continuously carried out the most tiring duties of artificial respiration for more than half an hour.

A CASE OF BULLET WOUND OF THE CHEST FOLLOWED BY PLEURISY WITH EFFUSION.

By RAM LABHAYA, L.M.S.,
Assistant Surgeon, Civil Hospital, Pind Dadan Khan.

MUSSAMAT KARAM BHARI, aged 35, of the village Wahula, was shot by a pistol on the night of 19th June, 1925. She was brought to the Civil Hospital, Pind Dádan Khan by the police on 20th June, 1925, for examination and treatment. There was a bullet wound $\frac{3}{8}$ in. by $\frac{1}{4}$ in. going through the chest wall on the right side of the chest, $2\frac{1}{2}$ in. below and to the inner side of the right nipple. Blood was coming out of the wound. There was no exit wound, but on the back in the middle line a hard mass feeling like a bullet was felt under the skin, a little higher in level than the wound in front. Her pulse was 94 per minute, respiration 56 p.m., and temperature 100.4°F.

Her condition began to improve in hospital and on 29th June, 1925, when the wound in the chest had nearly healed, after incision on the back the bullet was removed and the wound stitched. One end of the bullet was bent, which might have been due to its striking against the vertebræ.

By 7th July, 1925, the wound on the back had healed but she was getting slight fever—100° to 101°F.—and the respiration was hurried. Dulness on percussion and fulness of the interspaces on the right side of the chest developed, so the chest was aspirated on 16th July, 1925, and 26 ozs. of bloody fluid was withdrawn.

There was some improvement, but fluid filled in again so she was again aspirated on 27th July, 1925, and 32 ozs. of bloody fluid was again withdrawn. After this her temperature and respiration rate came to normal and she was discharged cured on 18th August, 1925.

The case is of interest because after a bullet wound which had gone right through the chest the woman recovered. Throughout her illness there was no cough, which meant that the lung had not been injured.

AN INTERESTING CASE OF TRANSVERSE PRESENTATION.

By MADAN H. JHAVERI, M.B., B.S. (Bom.),
Medical Officer, Loimwe, Kengtung Subdivision, Southern Shan States.

THE patient was a primipara, 16 years of age, of short stature and quite healthy. She was seen and examined by the Sub-Assistant Surgeon, Kengtung, on 8th June, 1925, who found the fœtus was in the normal second position—9 months and 7 days old (according to the patient). The pelvis was slightly contracted.

On 14th June, 1925, she was brought to the hospital at about 11 P.M. When examined by the Sub-Assistant Surgeon he found that the fœtus had turned its position, i.e., now the fœtus was in the first transverse position. He could only elicit from the patient that the pains had begun during the day and the uterus was massaged from time to time by the patient and her friends. When she was admitted the pains were irregular. He tried his best to correct the position by both versions but he could not succeed. He sent for me in the middle of the night. I reached Kengtung in two hours and a half—a distance of 17 miles. When I examined the patient the fœtus was in the first transverse position and the uterus was regularly and continuously contracting. The only course left open was to extract the fœtus in the breech position. The patient was put under chloroform; the cervix was fully dilated. The hand was passed under the fœtus and the nearest leg, that is the right, was searched for. Both the legs had become extended but they were brought out safely. The hands were then brought out. The after-coming head gave difficulty owing to the contracted pelvis but it was brought out safely by Smyly's method. The placenta came out without any trouble. The child when weighed was $8\frac{1}{2}$ lbs. and was well developed.

The patient was febrile, the highest temperature being 101°F. on the sixth day, although all aseptic precautions were taken. She was given the usual quinine and ergot mixture and hot vaginal douches, and for three days tinct. iodine (5 minims) was injected intravenously. The patient is doing well and at the time of writing the temperature was normal.

The question arises as to whether it is possible that after the fœtus was in normal position at full term, the position could be changed even after undue manipulation by the patient. Up to the present I have managed six cases of transverse presentations at Bombay and at Bassein, but in no case was the fœtus at full term.

INTRA-MUSCULAR INJECTION OF UREA STIBAMINE.

By S. KUNDU,
Assistant Surgeon on Kala-azar duty, Sylhet.

JUST after returning from Shillong and taking charge of my present duties in Sylhet, I was repeatedly asked by my Sub-Assistant Surgeons who are treating kala-azar cases whether urea stibamine can also be safely used intramuscularly, especially in children when the veins are too fine to be easily punctured. In order to satisfy their curiosity in this point, I should like to publish the following note which may help them in some way in undertaking the intramuscular use of urea stibamine.

In six of my cases where a little solution had escaped into the subcutaneous tissues at the time of intravenous injection, three had much pain in the site, swelling and induration and three had actually abscesses requiring opening. In two cases where deep intramuscular injections were given in gluteal region only pain was complained of for 2 days but no induration at all.

