

is deaf on the right side. Her general condition is much the same, but she sleeps a great deal.

January 24th. During the night there was an alarming haemorrhage from the orbit, the blood coming from under the eye. The house-surgeon controlled it by pressure and by perchloride of iron, but not before the patient had become much collapsed. At the end of the haemorrhage the eye sank back into the orbit, and there was no proptosis.

January 30th. The proptosis of the right eye is much increased. The lower cul-de-sac is occupied by a bleeding, fungating mass, which, however, showed no green colour. The general condition is unaltered, but patient passes most of her time in sleep. She takes little notice of her surroundings, but answers questions. Complains of no pain. She has apparently good vision in the left eye. The right cornea has sloughed. She is very deaf on the right side, but hears well on the left.

February 17th. There has been some dyspnoea for the last few days. Patient is semicomatose, but can be roused to answer questions. She is very weak, and has lost flesh. A second blood count gave—

Red cells, 1,450,000;
White cells, 17,000.

The child died on February 18th, the disease having been diagnosed as "chloroma."

Notes of Post-mortem Examination.

The body was much wasted, there being little fat present. Both eyes, which, during life had been pushed forwards, were retracted into their sockets.

On removing the sternum, a large flat growth was seen on its inner surface; this was pale olive-green in colour, and was under the periosteum.



The ribs were green by transmitted light.

There was about a pint of blood-stained fluid in each pleural cavity. The right lung showed some fibro-plastic pleurisy of recent origin. At the apex of each lung was a mass of new growth which fixed the lungs to the vertebrae. On section, the growth was found to be invading the lungs to the extent of about $\frac{3}{8}$ in. from the surface. The lungs were otherwise free from metastases. This growth was olive-green. Both lungs were very oedematous, but there were no haemorrhages.

The heart was normal, but the pericardium was covered with small ecchymoses.

The spine along its whole length was covered by large flat masses of growth varying in thickness up to $\frac{3}{4}$ in. These growths were subperiosteal, and were olive-green in colour. This growth was continued along the ribs, especially on the left side. Some ribs had a thicker growth than others.

The stomach and small intestines showed no naked-eye changes. The whole of the large intestine and rectum were contracted and empty except the first 4 in. of the ascending colon. At this spot there was a sudden narrowing in the lumen of the gut, but the gut did not appear to be infiltrated with growth.

The liver and spleen were normal in size, and contained no new growth. Both ovaries were enormously enlarged, and were infiltrated by masses of green growth. The right eye was entirely disorganized. There was not much growth in the orbit. There was a small mass deep in the orbit, and apparently growing from the outer wall and from the periosteum. The right lachrymal gland was invaded by a green growth.

In the right temporal fossa, under the temporal muscle and the pericranium, there was a large, hard, flat growth about $\frac{3}{4}$ in. in thickness. There were small masses of growth along the sagittal and coronal sutures, and a large mass on the right half of the occipital bone. There was an excess of cerebro-spinal fluid. The meninges were thickened and infiltrated with a green growth along the sagittal suture. The right cavernous sinus was filled with a green growth, and the lateral sinus on the same side was occluded by the same substance.

The specimens were placed into formalin solution 10 per

cent. After twenty-four hours the green colour was still as obvious as ever, and the intestines had a greenish tinge. The contraction of the colon was regarded as a congenital abnormality. The thyroid gland was enlarged, but not infiltrated with growth.

The specimens were sent to St. Bartholomew's Hospital, and the dura mater and an ovary have been added to the Museum. Dr. W. Branson examined the sections of the growth, and reports as follows:

"The growth is a round-celled sarcoma with an unusually well-marked stroma. At one spot it may be seen infiltrating the dura mater. The ovary shows a diffuse infiltration of the ovarian tissue with round-celled sarcoma."

The total duration of the case was about seven weeks. The exophthalmos was chiefly due to vascular engorgement and to thrombosis of the cavernous sinus. It was absent after the severe haemorrhage and after death. Very little growth was found in the right orbit.

