coffee colour, and about 40 ounces were passed in the first 24 hours. It contained hæmoglobin in solution. Examination of blood films showed *Plasmodium vivax* rings and gametocytes.

The patient had no history of fever, at least recently, and he had not taken quinine as he was under our observation in the hospital for about a week.

He was given alkaline mixtures, glucose and soda drinks, and quinocrine tablets (May and Baker)—two tablets of 0.1 gm. divided into three doses. He was also given an intravenous injection of 25 c.cm. of 25 per cent glucose solution with 5 c.cm. of 10 per cent calcium gluconate solution. Injection of glucose solution was repeated in the evening.

17th February.—Temperature between 98.4°F. and 100°F. Urine—about 25 ounces in 24 hours. Patient developed jaundice, hiccough and vomiting and could hardly retain anything by the mouth. Treatment same as before supplemented by rectal saline with glucose. An attempt was made to administer fresh decoction of leaves of *Vitex peduncularis* but the patient could not retain it because of frequent vomiting.

18th February.—Temperature between 98.4°F. and 99°F. Urine less than 20 ounces; colour red but intensity lessened. Vomiting and jaundice increased. Liver became tender and slightly enlarged. Treatment same.

19th February.—Temperature normal throughout the day. Urine comparatively clear but amount still diminished. Nausea still persistent. Treatment same.

20th February.—Urine brown. No fever. Quinocrine only one tablet given. Blood films were examined but no parasites were found. Patient became anæmic.

Recovery was uneventful and he was discharged cured on 23rd February, 1941.

Points of interest

(1) Occurrence of blackwater fever at an altitude of 2,800 feet where malaria is a rarity especially at this season of the year.

(2) Sudden appearance of hæmoglobinuria with slight rise of temperature in a subject, who had no history of recent fever nor quinine intake, but whose blood contained malaria parasites.

(3) Quick response to ordinary routine treatment *plus* quinocrine (May and Baker), which acted on gametocytes as well.

I am grateful to Dr. S. K. Biswas, Head of the Medical Department, Darjeeling Himalayan Railway, for his interest and suggestions in the treatment of the case.

[*Note.*—The important point is surely not where the patient first showed symptoms of blackwater fever, but where he acquired the infection that caused the blackwater. The writer gives no history of the previous movements of the patient. It is unusual to get blackwater fever with a benign tertian infection; it is however very difficult to be certain that the infection was not a mixed one.—EDITOR, *I. M. G.*]

OMENTAL LIPOMA

By HUKAM CHANDRA, M.B., B.S., P.C.M.S.
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K. B., aged 31 years, female, consulted me in the early half of October 1940 for the following complaints:—

(1) Amenorrhœa—duration two years.

(2) Progressive enlargement of abdomen—duration ten months.

She had been examined several times by native *dais* who had diagnosed pregnancy as the cause of abdominal enlargement. She had also experienced the usual symptoms of pregnancy, such as nausea, vomiting and fœtal movements but because the expected delivery did not come about and appeared to have been delayed much beyond the usual period of gestation, the patient and her relations felt anxious about it and fearing grave abnormality consulted a lady doctor who discovered the absence of pregnancy altogether, but gave no opinion as to the cause of enlargement of the abdomen.

Previous history.—Married at the age of 13; commenced menstruating a year later. Suffered from more or less continuous fever for six months—probably of enteric origin—two years after marriage; recovery from this illness was followed by good deal of increase in weight. Menstrual history normal for fifteen years during which period she never conceived. Two years ago menses stopped abruptly and the patient was believed to have become pregnant but nothing happened to support this belief. Fourteen months after this the abdomen began to enlarge and the symptoms of pregnancy appeared in due course.

Physical examination.—Patient rather obese. Abdomen enlarged to the size of full-term pregnancy. Palpation revealed a tumour, semi-fluctuant in consistence, rounded and lobulated in outline, freely movable and most prominent on the right side below the umbilicus, but no fœtal parts or movements could be felt and auscultation of the abdomen was also negative. Breasts were fully developed and contained milk which could easily be squeezed out of the nipples. Examination *per vaginam* negative except some fullness in the posterior vaginal fornix. Bowels regular and digestion good. Nothing abnormal about the heart, lungs or other organs. There was nothing to support the hypothesis of pregnancy and a provisional diagnosis of right ovarian cyst was made.

Operation was advised but the relatives of the patient insisted upon more definite exclusion of the possible existence of pregnancy. *X*-ray examination was suggested and done; the skiagram showed no evidence of pregnancy.

The patient was admitted into the civil hospital, Mailsi, on 8th November, 1940, and operated upon on the following day. The abdomen was opened under chloroform anæsthesia by a median incision below the umbilicus. Immediately on cutting the peritoneum a fatty tumour presented in the wound. Closer examination revealed this to be a lipoma encapsuled by the great omentum; it was decided to remove the tumour which consisted of two main lobes connected by a neck of fatty tissue. The whole mass was shelled out and bleeding points secured and ligatured. The margins of the cavity left in the omentum were brought together and sutured with fine silk. Examination of the uterus and ovaries showed nothing abnormal, and there were no adhesions between the omentum and coils of intestines. The abdomen was closed in the usual manner.

