

of the swelling. The incision was enlarged above and below. The swelling was aspirated through the lesser omentum. Fluid came out, and the diagnosis of pancreatic cyst confirmed. The cyst was approached through the lesser omentum above the lesser curvature. The cyst wall was incised, a large drainage tube was placed inside, the fluid was drained, and the wall of the sac was marsupialized. The abdominal incision was closed. Recovery was uneventful.

A CASE OF MADURA FOOT TREATED WITH PENICILLIN

By S. K. MITRA, M.B.

Medical Officer and Pathologist, Main Hospital,
Raigarh, Raigarh State (E.S.A.)

A HINDU MALE, aged 45 years, of Sarangarh State (E.S.A.), was admitted into the hospital on 21st June, 1945, with swelling of the left foot which was riddled with sinuses, discharging pus and yellow 'sulphur-like' granules; duration 1½ months. The swelling started from the sole and gradually involved the whole foot. The foot was deformed and anatomical landmarks were distorted. It was thickened, considerably swollen and its length was diminished. The foot had an ovoid form, the toes being separated and directed upwards and the sole convex. There was hectic temperature. Smear examination of pus revealed the fungus 'Actinomyces Maduræ', and the case was diagnosed to be one of Madura foot.

Treatment.—Preliminary treatment with sulpha group of drugs and local antiseptic dressing for 7 days produced no improvement.

Multiple radial incisions under anæsthesia followed by daily antiseptic dressing for another 7 days was also of no value.

Penicillin treatment was undertaken under the kind suggestion of Dr. N. G. Ray, chief medical officer, Raigarh State. 10,000 units were given intramuscularly to start with followed by injections of 5,000 units every four hours and a total dose of 100,000 units was given, all intramuscularly.

The temperature came down to normal within 36 hours of the beginning of the penicillin treatment, the pus disappeared in three days and the condition of the wound gradually improved.

The patient was cured and discharged in a month after the administration of penicillin; during the later period of his stay in the hospital only hæmatinic drugs were given with local dressing of the wound.

MENINGOCOCCAL INFECTION COMPLICATING CEREBRAL MALARIA*

By ROMESH CHANDRA BARUA, L.M.P., L.T.M.

Assistant Medical Officer, A. O. C. Hospital, Digboi,
Assam

A PATIENT was admitted to hospital at about 10 a.m. in an unconscious state. The history was that he had a high rise of temperature with chill, rigor, and frontal headache, and became unconscious six hours before coming to hospital.

The patient was deeply unconscious and cyanosed. The temperature was 100.6°F., and the blood pressure 120/60. The pulse was of good tension and volume,

and the rate 100 per minute. The heart and lungs were normal; the spleen and liver were not palpable. There was no stiffness of the neck and Kernig's sign was absent. The total white cell count was 6,500 per c.mm. The urine culture was sterile. Examination of the blood showed *P. falciparum* rings.

The patient was treated with intravenous quinine, a total of 20 grains in the day, and 10 grains by Ryle's tube. Continuous oxygen inhalation was given and the patient was fed by Ryle's tube. The temperature came down to 99.4°F. next day and the patient was in a semi-comatose condition. Intravenous quinine was continued. The patient regained consciousness about 36 hours after admission, and after 60 grains of quinine. The urine was tested for quinine and was found positive. Falciparum rings were also seen in thick films.

On the fourth day at about 9-30 a.m. the patient became unconscious again with sudden convulsions, profuse sweating all over the body, rolling of the eyes, frothing of the mouth, and later conjugate deviation of the eyes to the left. No history of epilepsy could be elicited. There were several epileptiform fits that day. The temperature was 101.8°F. and the pulse rate 110; all the tendon reflexes were normal; Kernig's sign negative, only slight restriction of anteroposterior movement of the neck could be detected. Culture of the nasopharyngeal swab showed only colonies of *Streptococcus viridans* and staphylococcus, but no meningococcus. The total and differential white cell counts were within normal limits. Lumbar puncture showed the cerebro-spinal fluid to be quite clear, and under normal pressure; there was no abnormal constituent; a direct smear showed no organism but the culture after 24 hours showed some colonies of meningococcus.

The patient was immediately treated with Dagegan sodium intravenously, and consciousness returned after 12 hours. Later sulphapyridine was given orally.

The case seems to be one of meningococcal infection developing during recovery from an attack of cerebral malaria.

My thanks are due to Drs. A. S. Prowse, R. H. P. Clark, and T. Das for valuable suggestion and help given.

A CASE OF ACUTE MELANCHOLIA TREATED WITH CARDIAZOL AND INSULIN*

By B. L. CHOPRA

Divisional Medical Officer, N.-W. Railway, Ferozepore

A BOY, aged 20 years, was admitted to hospital on 1st April, 1945, for the treatment of pain in the neck, back and legs, insomnia and dimness of vision for 20 days, and constipation for 3 days.

The patient was grey-haired, and with prominent eyeballs (exophthalmos) and prominent upper maxillæ. He had a look of depression, and would answer questions very slowly. Tongue dirty and coated; liver and spleen palpable; chest and heart normal; blood pressure 95/65; Kahn test negative; no abnormality in blood and urine; x-ray of the vertebral column normal. The deep reflexes were sluggish, and the plantar reflex was flexor.

Sedatives did not produce any effect. Purgatives and enema did not improve his constipation. After about a month, he was given cardiazol 6 c.cm. intravenously for three consecutive days. Though no shock or fit was produced, there were some good subsequent effects. The pain all over the body began to diminish. The patient was then given 10 units of insulin half an hour before meals twice daily for 5 days. With this,

* The paper has been condensed. The diagnosis in this case is open to question.—Editor, I.M.G.

* Paper rearranged by the editor.