for one assistant to lift it out of the abdomen to ligature the pedicle, which was short and broad. It was therefore tapped and most of the fluid, which was black in colour, was removed in this way; adhesions were broken and two strong ligatures were put round the pedicle and the tumour was removed. The total weight of fluid was 46 pounds and that of the sac 2 pounds which is by far the largest I have met with in my surgical practice of over 22 years. I do not like to tap such tumours before removal but in this case it was impossible to adopt any other course. The abdomen was closed layer by layer in the usual way and the woman made an uneventful recovery.

A CASE OF ASCITES TREATED BY AUTOSEROTHERAPY

By BEHARI LALL KAMRA, M.B., B.S.
CAPTAIN, A.I.R.O.
Medical Officer in charge, Rattewala Dispensary, Ferozepur District

A FEMALE, 19 years of age, was admitted on the 7th December, 1934, to Rattewala Dispensary, with swelling of the feet and legs and enlargement of the abdomen of 1 to 1½ months' duration. About 6½ months ago the illness started with an attack of dysentery, which lasted for about 5 months. About 3 months after the beginning of the illness she aborted and got a left mammary abscess, which ruptured spontaneously and had healed.

The abdomen was uniformly enlarged. The girth measured 34 inches at the umbilicus, which was nearer to the pubes than to the ensiform cartillage.

The abdomen was dull in the flanks and tympanitic in front. The spleen and liver could not be palpated. Fluid thrill and shifting dullness could be easily elicited. Her heart was normal. The pulse was 120 per minute and was small. Moist râles could be heard at both bases of the lungs. There was no jaundice. Œdema of both feet and legs was present and came on before the ascites.

She was put on the following mixture:—℞ Tincturæ digitalis—$\mathfrak{m}$ xx, spiriti ammonii aromatici—$\mathfrak{m}$ xx, tincturæ nucis vomici—$\mathfrak{m}$ v, spiriti ætheris—$\mathfrak{m}$ xx, aquam ad 1 oz. three times a day. Paracentesis abdominis was performed the same day, and about 20 pounds of clear fluid withdrawn. Its specific gravity was not taken nor could its chemical and microscopical examination be done. After tapping, the girth at the umbilicus measured 30 inches.

One cubic centimetre of the ascitic fluid was given subcutaneously immediately after tapping and some was stored in a sterile phial out of which 1.5 c.cm. and 3.5 c.cm. were injected under the skin on the 11th and 15th December, 1934, respectively. On the 22nd December she was again tapped, and about 12 pounds of fluid withdrawn—this time it was greenish in colour —5 c.cm. was injected, and on 26th December an injection of 10 c.cm. of the stored fluid was repeated.

Whatever amount of the free fluid was left behind after the last tapping now began to be absorbed instead of re-accumulating and on 5th January, 1935, not a trace of it could be detected. The spinal column could easily be felt through the anterior abdominal wall. There was absolutely no swelling of the feet.

Since admission she had been passing four stools a day, on the average. They were always semi-fluid and occasionally contained blood. On microscopical examination they were found to contain cysts of *Entamœba histolytica.* On 16th January, 1935, she was put on emetine hydrochloride, hypodermic injection of gr. i a day for six days. After an interval of three days three more injections were given and a course of twelve injections was completed after another interval of three days.

The blood and mucus disappeared from the stools and their number was reduced to 1 to 2 a day though they were still semi-fluid in consistency. A few days after the course of injections was completed the woman showed signs of muscular weakness, starting in the lower limbs, on account of which she was again bedridden and was unable to stand up although she could sit. Salol was prescribed and she was discharged on 6th February with emetine paresis but cured of ascites.

She attended the dispensary on the 22nd April, 1935. She came on horse-back from a village five miles away and could walk in all right but was feeling weak in the legs and arms. There was a moderate degree of anæmia. There was absolutely no trace of free fluid in the peritoneal cavity. The urine was normal; no cysts could be detected in the stools which contained no blood and looked quite normal. The liver was palpable.

Evidently this was a case of ascites due to non-suppurative peritonitis and belonging to a class which Megaw (1921) studied and was named 'chronic superior peritonitis' by Sprawson (Megaw *loc. cit.*), while the presence of amœbic cysts might have been due to an infection superimposed upon an attack of bacillary dysentery. Chronic superior peritonitis causes ascites as the result of fibrosis of the peritoneum following its inflammation. These cases follow diarrhœa or dysentery, probably caused by the bacillus of Flexner or some closely related organism.

Autoserotherapy in ascites is not a new thing. It has already been tried though the reports have not been favourable and conclusive. It may be useful only in the class of cases termed chronic superior peritonitis and the unfavourable results might have been due to treating cases of ascites other than this type. The successful application of autoserotherapy in the above described case has prompted me to report it so that others may try this treatment.

I am greatly indebted to Lieut.-Col. Batra, I.M.S., Civil Surgeon, Ferozepur, for his useful advice and kind permission to publish this note.

REFERENCE

Megaw, J. W. D. (1921). Chronic Dysenteric Peritonitis. *Indian Med. Gaz.*, Vol. LVI, p. 321.

AN UNUSUAL CASE OF CANCRUM ORIS*

By MAGANLAL D. LATHIGARA, M.B., B.S.
Medical Officer, Bilkha State, Bilkha (Kathiawar)

A MALE adult, aged about 24, came to the state dispensary, complaining of toothache on 17th June, 1935.

