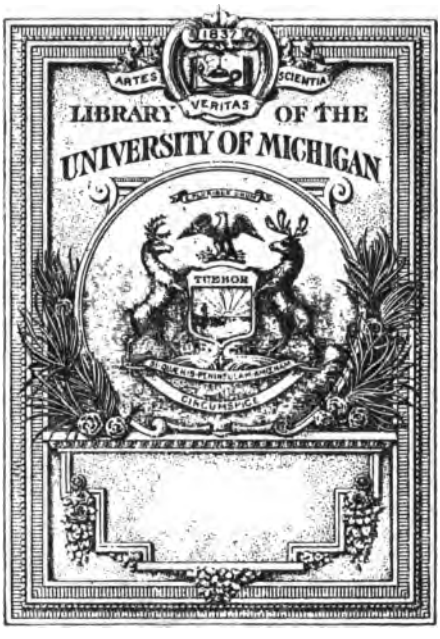
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ARCHIVES OF SURGERY.

ARCHIVES OF SURGERY.

BY

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LIST OF PLATES.

Note.—The reader is requested to observe that the Plates do not always bear consecutive numbers. They have been printed for a smaller Atlas of Clinical Illustrations of Disease (of which an announcement appears on the following page), and the plate numbers refer to their position in that work.

[redacted]

ARCHIVES OF SURGERY.

JANUARY, 1898.

SELECTED CASES IN ILLUSTRATION OF INHERITED SYPHILIS.

WHEN in 1878 I resigned my appointment on the staff of the Moorfields Ophthalmic Hospital, my sphere of observation in reference to the later results of inherited syphilis became greatly reduced. In private practice such affections are fortunately rare. It was at Moorfields that I had collected the cases upon which were based my observations as to the keratitis, choroiditis, and other eye affections which occur in connection with inherited taint, and also as to the peculiarities in the teeth by which such taint may be recognised. My Work on these affections which was published in 1863 contained narratives of most of the cases which had come under my observation up to that date, and after its publication it did not seem worth while to continue to collect cases in illustration of doctrines which were generally accepted by the profession. Since that time I have taken note almost solely of such cases as seemed either exceptional to the views which had been advocated, or which suggested new ones. From time to time I have since published brief annotations on these topics.

It may be convenient to briefly recapitulate some of those which have appeared in ARCHIVES.

Vol. I., p. 51, *et seq.* Two cases of infantile convulsions in connection with inherited syphilis.

Vol. I., p. 51. Severe chronic bone disease, one node having suppurated. No other indications of taint in the child, æt. 13, but mother syphilitic.

Vol. I., p. 53. A case in which a mother showed secondary symptoms apparently from fœtal contamination.

Vol. I., p. 53. Choroido-retinal disease in an infant after convulsions. I may now add to this record that four years later the child was partially idiotic.

Vol. II., p. 65. Are women liable to transmit syphilis to offspring during longer periods than men?

Vol. II., p. 66. A woman bore syphilitic children four or five years after her own disease (erroneously stated in text to have been *eight* years). The fallacy was that she or her husband might have contracted it again more recently.

Vol. II., p. 118. A case in which, of twin infants, both dead, the bones of one showed syphilitic changes, and those of the other were free. (Seen at Berlin.)

Vol. II., p. 291. A case in which two sisters, born with an interval of seven years, both suffered from late lesions, neither of them having had infantile symptoms. Both parents were probably tainted, the mother by fœtal contamination. (A very remarkable narrative.) Again referred to, with additional particulars, Vol. V., p. 70.

Vol. II., p. 294. Case in which it might have been believed that a man who married four years after his syphilis, communicated the disease to his wife.

Vol. II., p. 295. An example of glandular gumma in the neck of a girl the subject of inherited syphilis.

Vol. IV., p. 324. A case in which a man who married, with my consent, four years after syphilis, was supposed to have been the father of a syphilitic child. Diagnosis as regards the child erroneous.

Vol. V., p. 72. Severe syphilis inherited from a father. The mother remained in excellent health. Severe keratitis and nodes, but no peculiarities in teeth or physiognomy.

Vol. V., p. 75. Case of acquired syphilis (severe) in a man who was reputed to have had symptoms of inherited disease in infancy and also interstitial keratitis.

Vol. V., p. 76. Four healthy children born to parents both of whom had suffered from syphilis.

Vol. V., p. 76. Palmar psoriasis in a girl of eighteen the subject of inherited taint, and whose mother had the same affection.

