suffer from epilepsy—please leave me alone." I feel sure that this ingenuity must have been the outcome of bitter experience.

It will be seen that the principles 1 for restoration, i.e., warmth, artificial respiration and stimulation were the same as those carried out to-day, but the methods of applying those principles were of necessity more of an improvised nature and were undoubtedly more unpleasant to all concerned, for the reason that hot-water systems, rubber bottles, syringes, hypodermic tablets, electric batteries and such like were not invented.

The early beginnings also of a first-aid outfit are suggested and that such outfits should be placed in convenient situations where disasters from drowning are likely to occur is recommended.

Should any points be raised for criticism, they are firstly the difficulty and danger in unskilled hands of passing the inflexible metal tube into the larynx, and secondly, in view of recent accidents, there would be great hesitation in heating the bulb containing the ether with the open flame of the spirit lamp, the probable results of such a procedure being too horrible to contemplate.

The illustration, which is an enlarged copy, shows the forceps on the nose, the bulb attached to the stomach tube, the spirit lamp in the hands of an attendant, the box-bellows fitted to the laryngeal tube, the pensile galvanic pile suspended above the re-animation chair and the hands of the patient fixed by a bandage.

1 Indicates that the italics are by Lieutenant-Colonel Priest.

REFERENCES.


A CASE OF HYDROCELE TREATED BY INJECTION.

BY CAPTAIN G. T. L. ARCHER, Royal Army Medical Corps.

The injection treatment of hydrocele, although a method of long standing, fell into disrepute for some time, owing to the highly irritant nature of the drugs injected.

Thus we find in the eleventh (1924) edition of a "Manual of Surgery" (Rose and Carless) that "Injection of the cavity after tapping was for long a favourite method, but is now seldom employed. Many different reagents were used, such as port wine, tincture of iodine . . . perhaps the best is the tincture of iodine, but that contained in the B.P. is not strong enough"! In the "Index of Treatment" (Hutchinson and Sherren), 1931 edition, we still find tincture of iodine mentioned, though carbolic acid with glycerine is recommended instead. It is also suggested that the
patient be confined to bed for one or two days. A trocar and cannula, in addition to a hypodermic needle, are used in the method described. No wonder the injection method fell into disrepute, leaving the field to operative treatment with its associated week in bed!

The perfection of the injection treatment of varicose veins, however, with the consequent introduction of sclerosing solutions of an ever-diminishing irritant action unaccompanied by loss of efficiency, has led to a revived interest in the injection treatment of hydrocele. Pybus [1] describes the use of quinine and urethane with excellent results, though at first he continued to use a cannula and local anaesthesia in his technique. Delisle Gray [2] describes the use of twenty-five per cent sodium chloride, acting for a short time (five to ten minutes), and used in such quantity as completely to distend the sac. His first case emphasizes the necessity for caution in the use of this method, and his later technique is rather elaborate. He further describes some successful cases treated by injections of Morestin's fluid (equal parts of carbolic acid, glycerine and alcohol).

I do not know the number of days in hospital per annum accounted for by the operative treatment of hydrocele in the Army, but I would suggest that by the use of these or similar methods the figure can be reduced to almost nil. One may expect the day when operation from hydrocele will become as rare as the excision of varicose veins.

The case I wish to quote in support of this contention is that of an officer who had had a small hydrocele for about four years. It had been tapped on three or four occasions; the last occasion upon which I tapped it prior to the injection treatment being early in November, 1931, when about seventy-five cubic centimetres of fluid were withdrawn through an ordinary large hypodermic needle.

As the filling up of the sac was becoming more rapid, and as the hydrocele was increasing in size, and since the officer did not wish to spend a week in bed if it could be avoided, I decided that on the next occasion it became a nuisance I would treat it by injection of quinine and urethane; since I did not share Delisle Gray's fear of quinine which, in his case, was the result of his decision (on anatomical grounds) to distend the sac completely with the fluid used. A preliminary series of graduated doses per os would demonstrate the presence or absence of such an idiosyncrasy as he feared might exist.

On March 12, 1932, therefore, I tapped the hydrocele by simply inserting a fairly large hypodermic needle into the most dependent part of the sac. One hundred cubic centimetres (approximately) of clear fluid were withdrawn, this being almost the complete contents of the sac. Two cubic centimetres of quinine and urethane (P. D. and Co.) were then injected very slowly, the patient experiencing only slight discomfort during the procedure; a little gentle massage was then used to distribute the solution all over the lining of the tunica vaginalis.

The result was similar to that described by Pybus. The patient, except
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for about half an hour after injection and for a short time again the same night, when a slight but uncomfortable dragging pain, radiating towards the loin of the affected side, was experienced, suffered no inconvenience following the injection. For about a week the testicle was a little tender, but this tenderness was of such slight consequence that the patient was able to go out on horse-back on the day following the injection without undue discomfort or any ill-effect.

On the evening of the day after the injection a "crepitation" similar to that felt in a case of teno-synovitis was detected on gentle massage of the injected tunica.

On March 19, 1932, I again tapped the effusion (which had returned to some extent). The fluid was now cloudy, and contained a trace of blood; on standing, a thin clot formed at the bottom of the test-tube. The amount of fluid removed (as far as possible the complete contents) was thirty cubic centimetres.

Since that date there has been no return of fluid, and the hydrocele would appear, at the time of writing (six weeks after treatment), to be completely cured.

I was assisted in carrying out this treatment by Assistant Surgeon J. F. Freeman, I.M.D., to whom I am indebted for his help, rendered necessary by the fact that the patient was myself.

REFERENCES.


A FATAL PERISPLENIC ABSCESS COMPLICATED BY MALARIA.

By MAJOR W. W. S. SHARPE,

AND

THE LATE LIEUTENANT E. G. C. DARKE

Royal Army Medical Corps.

The following notes will, it is hoped, be of interest, on account of the difficulty of differential diagnosis. Private J., aged 28, had spent five years in India—in Calcutta, Nasirabad and for a short time in Ahmedabad, where he first contracted benign tertian malaria. There was no history of dysentery, and he stated that he had never suffered from diarrhoea, except very occasional slight attacks. His medical history sheet contains no relevant entries except those for malaria, viz.:

Fresh infection in October, 1928, mild benign tertian, four days in hospital. First relapse (?) in September, 1930, eight days in hospital. A second relapse in June, 1931, the precursor of his fatal illness. The spleen