

teeth were shaky. Even with the slightest pressure on the gums, there was much bleeding. The salivary glands were enlarged, and the breath was very foul. The skin was dry and rough and there were subcutaneous effusions on the legs, thighs and near the elbows. The knee joints especially were stiff. There was cardiac distress with a hæmic murmur near the apex. The urine was full of albumin. The patient had occasional headache and slight constipation. She was melancholic.

*Treatment.*—When brought to hospital, the patient was put on a well-balanced diet with raw tomatoes, raw onions, plenty of milk and ghee. She was also given cooked germinated gram. Of citrus fruits, she was given oranges, and as fresh lemons were not available, she was given lemon *achar*. She was given a tonic mixture, civitin injections 2 c.cm. daily and civibex tablets 6 daily for 15 days. For the gums, she was given hydrogen peroxide gargles with 2 per cent silver nitrate paint.

On the 7th day the patient noticed improvement; there was diminished stiffness in the legs, and the subcutaneous patches began to fade. From the 10th day the bleeding from the gums became less. She could walk a little on the 15th day. Slowly the bleeding from the gums completely stopped. Later the depression disappeared. The patient is still under treatment, and is progressing.

#### *Slight cases*

Thirteen cases are put in this group. Four cases had bleeding gums and weakness. They were first treated as cases of pyorrhœa but later were put on well-balanced diet with civibex tablets internally. Three of them improved but one discontinued the treatment.

Five cases had subcutaneous effusions with pain in the legs. Two of them were put on a well-balanced diet and civitin injections. Unfortunately these cases did not carry on the treatment and did not report regularly. Four had bleeding gums and slight effusions under the skin. They all improved under dietetic treatment.

#### *Summary*

Sixteen cases of scurvy are reported and details of three cases are given. Those treated with a well-balanced diet plus administration of vitamins showed improvement.

### A CASE OF CHEST INJURY EXPOSING PLEURAL CAVITY AND LUNG

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A FEMALE child, aged 11, was admitted into the hospital with an open injury of the chest. The child had been gored by a buffalo a few hours before. The site of the injury had been banded with a dirty cloth. She was brought in a bullock cart from a distance of 5 miles. There were no signs of shock. At operation under general anæsthesia, a wound 2 inches by

1½ inches was found on the sixth left intercostal space near the mid-axillary line. The pleural cavity was exposed. Air was rushing in and out with respiration, with a peculiar hissing sound, and the dome of the diaphragm and the lower margin of the lung were seen moving up and down with expiration and inspiration. There was no subcutaneous emphysema. No blood could be seen in the pleural cavity. The margins of the wound were freely excised including the torn pleural margins. During the excision of the pleural tissues, respiration suddenly stopped, probably because of pleural shock. Respiration restarted under ordinary artificial respiration. To combat further pleural shock, morphine hydrochlor gr. ¼ was injected intramuscularly with atropine sulphate gr. 1/150. No further respiratory trouble occurred. Sulphapyridine powder was introduced into the pleural cavity, and sprinkled in the excised wound. Two tension sutures were introduced. The wound was closed by three layers of buried catgut sutures securing pleural, muscular and subcutaneous tissue margins. A gauze dressing was kept in position by the tension sutures reinforced by two strips of leucoplast. With a looped chest bandage the patient was put to bed. Tetanus antitoxic serum, 1,500 international units, was injected during anæsthesia. The patient had an uneventful recovery; the stitches were removed on the seventh day after operation. There was no sepsis; the wound healed by first intention. The chest movements and breath sounds were normal from the second day onwards. On the eleventh day after admission, the patient was discharged.

### A CASE OF ANEURYSM OF THE TRANSVERSE PART OF THE ARCH OF AORTA

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L. N. T., aged 55 years, a business man by occupation, came to me for the treatment of following complaint; pain on the left side of back, radiating down towards the left, duration two years.

*History of the case.*—For the last two years, the patient has been experiencing pain on the left arm. The pain is dull in character commencing from the region of left side of back (infra-scapular region) down the whole of the left arm. At times, the pain becomes very severe and acute, resembling almost an 'electric shock', but such pain lasts for only a short time. He does not give any history of syphilis. During the last two years he has consulted at least half a dozen doctors at various places, but none could relieve his malady.

*On examination.*—Pulse—80 per minute; respiration—20 per minute. The temperature was normal. Teeth—a few left; teeth have been removed for pyorrhœa alveolaris. Epitrochlear glands were palpable. Throat,

tonsils and pharynx were normal (no evidence of any septic foci). Heart sounds were normal in all the four areas excepting the second sound in aortic area which was slightly accentuated (?). Blood pressure were 120 systolic and 80 diastolic. The lungs were clear and the abdomen was normal and soft.

