small boy I was prepared to find his illness due to that. Chicken-pox however was soon ruled out.

So was measles of which, so far as I could discover, no other cases existed in the neighbourhood.

Typhus appeared to be the most likely diagnosis, though the symptoms and their course were not typical.

I had a case of what I considered to be typical typhus in a British officer in the same bungalow about a year previously, and there were some interesting sequels to the above narrated cases.

1. A few weeks after I had sent these notes to the Superintending Surgeon I met him in Kashmir. He told me that on reading my cases he came to the conclusion that they were exactly similar to two which he had himself recently seen.

2. In September I was back in the Gilgit Agency and on tour in Hunza, about 60 miles from Gilgit, the compounder, an intelligent Indian with 30 years' experience, described to me an outbreak of a small epidemic which he had thought to be typhoid. In all there were about 15 cases, of which 8 were fatal. The disease spread very definitely up stream; it originated in a house to which a week or so before there had returned a man who immediately previous to his return had lived in the compound of the officer who was No. 2 case; and questions as regards the signs and symptoms of the disease left no doubt in my mind that it was the same as that which I have described.

The mortality was surprising in view of my small experience, but hygiene and nursing were undoubtedly nil and treatment, if any, very sketchy. I am quite certain that these cases were perfectly distinct from ordinary typhus. There was no history of tick-bite in either case.

A CASE OF INTESTINAL OBSTRUCTION.

By M. UMAR,

Officiating Civil Surgeon, Bijnor, U. P.

BUDHA, Hindu male, aged 60, was admitted to hospital suffering from severe and diffused abdominal pain, with a drawn and pale facies, and a subnormal temperature. There was no passage of either fæces or flatus, and bilious—but not stercoraceous—vomiting was present. The abdomen was extremely distended; the pulse weak, rapid and thready.

He was given three consecutive enemata, with no result. At the suggestion of one of my assistants a high enema with a big tube was given, but also without result.

Operation.—As surgical measures appeared to be the only possible line of treatment, he was anæsthetised and the abdomen opened by an incision from 2″ above the umbilicus to 1″ above the symphyisis pubis in the middle line. The great omentum was found to be adherent in four places to coils of gut, and this had apparently produced the obstruction. In removing these adhesions, the gut was perforated slightly in two places and had to be sutured with purse-string sutures. The abdomen was full of a reddish fluid, and apparently peritonitis had set in. After thorough cleansing of the abdomen, the intestines were replaced and the abdomen closed in the usual fashion.

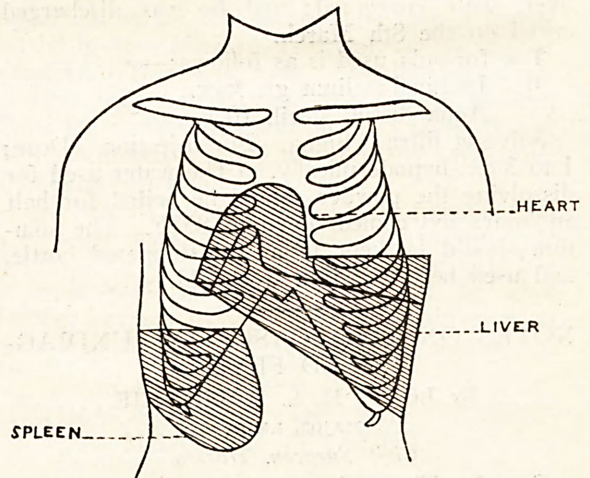
After operation the patient was allowed nothing at all except ice to suck for three days. Flatus was passed in large volumes and the abdominal distension disappeared. On the second day after operation a small, watery stool was passed. A day and night attendant was placed in charge of the case, and the patient made an uneventful recovery. The cause of the obstruction appeared to be plastic peritonitis with adhesion of the great omentum to the gut.

A CASE OF TRANSPOSED VISCERA.

By M. S. PAL, L.M.P.,

Medical Officer, Deamoolie Tea Estate, P. O. Doom Dooma, Assam.

GOKUL, a young male tea coolie on this estate, was admitted to hospital with malaria. On examination his spleen was impalpable, but there was a hard mass about two inches in width projecting below the costal region in the right hypochondrium, which was suspected to be an



enlarged liver. The patient gave a history of dysentery some months previously, but was not passing blood or mucus at the time of admission. He was treated, however, with quinine and emetine. The fever subsided the next day, but the supposed hepatic enlargement remained. After six injections of emetine, gr. 1 each, the enlargement on the right side remained, and the patient was examined by Dr. Moncrieff Joly, my Principal Medical Officer. He discovered that a distinct splenic notch could be felt in the mass on the right side; the heart was also lying to the right side; and the larger lobe of the liver to the left. The conditions present are illustrated in the diagram.

I am much indebted to Dr. Joly for permission to publish the notes on this case.