Vol. V., p. 183. Good health, and entire absence of physiognomical and dental peculiarities in a gentleman, aged 26, whom I had myself treated for infantile syphilis. He had suffered from a severe attack of keratitis at the age of nine.

Vol. V., p. 216. Several cases illustrating paralytic dementia in the subjects of inherited syphilis.

Vol. V., p. 264. Gumma in the tongue in a patient the subject of inherited syphilis.

Vol. V., p. 360. Arrest of sexual development, with mental peculiarities, in a boy the subject of inherited syphilis.

Vol. VI., p. 15. On the differences between syphilitic teeth and the malformations due to mercurial and other forms of stomatitis.

Vol. VII., p. 60. "Ringworm tongue" in a child of six years, who had suffered from inherited syphilis.

Vol. VII., p. 62. An instance of very severe keratitis, with choroiditis and vitreous opacities in a syphilitic girl of twelve, who showed no peculiarities of physiognomy. Synovitis of one knee.

Vol. VII., p. 63. Reference to the case described in Vol. II., p. 291.

Vol. VII., p. 294. An instance of severe syphilitic pemphigus present at time of birth. (Drawing kept.)

Vol. VIII., p. 245. Synovitis of the knees preceding keratitis in a young man the subject of inherited syphilis.

Vol. VIII., p. 280. A case of complicated and relapsing inflammation of the eyes in a young woman (one of twins) who inherited syphilis.

Vol. VIII., p. 283. On deafness in connection with inherited syphilis and on the greater liability of girls to suffer from it.

I now purpose to give from my private note-books a few facts which I have not previously recorded. Some of these appear to be of value because they supply further detail respecting cases already recorded, but most of them will concern wholly new ones. Amongst the special points which will be illustrated by them the following may be mentioned:—

That the subjects of taint often grow up into healthy men and women.

That complete exemption from other indications of taint does not exempt from the risk of an attack of keratitis.

That it is not unusual for one child in a family to suffer very definitely whilst all the others apparently escape.

That it is very exceptional for any considerable series of children to suffer in succession from inherited taint.

That the mother of one or more syphilitic children may herself remain throughout quite free from symptoms and apparently in good health.

That a condition of general arrest of growth may be one of the consequences of inherited taint.

That it is possible for children born within dangerously short periods of the primary disease in one or both parents, to entirely escape the inheritance.

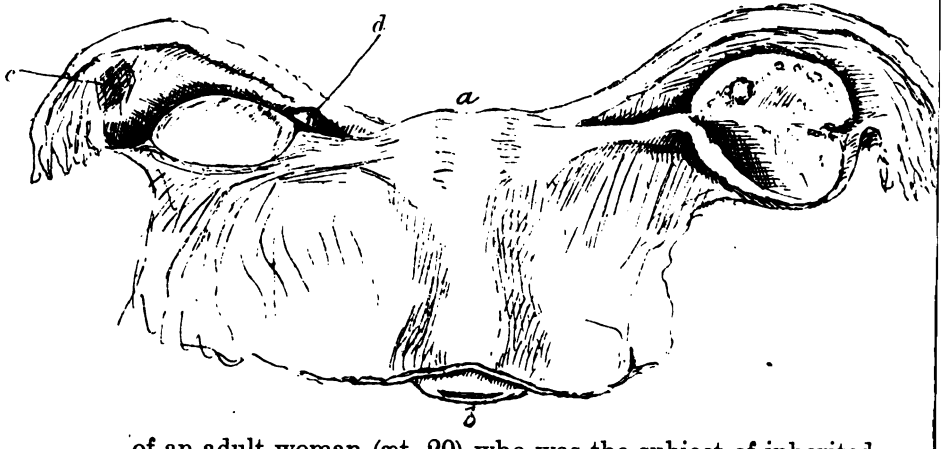
That although, as a rule, after keratitis, choroiditis, &c., the recovery is permanent, there are exceptional cases in which certain progressive changes continue.

That it is by no means improbable that some who really inherit taint never; either in infancy or subsequently, show any symptoms.

That the children of those who have suffered from inherited syphilis are usually quite healthy. That syphilitic infants may be suckled by their mothers as a rule without risk to the latter. (My life's experience affords no trustworthy exception to either of these two propositions.)