There were no apparent post-operative complications and the wound healed by first intention. Skin stitches were removed on the ninth day after operation when a soft fluctuant area was felt underneath the otherwise healed-up wound. A hæmatoma was suspected and confirmed by making a small opening through the lower part of the wound. About 3 ounces of fluid blood were mopped out, when the incision made through the peritoneum and muscular aponeurosis was seen to have healed up. Obviously the source of blood was from minute vessels in the subcutaneous fat which was present in abundance. The cavity left by the hæmatoma filled up slowly by granulation and the patient was discharged cured on 15th January, 1941.

Comments.—The occurrence of lipomata of any size (the one in the present case weighed 26 ounces) in the omentum is very unusual and I failed to find any reference to such cases in the literature on the subject available to me. Fatty herniæ of the linea alba and subserous lipomata are, in my opinion, entirely different from the one described above. The appearance of the usual symptoms of pregnancy, though

significant in this case, is not uncommon under similar conditions.

My grateful thanks are due to Captain D. D. Kapur, civil surgeon, Multan, for his permission to publish this report.

ITCHING IN SYPHILITIC SKIN ERUPTIONS

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and

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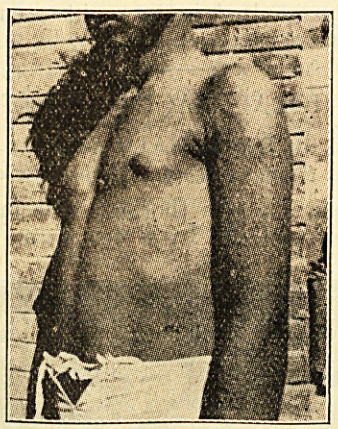
THAT there is no itching in syphilitic skin eruptions is so well known that the mere presence of this symptom is thought to be enough to exclude syphilis in diagnosis. The case in point was interesting for this; he had a skin rash which was very itchy, and the diagnosis ultimately turned out to be secondary syphilitic skin rash.

Case report.—A male, aged 20, was admitted to the Irwin Hospital on the 8th January, 1941, with the complaint of itching all over the body. The trouble started a few days back and was more-or-less generalized from the very beginning. There was no history of contact with a case of scabies, nor of syphilis. Patient has no history of having taken any drug like arsenic, etc.

Examination.—There was a skin rash distributed all over the body—limbs, trunk and face. It was most marked over the left arm where the skin between the



Photograph of the case of syphilitic rash showing the vesicular eruption with a black top.

individual lesions was also somewhat inflamed. The lesions were also present in between the fingers and toes. The volar aspect of the wrists was not involved. Evidence of itching was present in the form of scratches.

The individual lesions were small discrete vesicles with a pointed top which in many instances simulated very closely the black-topped lesions of scabies.

There was no evidence of a syphilitic sore on the penis but the epitrochlear nodes were markedly enlarged. There was no pyrexia, and the heart, lungs and abdomen showed no abnormality.

Laboratory findings.—Scraping was taken for *Sarcoptes scabiei* but was negative.

Blood: hæmoglobin 60 per cent, leucocytes 6,875 per c.mm., polymorphonuclears 60 per cent, lymphocytes 24 per cent, eosinophils 11 per cent, large mononuclears 5 per cent, Kahn's test was three plus.

Urine analysis revealed no abnormality.

Discussion.—Resemblance to scabies was marked from the type of lesions, their presence in the clefts between the fingers and toes, and the presence of marked itching. But the presence of the lesions on the face and their absence on the volar aspect of the wrists was strongly against this diagnosis. A negative scraping excludes this disease altogether.

Before the result of Kahn's test was known, itching was strongly against the diagnosis of secondary syphilitic rash. In fact, during the time we were waiting for the blood examination, we had actually put the patient on treatment with sulphur ointment. This gave no relief. The itching persisted but the vesicles were rubbed down during the application of the ointment and the lesions became more macular.

After the blood report was available, the patient was given three weekly injections of neosalvarsan each dose being 0.45 gm., as only these doses were available. The itching improved considerably after the first injection, and so also the rash; until now, after the third injection, there is no itching and the skin lesions have also disappeared. In some places, especially the thighs, there is some pigmentation left. The patient is now getting bi-weekly injections of bismostab.

The blood examination and the result of treatment leaves no doubt as to the cause of the skin eruption. It was syphilitic. The interesting point was the itching which led to difficulty in diagnosis and mistake in treatment. We have felt inclined to report this case because of this. An odd case of syphilis may have itching as demonstrated by this example and we should be open-minded on this question, because sticking blindly to the orthodox view that syphilitic lesions do not itch might lead to an error like this. Itching should be regarded as a point against the diagnosis of syphilitic skin lesions but when other data point to this disease itching alone should not exclude it.

Acknowledgment.—Our thanks are due to Lieut.-Colonel M. M. Cruickshank, I.M.S., chief medical officer, Delhi, for his kind permission to report this case.

A CASE OF LEUCOPENIA WITHIN TWENTY-FOUR HOURS OF THE INITIAL ADMINISTRATION OF PARA-SULPHANILYL-AMINOPYRIDINE

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THERE have been in recent times many discussions about the toxicity of the various drugs of the sulphonamide group. Little, however, is