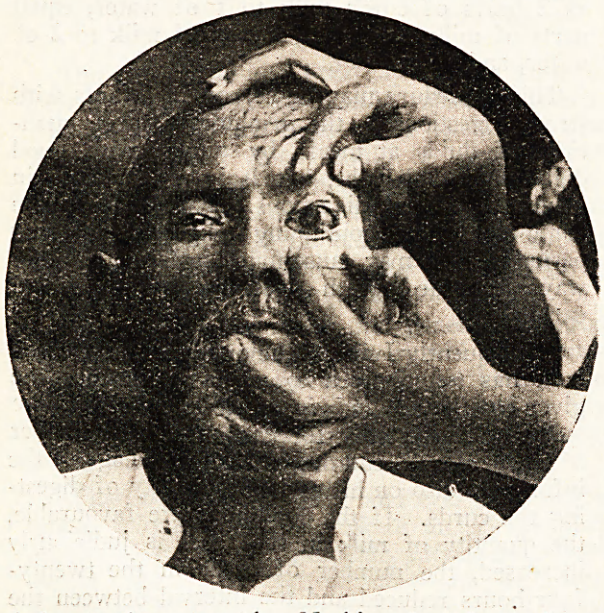
A Mirror of Hospital Practice.

A CURIOUS PRELIMINARY "TREATMENT" FOR COUCHING FOR CATARACT.

By B. K. NARAYANA RAO, M.B., M.R.C.S. (Eng.), D.O. (Oxon.),

Superintendent, Minto Ophthalmic Hospital, Bangalore.

On the 11th April 1924 Govinda Rao, a Hindu male about 60 years of age, presented himself for treatment for cataract of both eyes. His left eye had been treated by a Mohamedan coucher at Bellary a few days before and was somewhat red and watery. On examination it was found that a suture with an ordinary cotton thread had been inserted into the left eye about a quarter of an inch to the left of the cornea, a little below the mid-line of the cornea and enclosing in its grip about quarter of an inch of conjunctiva and sub-conjuctival tissue. Two knots had been tied and the threads had been left about 1½ inches long. There was a slight



inflammation around. Nothing had been done to the lens.

The patient gave the following account:—

The Mohamedan coucher was treating several patients for cataract and his method was as follows: On the first visit a few drops of a white medicine (? cocaine) were put into the cataractous eye; after about ten minutes the sound eye was covered and a suture applied to the affected eye with an ordinary needle and thread. Both eyes were then left open and the patient was told to visit the coucher once daily for three days. At each visit some drops were instilled into the affected sutured eye and some whitish liquid (? possibly a blister) applied to both temples and above the bridge of the nose, the size of a pin's head. On the fourth day the patient was taken to a room, a cloth was put over the heads of both patient and operator and in a few minutes the cataract was removed and the patient sent away with restored sight.

I report this case as the procedure is novel and probably calculated to enhance the prestige of the subsequent couching among the ignorant folk.

This patient whose photograph is given had run away after his first visit. He was operated on in the hospital and made an uneventful recovery.

A FOREIGN BODY IN THE RECTUS ABDOMINIS MUSCLE.

By I. R. ANDERSON, M.B., Ch.B.,

Mission Hospital, Kalna.

THE patient, a Hindu female, aged 25, was first seen on the 2nd April, 1926, when she complained of pain in the left side of the abdomen. The pain had commenced three weeks before and was gradually increasing. There was no history of previous illness.

On examination the left rectus was found to be very tight, hard and tender to the touch in about 1½ inches of its length just below and to the left of the umbilicus. Vaginal examination revealed nothing. The patient was advised to stay for observation as she was obviously having acute pain. She did not stay but returned a fortnight later and was then admitted. The pain was now much more acute, the patient being scarcely able to walk. On examination there was found a swelling about four inches long, very firm and narrow in the line of the left rectus muscle extending up to about 1½ inches above the level of the umbilicus. Vaginal examination confirmed the diagnosis of a swelling in the abdominal wall. The patient had had no fever during the present illness and there was no sign of fluctuation to indicate the presence of an abscess.

During the following two days the patient had no fever and the condition did not improve at all under local applications of heat. She then consented to operation and it was decided to explore.