No. I.—*Uterus and Appendages from a case of inherited Syphilis showing arrest of growth.*

The woodcut here given is from a drawing which I have had many years in my possession. It represents the exact dimensions (measured by compasses) of the uterus and ovaries



of an adult woman (æt. 20) who was the subject of inherited syphilis. She was of low stature and displayed a general arrest of development. Her mammæ were extremely small,

and her skin was dry and of earthy pallor. She had, I believe, menstruated a few times. Her physiognomy and teeth showed the usual characteristics. She died in the London Hospital, and as we had noted the especial absence of feminine development we were interested in examining the organs here delineated. They were the smallest I have ever measured. Thus the uterus was only an inch and a half (*a* to *b*) in length (half of what is normal), and the appendages were in proportion. The sketch shows the parts as seen from behind. The right ovary is laid open. C indicates a dark stain probably from ecchymosis; *d*, a small pedunculated growth.

A case which I have recorded in Vol. V., p. 360, is a good example of a parallel condition in the male sex. Although seventeen, the boy was quite feminine in his build and had, I have no doubt, arrest in development of the sexual organs. He had extensive choroido-retinitis.

No. II.—*A strong, healthy son born of a mother who had suffered severely from inherited Syphilis—The mother dwarfed in stature.*

Mrs. H—— was herself a sufferer from inherited syphilis in a very severe form. She was dwarfed and quite deaf. She had had under my care an attack of keratitis, and subsequently was much troubled with noises in the head. She was married and had borne one child. I saw this child when he was twelve years old. He was a fine, strong lad without a symptom of taint, had perfect teeth, and was as tall as his mother, to whom he offered a strong contrast.

No. III.—*Inherited Syphilis—Keratitis and Internal Otitis at the age of thirteen—Report on state of health at the age of forty—Important facts as to family history.*

Maria D—— was my patient at Moorfields Ophthalmic Hospital, for a severe attack of interstitial keratitis, in 1870. Twenty-three years later, in August of 1894, through the courtesy of Dr. W. H. Johnson, of Limehouse, I had an

opportunity for investigating her then present condition. She was now a tall, well-grown woman of 37. Her features were not peculiar, and the notches which had formerly been present were worn out. She was absolutely deaf. The history of her deafness was that in 1871, whilst still taking small doses of mercury, which I had prescribed for her keratitis, her hearing began to fail, and that within a fortnight she had become quite deaf, and had remained so ever since. She had learned to talk with her fingers, but of late her sight had failed so much that it was feared she would lose even this means of intercourse with others. She was liable to attacks lasting a few moments at a time, during which she was in darkness. Her corneæ showed the characteristic steel-haze, and the pupils were small. There were white patches near the borders of the corneæ, and a conspicuous white arcus at the upper part.

As regards family history, this patient was the fourth child, and had younger brothers and sisters. She was the only one who had suffered. I saw one sister only eighteen months younger who had ailed nothing whatever.

Three years later still, in November, 1897, I again examined this patient, and obtained from her elder sister in more detail the important facts at to the history of their family. Fortunately the fears which had been entertained as to the advancing failure of sight had not been realised. She had ceased to be liable to retinal epilepsy, and although her left eye was disabled by pupillary occlusion, could still see fairly well with the other. It was impracticable, owing to the smallness of the pupil, to examine the fundus; at any rate I found it so, and a note on a Moorfields Hospital letter recorded the same result. In spite of this, however, I was assured that she was a great reader and could do the finest needlework with ease. Apart from her disability from deafness, &c., she enjoyed excellent health, was of a happy disposition, and always busy. She was now 39.

An elder sister who brought her to me in November last at my request, that I might ascertain her present condition, gave me the following important particulars as to their family: Maria D—— is the third living, and there are six

younger than her. All these six are in good health, and have never suffered anything suspicious of syphilis. My informant's remark was: "We are a remarkably healthy family, and all well grown and strong." Asking as to their parents, I was told that their father, who was a pilot, was a man of splendid frame and always healthy, but who had "lost part of his palate after a bad sore throat." He finally fell down dead from heart disease when between sixty and seventy. Their mother enjoyed good health until her death from bronchitis at 65.

No one can reasonably doubt that this woman is the subject of inherited taint; her deafness and keratitis sufficiently prove that, and the statement that her father had a perforation of his palate as a consequence of a bad sore throat indicates the source from which the disease was derived. As her sister, only three years older than herself, is wholly without indications of it, there cannot be much hesitation in believing that her father acquired the disease after his marriage, and not long before our patient was begotten. It is of interest to note that not only does his wife appear to have wholly escaped, but also all their subsequent children. The man and wife continued to live together as though nothing had happened, and a succession of six children were born, all of whom lived and have remained well up to adult life (all being, in fact, still living and robust). The one next to our patient is not more than eighteen months her junior.