The case was first regarded as a sarcoma of the orbits and temporal fossa, then as a case of lymphatic leukaemia with lymphomata in the orbits, but was finally correctly diagnosed as a case of "chloroma."

In spite of the intracranial tumours and the excess of cerebro-spinal fluid, there were never any symptoms of compression.

The case is very similar to one described by Dr. Melville Dunlop in the BRITISH MEDICAL JOURNAL for May 3rd, 1902. He gives references to 26 previous cases. There has been one recently at St. Bartholomew's Hospital, and Dr. Coles of Bournemouth tells me that he saw one at York Hospital. In any case the disease is very rare.

My thanks are due to Dr. J. Cropper of Chepstow, who kindly examined the blood films, to Dr. Branson of St. Bartholomew's Hospital for his report on the histology of the growth, and to Dr. T. H. Barton, Senior House-Surgeon to the Hospital, who made careful blood counts. I am also indebted to him and to Mr. Russell, Junior House-Surgeon, for making the *post-mortem* examination.

ALBUMOSURIA AND THE DURATION OF ALBUMINURIA IN CHOLERA.

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The constant presence of albumose in the urine of patients suffering from cholera after suppression has ceased is, as far as I am aware, a new observation. In all the cases that I examined this was as constant as albumen. In most of them it disappeared from the urine along with the albumen. In some cases the period of albumosuria was shorter than that of albuminuria, and in very rare cases it continued to exist some hours after the disappearance of the latter. (See Table.) The amount of albumose present varied from a mere turbidity to a distinct precipitate, and was not in all cases proportional to the amount of albumen present. In a few cases there was a mere trace of albumose, while the quantity of albumen was large. The albumose present was characterized by the following tests:

1. Not precipitated by heat.
2. Precipitated by HNO₃. The precipitate was soluble on boiling and reappeared on cooling.
3. The precipitate was granular and never crystalline under the microscope.

The period of albuminuria ranged in my cases from 24 to 300 hours with an average of nearly 120 hours, which is much greater than what is stated by any previous observer. (See Table.) I append here the table containing the results of my observation.

Nos.	Albumosuria.	Duration of Albuminuria	Duration of Albumosuria.
		Hours.	Hours.
1	Present	36 (death)	36 (death)
2	"	60	60
3	"	24	12
4	"	60	12
5	"	84	60
6	"	36 (death)	36 (death)

Nos.	Albumosuria.	Duration of Albuminuria.	Duration of Albumosuria.
	Present.	Hours.	Hours.
7	"	132	132
8	"	172	132
9	"	300	300
10	"	196	196
11	"	132	132
12	"	64	64
13	"	120	120
14	"	144	144
15	"	60	60
16	"	132	132
17	"	132	—
18	"	72 (death)	—
19	"	60	—
20	"	36	—
21	"	208	—
22	"	54	—
23	"	54	—
24	"	114	—
25	"	204	204
26	"	240	240
27	"	80	80
28	"	64	64
29	"	200	200
30	"	96	120
31	"	96	72
32	"	66	66
33	"	300	300
34	"	—	—
35	"	—	—
36	"	—	—
37	"	—	—
38	"	—	—
39	"	—	—
40	"	—	—

MEMORANDA:
MEDICAL, SURGICAL, OBSTETRICAL.

THE INTESTINAL ORIGIN OF LEPROSY.

IN the BRITISH MEDICAL JOURNAL of November 10th, 1906, you note some very interesting experiments on kids and goats carried out in the Pasteur Institute at Lille as to the intestinal origin of tuberculosis. As the result of these investigations it is inferred that in man the intestine is the usual means by which the tubercle bacilli infect the lungs and other parts of the body, especially as "evidence is not wanting that the penetration of airborne bacilli into the lungs is difficult, if not impossible." Can we not apply this hypothesis to another disease analogous in pathology—leprosy?