On examining him I found the two upper lateral incisors painful and the gums over them red and inflamed. Potassium permanganate gargle, tooth powder and gum paint was prescribed. He attended the dispensary for about five days and then ceased coming. The patient did not take any further treatment. He returned on 11th July with a foul-smelling gangrenous slough over the upper lip on the left side just below the left nostril which was partially eaten away. On examining the mouth the gums were found to be gangrenous and both the teeth were loose. Inside the mouth, the mucous lining over the left cheek was black and sloughing, with a very foul odour. His pulse was rapid (110), and he had a temperature over 100°F.

* Rearranged by Editor.

He did not complain of much pain and could take liquid food.

Suspecting the case to be one of acutely spreading gangrene I removed the two teeth and a considerable portion of the slough. On cleansing the part a hole appeared which communicated directly with the oral cavity, just below the left nostril. I irrigated the cavity thus formed with warm Milton lotion and packed it with sterile iodoform gauze. Potassium permanganate gargles were ordered and complete isolation from flies was strictly advised. He attended the dispensary as an outpatient for about a week, during which time the above treatment was carried out. He flatly refused to take any injections. His condition was going from bad to worse and his facial gangrene was spreading.

On the 16th July, when I examined him the gangrene had spread over the cheek and the left side of the nose was destroyed. I had to dissect out the slough daily and by this time the whole of the left nasal cavity was exposed and the gangrene had spread up to the eye. He was unable to walk and refused any food. I advised him to go to a hospital and to get admitted there as an inpatient. He agreed to go but absconded after four or five days and took no treatment for about a week, during which period he was confined to bed at his home and his condition became much worse.

I went and saw him on the 29th July and found the nose completely destroyed, and the nasal and cheek bones exposed. The left eye was gone and the bony margins of the orbit were visible. The lips were also gone and the jaws exposed, and the whole area was crawling with maggots. In spite of the seriousness of his condition he complained of no pain but only irritation caused by the maggots. It was not possible to do anything for the man so I just sprayed the area with weak lysol and removed a number of maggots. He died on the 31st July.

The unusual features of this case are :—

(1) Cancrum oris is usually a disease of childhood and is comparatively rare in adult life.

(2) In this case it began as a mild gingivitis.

(3) The patient was not weak, nor was his vitality lowered so as to account for this acute gangrene of his face.

SPONTANEOUS BURSTING OF A STONE IN URETHRA

By B. R. JAIN, M.B., B.S., P.M.S.
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A MAN, aged 36 years, was admitted on 20th April, 1935, with retention of urine and extravasation for the last 36 hours.

He gave no history of venereal disease, but had had pain on micturition for the last year, recently becoming worse. About a week ago when the pain became very severe he went to Nadigaon hospital. Here he was given 'something to apply' and he went home. That day while straining in the act of micturition, he felt something give way inside and after that his pain increased. Thereafter he only passed urine with great pain and in drops, and for the last thirty-six hours he has not passed any urine at all. He denies all history of instrumentation.

Present condition.

General.—Patient suffering from severe toxæmia, face drawn, quick and feeble pulse, restlessness, rapid breathing.

Local.—Scrotal tissue œdematous and gangrenous; superficial cutis peeled off exposing red skin beneath; skin over pubis and right loin red and indurated. Blisters have formed over loin. A similar condition of the skin is present in the perineum where also the cutis has disappeared exposing grey gangrenous tissue beneath.

Bladder region dull on percussion and tender on pressure. Distension up to just below the umbilicus. Bowels not moved for last three days.

Operation.—Under chloroform and ether anæsthesia multiple incisions all over the scrotum were made. The incised tissue was gangrenous and urine trickled out freely from the incisions. The perineum was also similarly incised. A full-sized metal catheter was then passed from the external meatus. It went in easily as far as the prostatic portion and there a distinct stone click was heard and felt, and the instrument went no further. One of the cuts already made in the perineum was deepened and a finger put in through the perineal gangrenous tissue. The cut was further deepened by the finger and the stone reached. The stone was found already broken into pieces. Twelve pieces were removed by lithotomy forceps. (The total weight was 6½ drachms and the largest piece was about 1 by ¾ inch by ½ inch. The stone was phosphatic and quite hard in consistency.) The catheter then went in easily and the retention was relieved. The wounds were dressed and the patient put to bed.

Shock and toxæmia were treated with glucose and stimulants, and urotropine was also given internally. The skin over the pubis and loin sloughed away during the next three or four days and a large slough came out through the perineal wound. The man was later on put on iron, quinine and digitalis and he steadily improved. On 29th April a full-sized (no. 12 English) catheter was passed, kept in place for ten minutes and removed. The patient passed one more small piece of stone through the perineal wound on the 8th May. On 10th May he had an attack of influenza and got better by the 14th. Thereafter a no. 12 catheter was passed every fourth or fifth day. On the 30th May, a plastic operation was done when the skin over his loin and pubis was undermined, and flaps brought together and sutured. Eight small skin grafts were also taken from the thigh and planted over the scrotal wound. Thereafter he made an uneventful recovery and was discharged cured on 23rd June, 1935.

The interest of the case was the spontaneous bursting of the stone which had obviously been forming in the membranous portion of the urethra anterior to the prostate. The man was very carefully interrogated about any instrumentation being done previous to his coming to this hospital. The medical officer of Nadigaon hospital was written to to find out if he had passed any instruments but he had not done so and the man denied all history of instrumentation previous to admission here. As I have never read nor heard of any stone bursting spontaneously by muscular action only, I am reporting this case.

I have to thank the Civil Surgeon, Jalaon, for permission to report this case.

A CASE OF ASTHMA TREATED WITH OLEO-SANOCRYSIN

By S. M. DAS, M.B.
Sylhet

Patient.—S. R., a Hindu female, aged 19 years.

Typical asthmatic attacks began in the latter part of August 1933, following a miscarriage. It was preceded by nasal catarrh and cough with expectoration