In spite of this experience in the intramuscular use of urea stibamine, I had occasion to treat a case, in a child of our own family, which requires publication as of some interest to the medical profession. This is the only solitary case, in our family, who lived in Barisal town since his birth and none had any occasion to mix with the kala-azar cases anywhere except myself, as my duty keeps me constantly exposed to kala-azar infection. The child had no occasion to live with me in Assam before he was actually sick.

The child, aged 1½ years, was found to be suffering from suspected fever for 6 months and was taken to me for treatment through my advice. Past history shows continued type of fever for 1½ months in the beginning and laterly irregular fever. Present condition gives—spleen up to umbilicus, liver 2 fingers below costal margin, anæmia and œdema most marked; leucocytes counting below 2,000, dysentery severe and temperature running 103 to 104. Diagnosis of kala-azar was made by finding Leishman-Donovan bodies in the peripheral blood and positive aldehyde test. Urea stibamine was started by intramuscular injection, veins being too thin for the needle. Ten injections were given in the doses of—

.01 gm.	in 1 c.c. of	distilled water
.02	do.	do.
.04	in 1½ c.c.	do.
.06	do.	do.
.06	do.	do.
.06	do.	do.
.08	in 2 c.c.	do.
.08	do.	do.
.08	do.	do.

every third day, representing a total of 0.65 grm. of urea stibamine and nothing was complained of except on the last injection. With these injections the patient was progressing well, temperature became normal on the fifth injection, spleen diminished, œdema completely disappeared, general constitution wonderfully changed and weight much gained. Intramuscular injections were given two in deltoid, six in gluteal, and two in thigh muscle and the result was very satisfactory on the whole, but on the tenth injection the child got very high temperature which continued for 3 days accompanied by much pain and swelling at the site of the last injection which was in the thigh. Intramuscular injection was stopped and, with the stoppage of fever, his general condition gradually improved and after a fortnight he appeared to be cured. Veins being prominent at this stage, 4 more intravenous injections (not intramuscular) in the doses of .05, .08, .1 grm. in 2 per cent. solution were given without any trouble with a view to prevent relapse, as spleen puncture could not be taken to know the sterility. The child is now quite healthy. It is a year since the child was treated by urea stibamine.

From this it appears that urea stibamine is not a very irritant drug like antimony tartrate, though a little local irritation may be noticed in some when used intramuscularly or subcutaneously. In any case intravenous injection is the most suitable and popular method as this does not cause any irritation or pain at the site of injection, if given properly, but if intramuscular use is to be made, a great deal of precaution about the sterilisation of skin, syringe and solution is absolutely necessary. Any defect in these is sufficient to cause irritation in the site when used intramuscularly.

A CASE OF PERNICIOUS MALARIA TREATED WITH QUININE INTRAVENOUSLY.

By KHAGENDRA NATH CHATTERJI, M.B.,
Chinsurah.

ON 1st September, 1925, I was called in to see a young boy who became collapsed after violent vomiting and purging which followed an attack of fever. It was the fifth day of the attack, the fever used to come every day with shivering and was followed by diarrhœa and vomiting. On the third day the boy passed hæmorrhagic stools and became pulseless. His pulse was however restored by the injection of pituitrin by a local doctor, and the hæmorrhage from the bowels also stopped, but on the fifth day, the collapse was severe; the extremities, especially the upper, were cold and shrivelled, both pulses were almost imperceptible, the temperature was subnormal, there was agonising pain near the umbilicus and liver area accompanied with persistent bilious vomiting and purging. The stools resembled very much those of dysentery. The patient was restless and sighing in respiration. I took the history, and was told, that shortly after the boy had come back from Jessore, where he stayed a week, he had intermittent fever, which was usually followed by diarrhœa and vomiting. From the above symptoms and the history, I thought it might be a case of a bad type of pernicious malaria and this was confirmed when I found the spleen was much enlarged. I thereupon decided to adopt a method of treatment which would bring about the most prompt and sure effect, and I gave the patient quinine bihydrochloride 5 grs. intravenously, diluted with 20 c.c. of normal saline, with 10 minims of adrenalin chloride sol. added to it. This brought immediate relief with cessation of all the symptoms. The patient becoming quiet, I left him with instructions for a rectal saline to be given. When I left, I saw the patient was getting a reactionary rigor which was not severe. In the evening when I went to visit the patient again, I found him much better; his pulse had returned, his extremities were warm, and there was no more purging nor vomiting. The next morning I gave the patient quinine 5 grs. intravenously diluted with 10 c.c. of normal saline, and another on the following day. The boy is keeping well since then.