Reflexes—knee jerks, biceps jerks normal. Sensibility to pin-prick normal all over the body.

Urine examination.—Specific gravity—1018; acid reaction; sugar and albumin—nil.

Wassermann reaction could not be done due to lack of laboratory facilities.

A provisional diagnosis of 'neuralgia' was made by me, and I put him on symptomatic treatment for about a month but he had no relief. The patient insisted on a skiagram of the chest (in fact he had been insisting on this from the very beginning). Merely to satisfy him, a screening of the chest was done.

Screening and x-ray report. A deep-seated, small aneurysm at the transverse part of the aorta.

The diagnosis now became complete. The nature of the pain can now be explained. I re-examined the patient. The blood pressure was different on the two sides : right side—120/80; left side—100/76. The tracheal tugging test was positive.

There was absolutely no pulsation visible either in front or at the back of the chest. The accentuation of the second sound in the aortic area could now be explained.

The patient was put on potassium iodide and calcium lactate, and the diet was restricted; some relief of pain was obtained.

Ten months later the patient was under ayurvedic treatment and was showing all the classical signs of aneurysm of the aorta, with marked pulsation and pressure symptoms.

Points of interest.—(1) A diagnosis of a small, deep-seated aneurysm is difficult unless x-ray is done.

(2) In early cases of small aneurysm, the typical signs and symptoms are absent. In this particular case, there were no signs and symptoms present other than the pressure symptoms on intercostal nerves and accentuation (?) of the second sound in the aortic area.

Acknowledgment.—My thanks are due to Dr. N. V. Mhaskar for the x-ray report.

### A CASE OF HÆMOTHORAX

By B. L. CHOPRA, L.R.C.P., L.R.C.S., L.M., D.P.H., D.T.M.  
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A GANGMAN was admitted into Ferozepore Railway Hospital on 25th February, 1943, suffering from an injury of the left side of the chest. The left side of the chest was found immobile on respiration and the intercostal spaces appeared to be slightly bulging; there was dullness on percussion and no vocal fremitus could be elicited. It was further discovered that there was a fracture of the 9th rib on this side. Hæmothorax of the left side was suspected as a result of the fracture of the 9th rib and this was confirmed by x-rays (see figures 1 and 2, plate XX).

Aspiration of the fluid was undertaken and about 10 ounces of blood were drawn off, giving the patient considerable relief. After 3 days, however, he again complained of heaviness, and it appeared that some blood was left. Calcium was given and absolute rest was ordered. With this treatment, breath sounds and vocal fremitus again became normal over most of the area except for a narrow strip of dullness.

Aspiration was repeated, and an ounce of blood was withdrawn. The man made an uneventful recovery and was discharged cured 6 weeks after his injury.

This case is interesting as it brings about the following facts :—

1. That blood when effused in the pleural cavity does not as a rule clot *en bloc*, but the fibrin is deposited as a layer over the parietal and visceral pleura as a result of churning movements of respiration.

2. That a small hæmothorax (that is, one about a hand breadth in length) may usually be left to the natural powers of absorption, and if it does not quickly decrease, aspiration should be employed.

3. A large hæmothorax with fluid blood present should always be aspirated early, and, if necessary, the aspiration must be repeated and the removed fluid replaced by air.

The exudate was examined under the microscope and no pus was found; otherwise open operation with a view to emptying the cavity completely would have been undertaken. The presence of a large hæmothorax with clotted blood which cannot be withdrawn through an aspirator is also an indication for thoracotomy, which should consist of removing about 4 inches of a rib suitably situated, so as to permit the introduction of a retractor or rib spreader.

My thanks are due to Dr. C. D. Newman, Chief Medical and Health Officer, N.-W. Railway, Lahore, for his permission to publish this note.

### SCIATICA AND ITS TREATMENT BY SALINE INJECTIONS ROUND THE NERVE

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In two different parts of North India I have found sciatica to be common, and I have used in treatment the method described by me in 1938 (Chopra, 1938).

The treatment consists of giving an injection of four to eight ounces of normal saline solution at a temperature of 104°F. round the sciatic nerve near where it leaves the pelvis.

The site of the sciatic notch was found by drawing a line from a point midway between the outer border of the ischial tuberosity and the posterior superior angle of the greater trochanter to the upper angle of the popliteal fossa; the uppermost posterior point of this line was taken as the site for injection into the nerve.

A lumbar puncture needle was used for the purpose of injection. As soon as the needle