

antimony tartrate. He did so well that, when the urea-stibamine ordered arrived, the parents refused to pay for it, preferring the cheaper sodium antimony tartrate. The injections were given by Dr. S. K. Biswas.

Points in connection with such cases are (1) what is the diagnostic value of a partially positive aldehyde test? (2) What caused the entire absence of malarial parasites in these febrile, and non-quininised cases, which were certainly cases of malaria? (3) Why did the mother and child show partially positive aldehyde tests?

A CASE OF RETROGRADE STRANGULATED HERNIA.

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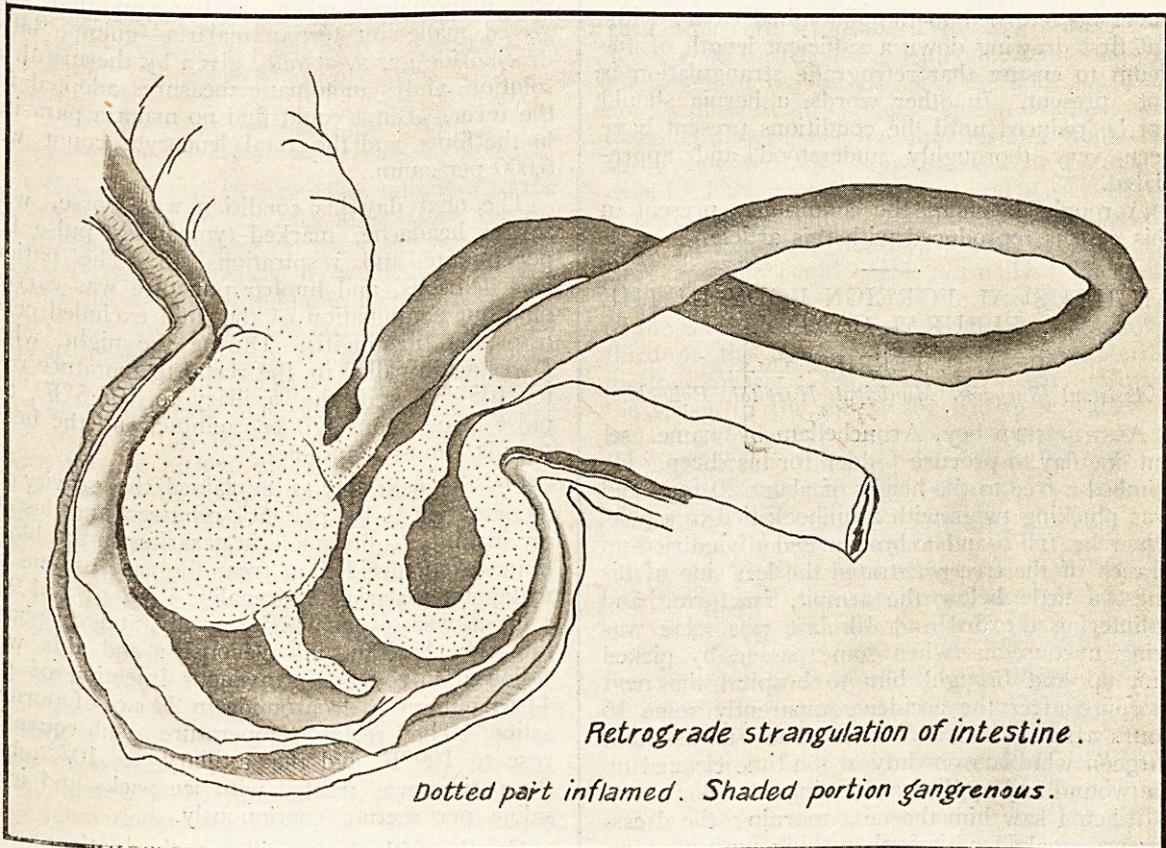
THE following case seems to me to be worthy of record, owing to the rarity of the condition described, and it may be of interest to those who

hours to bring him in, and he was first seen at 8 a.m. on the 1st October, 1927.

His condition on admission was very bad. Pain in the tumour had practically ceased; the temperature was subnormal; the pulse slow, thready, and almost impalpable. In other words, he was in a severely toxic state and completely collapsed, and the first question which I had to answer was whether he would stand the shock of an operation.

As operation, however, was the only chance of saving life, continuous hot saline was administered *per rectum* from 8 a.m. till 10 a.m., when the patient was placed on the operating table, and injections of adrenalin and pituitrin given. When placed on the table he was packed in warm blankets and hot water bottles, and the apparatus for intravenous saline was got ready. The patient stood the actual operation itself apparently well, though it lasted nearly three-quarters of an hour.

I was under the impression that I was going



are called upon to carry out emergency operations in India.