Operation.—An incision was made in the line of the swelling and the rectus muscle exposed and freed as far as possible. The swelling was found to be in the muscle, which was very hard and of a grey colour. Muscular striation was absent, the appearance being that of a solid tumour. The muscle was incised longitudinally and the same grey solid-looking appearance was found. On deeper incision the knife was felt to enter a cavity in the centre of the muscle. A finger was inserted and there was felt a foreign body. On extraction this proved to be a twig 5½ inches in length and 1/6 inch in diameter, lying in the vertical line of the muscle with its centre just at the level of the umbilicus. There was no sign of pus but the twig had a very foul smell. The cavity had no connection with the abdominal cavity. The twig was recognised to be such as is used in India to produce abortion. The patient at first denied that she had ever been pregnant but on being shown the twig she gave the following history:—Three years previously she had been two months pregnant and abortion had been procured by the insertion of such twigs into the uterus. She had severe pain in the right side of the abdomen but that had cleared up in a month by the use of medicine. Since then she had had no illness at all until the commencement of the present trouble five weeks previously.

In view of the foul smell present and the condition of the muscle it was deemed advisable to leave the wound open and to treat it by hot dressings.

On the second day after operation pus was present and poured from the wound. This cleared up rapidly and the patient was discharged with the wound quite healed twelve days after operation. One presumes that the pus was caused by the presence of an aerobic organism which became active on being exposed to the air. I regret that it was not possible to culture the organism present at the time of operation.

One leaves it to the imagination to work out the course taken by the twig before it came to rest in the rectus muscle.

It is interesting to compare this case with that described in the *Indian Medical Gazette* of May 1926.

THREE CASES OF BRONCHIAL SPIROCHÆTOSIS.

By J. E. LESSLAR,
and
K. KANAGARAYER, D.T.M. (Bengal),
Assistant Pathologists, Institute for Medical Research, Kuala Lumpur, Federated Malay States.

To the practitioner in the tropics who makes frequent use of the microscope, infection by the spirochæte of Vincent is becoming a problem of increasing interest. This spirochæte, in association with the fusiform bacillus, presents itself in many different conditions involving mucous membranes and raw surfaces. It may supervene as a secondary infection in ulcers and wounds of the skin, and as a sequel to amœbic ulceration in the gut. In the mouth and throat it is responsible for well-defined infections such as Vincent's angina, glossitis and stomatitis. Apparently in most cases Vincent's infection is comparatively mild, but it may give rise to great destruction of tissues as in ulcus tropicum and Naga sore—(Knowles, 1923)—in India. When the bronchi are involved, either as a primary infection as in the three cases recorded here, or as an extension from a focus in the mouth or throat it forms a distinct clinical entity; the disease may run a long course with exacerbations at irregular intervals and it is difficult to eradicate it entirely. From clinical and microscopical findings there are reasons for regarding the three cases recorded below as cases of primary infection of the bronchi with Vincent's spirochæte and the fusiform bacillus and for concluding that the disease may be identical with the bronchial spirochætosis of Castellani (Castellani and Chalmers, 1919). In a case of gangrene of the right lung and extensive cellulitis of the neck and chest wall following sepsis in the mouth which recently came to post-mortem examination large numbers of Vincent's spirochætes and fusiform bacilli were seen in smears from different parts of the gangrenous lung and from the mouth and chest wall.

DESCRIPTION OF CASES.

Case 1.—A Tamil woman, 19 years of age, of normal development and nutrition, complained of cough, severe pain in the sternal region and hæmoptysis which came on suddenly a fortnight previously. When first seen by one of us in consultation with her medical practitioner, her good state of nutrition and the afebrile course of the disease on clinical grounds ruled out pulmonary tuberculosis, which was suspected though no tubercle bacilli were found in her sputum. She was expectorating large amounts of frothy blood-stained glairy sputum in which were floating small whitish flakes of tissue. These flakes resembled the whitish patches which we have seen in Vincent's infection of the throat and in a case of glossitis which recently came for examination. They are like diphtheritic patches with the difference that they are easily swabbed off. Physical examination of the lung revealed nothing except a few wheezing rhonchi as in an asthmatic lung. The gums, mouth and throat presented a normal appearance.

On microscopic examination of the sputum, large numbers of spirochætes and fusiform bacilli were seen under dark-ground illumination and by Fontana's and Giemsa's stains. The spirochætes were of different lengths varying from about 7 μ to 18 μ with loose open spirals 2 to 7 in number. The fusiform bacilli are stated to be non-motile (Chamberlain, 1911) and they were seen to be so in fresh smears in the second and subsequent examinations of the sputum of this patient and the other two cases. In the first examination of the sputum of this patient, however, the fusiform bacilli were seen to be progressing forward with a graceful undulating movement and in directions contrary to the currents in the fluid. This was specially looked for in the subsequent examinations but was not seen again. The fusiform bacilli were of