excellent drawings he made of the case of perforation of palate. The three cases described are among the first patients treated with salvarsan in India.

A CASE OF RETRO-PERITONEAL SUPPURATION.

By Lieutenant G. H. Dive.

Royal Army Medical Corps.

The patient, aged 23, was admitted to the Queen Alexandra Military Hospital, September 21st, 1910, suffering from fever of unknown origin. Temperature 101.8, pulse 122, respirations 24.

History.—For seven days the patient has had pain in the right side of the chest on full inspiration, and profuse night sweats. During the last month he has been losing weight, but has not had any cough, haimoptysis or pleurisy. He has also suffered from epigastric pain for about two months; this pain usually came on about one hour after food, and was sometimes followed by vomiting which gave relief. He has also had occasional diffuse pain on the right side of abdomen, but no haimatemesis or melena.

The condition on admission was as follows: Tongue, covered with brown fur; heart, apex beat displaced 1 inch outwards to the left, no murmurs heard; lungs, some impaired air entry on the right side; abdomen, no “spots,” no splenic enlargement, no abdominal tenderness. There was marked tenderness and hyperaesthesia in the lower three right intercostal spaces behind, extending in the right lumbar region down to the iliac crest and as far forward as the mid-Poupart plane. The pain was not referred to any other region or increased by deep respiration.

Urine.—No abnormal constituents. No jaundice. Blood: Widal reaction for Bacillus typhosus proved negative, leucocytes 18,800 per cmm.; culture negative.

The pain together with fever of a septic type continued, but no localising signs were found until September 27th, 1910, when pleural friction, with diminished air entry low down, was found on the right side.

Exploratory punctures were made in the right pleura and the right loin with negative results.

The possibility of interlobar empyema was raised at this juncture, particularly in view of the existence of patchy areas of dulness in the right axilla. Accordingly exploratory punctures were made along the septal line, again with negative results.

Examination under X-rays showed that the movements of both sides of the chest were full and equal. No abnormally dense areas were found in the thorax. The dome of the liver, and the movement of the diaphragm appeared to be natural. The heart was not displaced, though considerably enlarged.
Clinical and other Notes

October 6th, 1910.—A diffuse macular rash developed. The pain, fever and leucocytosis continuing, an exploratory operation was decided on.

In the absence of localising signs and with such evidence as was available a diagnosis of retro-peritoneal suppuration seemed the most feasible.

Operation October 8th, 1910, by Major Pilcher. An aspirating needle entered perpendicularly in the tenth right intercostal space in the mid-axillary line encountered pus at a depth of 3½ inches.

Three inches of the tenth right rib were resected, the parietal and phrenic pleura sewn to the diaphragm and this incised. The needle was followed through the liver and 12 ounces of pus evacuated from a cavity of no recognisable anatomical boundaries but extending inwards to the middle line and downwards to the right. The pus provided a pure culture of Staphylococcus pyogenes aureus.

Temporary improvement followed, but persistence of fever and leucocytosis indicated further surgical interference.

November 11th, 1910.—A counter incision was made in the right loin to meet a probe passed into the sac from above.

The upper wound healed rapidly, but despite several operations a sinus still persists in the loin.

As to the origin of the condition it seems probable that a duodenal ulcer had leaked through and infected the retro-peritoneal tissues of that region.

The pain and hyperaesthesia would then be explicable by the anatomical distribution of the lumbar nerves.

I am indebted to Lieutenant-Colonel Maher, R.A.M.C., for permission to publish the notes of this case.

A CASE OF BILATERAL PERIPHERAL FACIAL PALSY.

By LIEUTENANT G. H. DIVÉ.
Royal Army Medical Corps.

The following brief account illustrates this rare condition.

The patient, aged 23, was admitted to the Queen Alexandra Military Hospital on August 18th, 1910, with right-sided facial palsy of fourteen days' duration. This was peripheral in type, and probably consequent on exposure. Seven weeks after the onset, and whilst still undergoing treatment, facial palsy of the left side appeared; this was also peripheral in type. Both palsies were severe, and the reaction of degeneration was obtained on both sides. There was no evidence of central disease.

Treatment consisted of rest and sedatives, followed by galvanism, faradism and massage.