The patient, a man aged about 55 years, was admitted to the Pentland Hospital with strangulated hernia on the morning of the 1st October, 1927. The hernia was of about the size of a cocoanut, and had suddenly become strangulated about 10 p.m. the previous night. As the patient lived some 10 miles from the hospital, it took ten

to deal with an ordinary "common or garden" type of strangulated inguinal hernia. The seat of the strangulation was at the neck of the hernial sac, as usual, but the strangulated coil was not in the sac at all, but in the abdomen. This is a very rare type of strangulated hernia.

On opening the sac two nearly normal loops of small intestine were found,—a W-shaped hernia. In addition to this, the sac contained the

cæcum, the appendix, the end of the ileum, and the previously mentioned loops of ileum. These were all in a healthy condition, whilst the sac contained a lemon-yellow fluid, apparently due to a condition of hydrocele. The tumour was about the size of a cocoanut.

On drawing down the intra-abdominal loop of small intestine, an intermediate portion, about six feet in length, blackish, and in a condition of gangrene, was brought into view. To carry out a resection and an end-to-end anastomosis was impossible, owing to the critical state of the patient, for his pulse was failing and he was gasping for breath. The gut was returned to the abdomen; the incision sutured, and a pint of saline with adrenalin run into the median cephalic vein. The patient died about half an hour after he had been taken back to the ward.

Although very uncommon, retrograde strangulation is an extremely grave condition, and the lesson which such cases teaches is this; that the contents of a hernial sac—no matter how satisfactory their condition may appear to be—should never be returned to the abdominal cavity without first drawing down a sufficient length of the ileum to ensure that retrograde strangulation is not present. In other words, a hernia should not be reduced until the conditions present have been very thoroughly understood and appreciated.

A rough sketch of the conditions present in this case is reproduced with this article.

AN UNUSUAL FOREIGN BODY IN THE PLEURAL CAVITY.

By A. G. PEREIRA, L.M.S.,

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A SHEPHERD boy, Arunchellam by name, set out one day to procure fodder for his sheep. He climbed a tree to the height of about 20 feet, and was plucking twigs with a billhook tied to a pole, when he fell and a broken end of a dried-up branch of the tree penetrated the left side of his chest a little below the armpit, fracturing and splintering the 3rd and 4th left ribs. He was lying unconscious when some passers-by picked him up and brought him to hospital the next morning after the accident, apparently some 16 hours after it had occurred. The sub-assistant surgeon who was on duty at the time cleaned up the wound and applied a dressing.

When I saw him the next morning, the dressing was soaked with foul-smelling pus; his temperature was 104°F., and respirations 80 per minute. Operation was carried out immediately. The splintered rib fragments were snipped off; a large drainage tube inserted, and retaining sutures put in.

After operation the patient's temperature dropped to 100°F., and for some days continued between 100° and 102°F., but his progress was unsatisfactory. Finally, on the 16th day after the accident, the pleural cavity was explored,

whereupon a fairly big, rough, loose body was felt inside the pleural cavity. He was now operated upon again, and an irregular splinter of wood measuring 2½" long by 1½" wide was removed from inside the chest.

Subsequent to this the patient's progress was uneventful. The pleural cavity was irrigated daily for some days with an iodine solution and afterwards with a perchloride lotion. He was discharged cured on the 17th day after the second operation.

A CASE OF MALIGNANT MALARIA.

By N. CHATTERJEE, M.B.,

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BHUPENDRA NATH CHUKRAVARTI, a student, was suffering from fever, and I was called in to see him on the second day of illness. I found him with a temperature of 104.5°F., intense headache, pains all over the body, nausea and bilious vomiting, and constipation. A blood film was immediately taken—as the condition suggested malignant tertian malaria—quinine bihydrochloride gr. x. at once given by the mouth in solution, and symptomatic measures adopted for the fever. But I could find no malaria parasites in the films, and the total leucocyte count was 6,000 per c.mm.

The next day his condition was worse, with severe headache, marked tympanites, pulse 160 per minute, and respirations 45. The patient was delirious, and lumbar puncture was carried out; but examination of the fluid excluded cerebro-spinal meningitis. During the night, when I was again called in, the rectal temperature rose to 105°F., and the axillary to 103.5°F., the pulse being about 170 per minute, and the heart sounds almost inaudible.

On the next day, I explained the gravity of the situation to the patient's relatives, and despite my inability to find malaria parasites in the blood films taken, decided to treat the case as one of malignant malaria. Adrenalin, ½ c.c. of 1:1,000 solution was given hypodermically, and strophanthin, gr. 1/500th intravenously; and this was followed up by an intravenous injection of gr. 4½ of quinine hydrobromide in 20 c.c. of normal saline. The rectal temperature subsequently rose to 109°F., and the axillary to 107°, but the patient was treated with ice packs and iced saline per rectum continuously.

On the fifth day of illness the patient was definitely better, with an oral temperature of only 103.5°F., and conscious. I now found scanty ring forms of *Plasmodium falciparum* in blood films taken that morning. I therefore continued the administration of quinine intravenously, giving another gr. 4½ that morning. On the sixth day the patient was convalescent with a normal temperature, and on administration of quinine by the mouth made an uninterrupted recovery.