I am well aware that the absence of symptoms in infancy and childhood, and good health up to adult age, does not prove escape from taint. Those who have so escaped may still in exceptional cases suffer from keratitis or other of the less common late manifestations. They may, however, be fairly held to have escaped so far as serious peril to health is concerned.

No. IV.—*Syphilis inherited from the father—Severe infantile symptoms and subsequently Keratitis—A younger sister free from symptoms, but showing typical teeth.*

The next case which I have to relate is a very conclusive one in proof of what has just been remarked as to the possible

escape from all obvious symptoms, in childhood, of those who yet most certainly inherit a taint. A gentleman who had suffered from syphilis resumed, after a short time, cohabitation with his wife and became the father of a child (a girl), who suffered severely in infancy. It was not expected that she would survive. With great care, however, she was reared and became a healthy woman. At the age of twenty-nine, however, she passed through a most severe attack of keratitis, which left her corneæ permanently damaged. It was for this that I was consulted when she was thirty-two years of age. The bridge of her nose was much sunken, her corneæ opaque, and her teeth very characteristic. Her whole frame was somewhat dwarfed. With her came a younger sister, aged 28, who was married and the mother of a fine, healthy child. This woman had never suffered anything. She was well grown and showed nothing peculiar in physiognomy, yet she had teeth as characteristic as any that I have ever seen. Between the patient and this her younger sister, two births had occurred. One of the infants was stillborn, and the other lived five weeks and then died of diarrhœa. In this instance the mother, who had continued to live with her tainted husband and had borne to him during five years four tainted children, never herself suffered in any way. She is still living and in excellent health. She suckled her eldest child for some time whilst it was ill, and never contracted any sore on her nipple.

Incidentally in the above narrative we have an instance of healthy offspring in the second generation.

No. V.—*Hereditary Syphilis—Interstitial Keratitis at the age of twenty-six—Patient the father of healthy children.*

The following case is of interest as an example of the production of healthy children in the second generation, and also of the late occurrence of keratitis.

"*December* 11, 1873. J. C——, a six-foot soldier, attended me in 1862, æt. 26, for interstitial keratitis. He got well, and remained well for five years. Then he had ophthalmia, which ended in granular lids. He was a tall, stout, florid man in splendid health, and the father of six

healthy children. Yet his teeth were quite characteristic as also was his keratitis.

"His elder sister came with him (five years older), and she had no signs of hereditary syphilis. I was informed that a younger brother had had an attack of inflammation of the eyes."

No. VI.—*Healthy child of a mother herself the subject of inherited Syphilis.*

Mrs. C——, aged 28, had borne two children. One had died of bronchitis after measles, æt. 18 months; the other, aged three months, she brought with her, and it appeared to be perfectly healthy.

This woman came to be inspected at my request, because I had diagnosed inherited syphilis in a younger sister. Mrs. C—— had deep scars about the mouth, and her teeth, although not greatly malformed, were quite characteristic. She had suffered from keratitis at the age of eleven, and the corneæ were still hazy. She now appeared to be in good health. She stated that she had been told that up to three months old she had a bad rash on the face.

No. VII. — *Effusion into one knee-joint in a boy aged 5, pale and puny — Interstitial Keratitis of marked character three months later—No history of infantile symptoms. April 9, 1873.*

A further note on August 29th of the same year records that the eye was well, but the knee still somewhat swollen. It will be seen that the synovitis, contrary to rule, preceded the keratitis.

No. VIII.—*Hereditary Syphilis in a child of eleven, whose mother I had attended for a syphilitic gumma—Interstitial Keratitis—Teeth not malformed. July, 1873.*

No. IX.—*Congenital Syphilis—Infantile convulsions followed at the age of eight by threatened dementia.*

Mr. C——'s child, aged 8½ years, was brought to me in February, 1892. At the age of three months she had had

pain in all the epiphyses, and a month later she had a convulsion. When six months old she had a very severe fit, attended by squint. Last summer her mind seemed to fail, and she was no longer able to say hymns as before. Although she had not been taught at school, yet she had picked up a good deal. During the past few months she had become dirty in her habits. I examined her eyes, and found grey degeneration of the optic nerves.