Leprosy is not infectious, it is doubtful if it is contagious, certainly not hereditary. In parts of China, as Pakhoi, where leprosy is common, there are lepers who sell eatables on the street. They and the food are, of course, surrounded by flies, which come in contact with their sores. Some time ago a medical man in Pondicherry gave as a possible explanation of Hutchinson's theory the fact that the fish in the local market, he observed, were black with flies, which probably had before settled on lepers, and thus would carry the bacilli with them to the fish. That putrid fish makes an excellent nidus is impossible to deny, and if eaten half raw some of the bacilli

must certainly enter the alimentary tract in a living condition.

But, if fish, why not other edibles, especially if these, after coming in contact with flies laden with the bacilli, undergo no further cooking? Does not this explain why Hutchinson's theory sometimes appears so plausible and at other times seems to break down? I mean that the practice of eating putrid fish in a more or less raw condition is not essential to the spread of the disease; that the bacilli can reach the intestine through the medium of other food also. In this district, where leprosy is fairly rife, I doubt if much fish is eaten; the lepers grow and sell vegetables.

In tuberculosis the bacilli are carried by leucocytes which lose their amoeboid movement. In leprosy the bacilli have been found occasionally within white blood corpuscles; perhaps the lepra cells were originally leucocytes?

The taking of common salt really seems to benefit the patient; this may be because of increased hydrochloric acid, which helps the digestive juices to destroy the germs, and the system is thus relieved from ingesting more living bacilli.

Three points leprosy has in common with tuberculosis: There must be a predisposition, natural or acquired, in the patient; both may have a long incubation period; and both are incurable—the patient is said to be "cured" because treatment and environment have "stayed" the disease.

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SALICYLISM AND EPISTAXIS.

IN reference to the memoranda which have appeared recently in the BRITISH MEDICAL JOURNAL on Influenza and Epistaxis, may I be permitted to point out that in many of these cases the epistaxis has probably no relation to the attack of influenza, but is rather due to the salicylate administered for its treatment, a symptom of salicylism which is not very uncommon? Whether this, as seems probable, be due to certain impurities in the drug or not I am not prepared to say.

A rather striking example of the onset of epistaxis after taking salicylates in a patient once under my care is, I think, worth recording. He was the master of a large Eastern liner, and, like many of his calling, suffered from gout. A medical friend gave him a prescription as follows: R. Pot. bicarb., sod. salicyl., aa ʒjss, vin. colchici, ʒjss, aq. ad ʒvj. Sig.: Two tablespoonfuls four times a day. He insisted on trying this mixture during three separate attacks. On each occasion epistaxis followed.

At no time was the bleeding severe, but the point that is so very interesting is that on the two subsequent occasions the epistaxis was accompanied by the development of a rash, the latter resembling more than anything else large so-called "blind boils."

On stopping the sodium salicylate but still giving the potassium bicarbonate and colchicum the rash disappeared, nor was he troubled with further epistaxis. There were no other symptoms of salicylism present, no ringing in the ears, headache, etc. There was no local disease, and the urine was free from albumen throughout.

Eccles, Lancs. E. LEACH, M.R.C.S., L.R.C.P.Lond.

HERNIA OF THE GALL BLADDER.

THE patient in the following case, a Hindu woman aged 50, was admitted into the Kinnaird Hospital at Lucknow on February 11th, under Dr. Christina Mayne, by whose permission I report it. On the right side of the abdomen was a soft, round, tender swelling, diameter 1½ in., its centre 2 in. to right of mid line, and 3 in. below the margin of the ribs. She complained of having had indigestion for the last two months, and said that the swelling had appeared suddenly one month previously, when she was doing some heavy grinding. Pain, she said, had been present only ten days, but histories in Indian women are very unreliable. On February 12th the patient was operated on by Dr. Mayne. Below the subcutaneous fat and beneath the abdominal muscles was the fundus of the gall bladder enclosed in a peritoneal sac. The edges of the stricture round the neck, formed by the abdominal muscles, were snicked, a few adhesions between stricture