the interior of the stomach, relying upon the intimate sympathy between the brain and that organ of digestion. Accordingly, I made the man drink a tumblerful of mustard and hot water mixed to almost creamy consistence, and followed it up with repeated copious draughts of hot water until he said he could not hold any more.

The result was nearly immediate; the man fell back on his bed and went off into a deep sleep, during which general perspiration oozed so profusely as to resemble the squeezing of a soaked sponge. Next morning he awoke feeling well and without any discomfort from the free dosing with mustard.

I did not know what to call the case. It was not an example of heatstroke, as there was not any degree of insensibility; nor was it one of exaggerated prickly heat, as itching and papulæ were absent; ephemeral fever was negatived, as the mental faculties were not impaired and the attack was so transient. Certainly it was an extraordinary instance of excessive elevation of the body temperature; and my impression was strong that the patient had been saved from brain mischief.

The same day another case worth mention came under my notice. While going the usual round of the wards that evening I happened to meet the eye of a man in bed with an ailment unconnected with the oppressively sultry temperature prevailing. As I looked his eyes began to redden and to glare, whereupon I ordered leeches to be applied immediately to both temples. While blood was being drawn, the man, feeling relief, exclaimed, “You have saved my life!” It was evident that the threatening of heatstroke was being averted by the lessening of brain circulation pressure; the case did well.

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TOXÆMIC ARTHRITIS AS A COMPLICATION OF ACUTE DYSENTERY.

By Captain W. E. C. Lunn.

(Royal Army Medical Corps.)

Lieutenant H. was admitted to the Station Hospital, Lahore Cantonment, on July 3, 1913, suffering from acute dysentery. He attributed the attack to a chill caught during a long train journey taken two days previously. Amoeboid bodies were present in the faeces, and were thought to be the cause of his condition. The patient was placed on a whey diet and treated with subcutaneous injections of emetine hydrochloride and a preliminary dose of castor oil and opium. The emetine was discontinued after two days as the patient got worse, and magnesium sulphate in one-drachm doses every two hours was substituted. Immediate improvement set in; this was considered to be possibly due to a delayed action of the emetine, so on the following day the magnesium sulphate was stopped and the emetine injections were recommenced.
Within twenty-four hours all the symptoms became exaggerated and the temperature rose. I decided after this experience to adhere to the magnesia sulphate treatment. The dysenteric symptoms had completely disappeared by July 18.

The patient complained on July 15 that his right ankle was painful. On examination it was found to be slightly swollen and red, and there was a rise in his temperature. The ankle condition had subsided by the next day, but the left knee had become very painful and his temperature continued to rise. On July 17 there was a sudden and sharp outbreak of acute arthritis in the right ankle, left knee and left elbow; the temperature rose to 101°F. This was accompanied by a well-marked purpuric rash (peliosis rheumatica) over the lower part of the abdomen, thighs and left leg. Several days later many of these spots turned to minute abscesses and gave him considerable trouble. Salicylate of soda, gr. xx, was given every two hours, the joints were painted with glycerine and belladonna, and cased in wool.

The general condition of the patient was now pitiable, in addition to the above complications he was covered with prickly heat; there was also acute conjunctivitis in both eyes, and a small ulcer had developed on the left cornea. All movements caused him intense pain, but fortunately the bowel condition had improved. The patient was unable to rest without morphia. Steady improvement was noted during the next few days with the exception of the left knee; this joint continued to swell until it felt like a bag of fluid. On July 21 the knee was tapped in consultation with Major Forster, I.M.S., and a clear sterile fluid was drawn off, to the great relief of the patient. The patient from this date continued to improve in every way. There were occasional slight relapses in the joints already affected, and he suffered from fresh pains in other joints. He had also the misfortune, as if his troubles were not already sufficient, to contract dhobie itch. He was able by August 10 to be transferred to Karachi. I received a letter from him in September, just previous to his proceeding home on sick leave, and he informed me he still had slight stiffness in his knee and ankle, but was able to walk about slowly without assistance.

There are several points of considerable interest in this case, which, despite the fact that ameboid forms were discovered in the feces, was probably one of bacillary dysentery, for the following reasons:

(a) The acute onset and short period during which the actual bowel trouble lasted.

(b) No improvement following emetine injections.

(c) The marked improvement after magnesium sulphate.

(d) The absence of relapses.

(e) The presence of toxæmic arthritis.

The last condition deserves some consideration on account of its
rareness. The arthritis might have been considered as a concomitant attack of acute rheumatism or gonorrhoeal rheumatism.

Acute rheumatism was suggested by the way the inflammation spread from joint to joint, its onset during the damp rainy season, and the presence of peliosis rheumatica. Gonorrhoeal rheumatism by the large accumulation of fluid in one joint.

The arthritis in this case was, however, distinguished from rheumatism by the absence of profuse sweating during the attack, by the slight relief obtained from the use of salicylates, and the ultimate large accumulation of fluid in the knee-joint.

From the second condition it was distinguished by the absence of discharge from the penis, no history of gonorrhoea, the clear sterile fluid from the knee-joint, the presence of peliosis rheumatica and the speedy convalescence.

I am inclined therefore to consider the joint symptoms as purely toxæmic after an acute attack of bacillary dysentery.

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CLINICAL NOTES ON A CASE OF ECLAMPSIA.

By MAJOR J. TOBIN.
Royal Army Medical Corps.

Mrs. G., aged 22, a primipara, was delivered on December 5 at 2:30 a.m.; about 8:30 a.m. she had an eclamptic seizure passing through a tonic stage, followed by a stage of clonic contractions; respiration was in abeyance, the trunk in a condition of episthotonos, the face livid and tongue protruded. Several fits recurred in rapid succession. The patient had suffered from some well-marked pre-eclamptic symptoms for about two months before the onset of labour, viz., swollen feet, puffy eyelids, severe headache, mostly frontal, backache and diplopia. She was advised to see a medical officer, but did not do so as she was off the strength and understood that she had no claim to medical attendance. When first seen in the seizure she could swallow and was given 3111 of croton oil on the back of the tongue, followed later by large doses of magnesium sulphate; ½ gr. of morphia hydrochlorate was injected into the arm. She was placed on her side and hot fomentations were employed every two hours over the loins. The patient was seen to be under the influence of morphia until about five hours after the first injection, when she started fibrillary twitchings, followed by a severe fit; another ½ gr. was injected; the injections were continued, 2½ gr. being given in twenty-four hours. Arrangements were made in case of coma supervening for subcutaneous injection of a solution of sodium bicarbonate 2 dr. to the pint of sterile water, on the principle that this treatment does good in diabetic coma. It is now the opinion of the best authorities