pable 3½ finger breadths below the costal arch. After a week the patient looked more cheerful, the temperature came down and a craving for food returned. It must be noted that neither could malarial parasites be found nor was there any Widal reaction during the remittent period. During the second week the temperature began to show a daily double rise, at first low which soon became high, becoming low again after 10 days from the beginning of second week. The spleen all the while increased rapidly. The tongue was quite clean and no one would have suspected that the patient was getting fever by merely looking at her. During the fourth week the temperature was of a low intermittent character: pretibial œdema was just appearing, and the patient was emaciated. A leucocyte count was made:—Total W. B. Cs.=3,700 and differential count—Polymorphs 51 per cent., large Mononuclears—21 per cent., small Mononuclears—24 per cent., Eosinophiles—4 per cent.

From the physical signs alone there was very little doubt about its being a case of kala-azar. The patient was put on to antimony and she recovered in 6 weeks.

The second and the third cases were of an exactly similar kind: there was pyrexia with rigors which reacted to quinine immediately: the spleen enlarged each time with the fever but did not disappear with the cessation of the fever. Each time the mouth temperature was taken, it was below normal during the apyrexial period. After two or three such attacks a remittent type of temperature was the rule, at times high, at times low, and not reacting to quinine in any way. The temperature then came down, often touching the normal, but rising and falling every evening. At this stage the typical signs and symptoms of kala-azar appeared. In one case spleen puncture was done and L. D. bodies were found. The spleen was enormously enlarged in each case.

Conclusions.

(I) It is not at all safe to diagnose a case of fever to be malarial in origin merely from the history, the physical signs and reaction to quinine.

(II) When the spleen does not disappear after the temperature comes down to normal, and remains so for some time in spite of the patient taking quinine in solution in proper doses, the suspicion should at once arise that probably the fever is not malaria

(III) The enlargement of the spleen is most noticeable during the pyrexial period, when the consistency of the organ is more or less soft. During the afebrile time the spleen becomes hard.

(IV) If the temperature persists, especially a moderate evening rise after the remittent stage, and if the spleen remains enlarged to the same extent as it was during the remittent period the case is probably one of kala-azar.

A CASE OF UNUSUAL MALPRESENTATION.

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Some time ago I was asked to attend a woman (multipara) who had been in labour for more than 24 hours. Three sub-assistant surgeons were already in attendance and the general condition of the woman was unsatisfactory. The sub-assistant surgeons were of opinion that the case was one of twins.

Whilst admitting that the abdomen was abnormally large for a single fœtus I refrained from positively stating that the woman had twins. As the labour pains were very strong a detailed abdominal examination was difficult. On making an examination per vaginam I found the head (vertex), hand and foot *firmly impacted* in the vagina, the head being between the hand and foot.

As the District Surgeon (Dr. Haworth) had come into the station I availed myself of his presence. The woman was anæsthetized and every effort made to effect delivery. It was found impossible to return any one of the presenting parts into the uterus. The possibility of interlocked twins was thought of, but no definite diagnosis could be arrived at. The head was perforated with great difficulty owing to the œdematous condition of the vagina, and an arm was removed at the shoulder-joint. Attempts were next made to bring down the leg, simultaneously pushing back the head into the uterus. This was not possible. The head was severed from the thorax by cutting through the neck with a pair of blunt-pointed scissors. It was then found possible to push the head into the uterus. This gave an opportunity of conducting an examination of the uterus. It was ascertained that there were no twins. A leg was pulled down and the body of the fœtus extracted. The fœtus was a full-term child of normal size. As is usual there was difficulty in extracting the after-coming head.

On completion of delivery it was found that the woman had a sessile submucous fibroid tumour, the size of a large orange, situated in the upper segment of the uterus. It was also noted that the tumour was incompletely split in halves. Previous to this confinement the patient had had two normal deliveries. The relatives of the patient would not agree to keep her in hospital. She expired about 24 hours later.

Remarks.—The interest in this case is the unusual degree of malpresentation; a head, foot and hand presentation must be rare in a full-term child. Although a fibroid in the body of the uterus interferes with natural uterine action it is difficult to understand how a fibroid of the size found could cause a malpresentation of this kind. The diagnosis of intra-uterine fibroid under the circumstances would have been extremely difficult.