If the girl could have been told that her husband is partially impotent, so that for his sake and more especially her own she must, at first, at any rate, only permit him to try in what Van de Velde in his book *Ideal Marriage* calls the 'Attitude of Extension', that is, after the penetration of the penis, the woman, who is lying on her back, closes her thighs and stretches out her legs to their full extent. This attitude is especially successful when the male organ cannot attain full erection. For the man, this attitude has the further advantage of increased stimulation of the penile shaft in a somewhat crude but effective way. The extended attitude of the woman is made more complete by keeping the upper part of her body quite flat and placing a firm hard pillow under her buttocks. Had it been possible to give either bride or bridegroom this information, the sequence might have been averted, but every reader of the *Indian Medical Gazette* will know that the pruriency and false modesty of an uneducated Indian girl is so intense that to try to put across this advice is impossible. To give it to the bridegroom, who entertained great notions of his sexual prowess, in spite of the defective erection which he was feign to ignore, would probably have added to his impotency.

The implications of the above clinical history are, I think, very considerable. They are not only of medical interest, which nowadays includes psychological, but of sociological importance. So long as the importance of sexual knowledge continues to be rather less understood among Indians than it is among most Britishers, these disastrous situations are likely to appear and re-appear *ad infinitum*.

A LIVER ABSCESS BURSTING INTO THE PERITONEAL CAVITY WITH SIGNS OF INTESTINAL OBSTRUCTION

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C. B., miner, aged about 40 years, came to the Sendra dispensary on the night of 28th November, 1941, with the following complaints:—

(1) Swelling of the abdomen—3 days.
(2) Inability to pass flatus and stools—3 days.
(3) Pain in abdomen, especially the upper part—3 days.
(4) Vomiting—3 days ago; none since then.

The patient was emaciated with a distended abdomen. Answered questions with difficulty. Coughing at intervals with slight expectoration. Œdema of the legs and abdominal wall was present and the patient was markedly anæmic. No sign of jaundice could be detected. The breathing was thoracic in type although a slight movement of the upper part of the abdominal wall was noticeable. There was slight rigidity of the abdominal wall and signs of free fluid in the peritoneum were present. No peristalsis or distended coils of intestine were visible. The abdomen was tender all over. The liver was enlarged and tender. The spleen was not palpable. No distended veins could be seen on the abdominal wall.

Temperature 99°F.; pulse rate 130 per minute; respiration 35 per minute.

The patient was given an enema and a small quantity of liquid stool with blood and mucus was obtained. He was given an injection of atropine sulphate to ease the pain and was sent to the Mudidih hospital.

Here the patient's relatives were questioned and a history of chronic dysentery for the last 3 months was elicited. No rigidity was detected at this time. The soft abdomen without any rigidity and absence of vomiting was a feature that could not be made to fit in with the diagnosis of acute abdominal catastrophy.

The stool was examined after obtaining a small quantity through a thick rubber tube and was found to be teeming with vegetative forms of *Entamœba histolytica*.

The condition of the patient was very low hence an injection of strychnine sulphate, gr. 1/32 with atropine sulphate gr. 1/100, was given and glucose 25 per cent (25 c.cm. intravenously). Later an injection of emetine hydrochloride gr. ¼ was given.

The patient died 4 hours after reaching the hospital.

A *post-mortem* examination was held on the following day. On opening the abdomen the coils of intestine were found distended, congested and matted together with plastic exudate. The whole of the peritoneal cavity was full of pus. The greater omentum was adherent to the under surface of the liver. On gently separating this, a big abscess was found protruding at the under surface of the right lobe of the liver with the gall bladder at its left border. The abscess was leaking towards its posterior part. The liver was removed and its upper surface showed a thin layer of purulent exudate situated between the two layers of peritoneum. The lesser sac was full of pus.

On opening the large intestine a large number of typical amœbic ulcers were seen.

The pus in the peritoneal cavity showed pus cells, mostly large mononuclear and degenerating liver cells, but no organisms.

Discussion

The presenting symptoms of this case were those of intestinal obstruction, *e.g.*, inability to pass fæces and flatus with pain in abdomen and gradual distention. The absence of rigidity was against any inflammatory condition of the peritoneum and we thought it to be a case of amœbic dysentery with hepatitis and possibly abscess. We could not account for the fluid in the peritoneal cavity and it was only the *post-mortem* finding of pus which showed no pyogenic organisms with degenerating liver cells in it that explained the whole picture, except the absence of rigidity. The signs of intestinal obstruction were due to paralytic ileus following the involvement of the peritoneum.

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