There were two younger children of the same family who were quite healthy.

Comments.—I do not know the sequel of this case. The child was obviously threatened with failure of mind, &c., such as is illustrated by the cases cited at p. 216, ARCHIVES, Vol. V., and concerning which Dr. Shuttleworth has published some important facts.

No. X.—*One only in a family of eight showing signs of inherited Syphilis — The others living and quite free.*

Clara T——, æt. 16, attended on September 10, 1870, on account of the remains of interstitial keratitis. Her teeth, physiognomy, and eyes were in most characteristic conditions. With her came two sisters—one æt. 24, the eldest of the family, and one æt. 7, the youngest, neither of whom showed the slightest indication of inherited taint. Both had perfect teeth. I was told that there were eight living children in the family, that Clara had suffered severely all her life and none of the others at all. The attack of keratitis in Clara was very severe, and she had to be kept in a dark room for six months. There are three younger than Clara living and four older. Two had died in infancy.

Comments.—The above facts are best explained by supposing that the father of C. suffered from syphilis not long before her begetting. This would explain the escape of all born previously. The husband of her mother was a sea-captain, and often away from home, and in connection with this fact several possibilities suggest themselves. Unfortunately I have not noted how long the interval was between

C. and the one born next to her. It may have been long enough to allow of the infecting parent having got rid of the taint. Possibly the two who died intervened.

No. XI.—*Inherited Syphilis — Father alone the source of infection—Mother remaining quite healthy throughout.*

A surgeon had a chancre on his index finger in August, 1883. He took mercury, and did well under it. His wife bore a child in December, 1884. It was a fine child at birth, but when two weeks old, quite suddenly, as the nurse said, it, in one night, became covered with an eruption. After that it never thrived. Grey powder was at once given, and when the child was brought to me on January 16th, at the age of five weeks, the rash had faded, but there were unmistakeable symptoms of inherited taint. Its buttocks were then covered with a red excoriated eruption, which tended to assume a polished surface. There was also some eruption about its mouth. It had had no snuffles. Under mercurial inunction the symptoms disappeared, and the child afterwards throve well.

In this case I know that the mother remained throughout quite free from symptoms. It appears to be a good instance of inheritance from the father only. As the chancre was not on the penis, there was but little risk of direct contagion to the wife. That a woman should bear to a syphilitic husband a syphilitic child, and yet, apparently, wholly escape herself, is, I believe, not uncommon. Fœtal infection, although a possibility, is by no means invariable. Much probably depends upon the development attained by the virus in the infant during its intra-uterine life. In this instance the child at the time of birth was in perfect condition. The virus was then apparently latent, and we may suppose that it was possibly inactive as a means of contagion.

It is interesting to add to the narrative, that three years after the date of my notes the father reported to me that his wife, his child, and he himself were all in excellent health.

No. XII.—*Congenital Syphilis—Keratitis severe in eldest and youngest of three children — Absence of teeth symptoms.*

Mr. D—— brought me his three children.

W. (M.), æt. 14, had suffered from keratitis, and had a characteristic forehead. His corneæ were now clear.

F. (M.), æt. 12, showed nothing and had ailed nothing.

E. (F.), æt. 10 (my present patient), had now the remains of most severe keratitis.

None of the three had peculiar teeth.

No. XIII.—*Scrofula and congenital Syphilis together. Keratitis of several years' duration on and off; cured by setons. I had treated both father and mother for Syphilis only four months before this child's birth, yet no very definite symptoms had occurred in the child. Inherited tendency to Phthisis, and great enlargement of the glands in the neck. May 20, 1892.*

No. XIV.—*Syphilitic Pemphigus developed during intra-uterine life—Ricord's Plate and* ARCHIVES VII. 294.

No one who has seen the 46th plate of Ricord's Atlas can doubt the occasional occurrence of the intra-uterine development of syphilis. The infant whose body is depicted was born dead, and it is covered with abrasions and pemphigus blebs. The hands and feet are affected with special severity. The infant was a male, and born at full time. Its father had suffered from syphilis quite recently, but the mother remained, so long as she was under observation, in perfect health, and had never had a symptom. The child was believed to have been dead three or four days before birth. It had no special visceral disease.

No. XV.—*Recovery from Syphilitic Pemphigus in an infant—Choroido-retinitis and much damage to Eyes.*

Nellie B——, aged 6 years (July 13, 1873), had been in infancy the subject of syphilitic pemphigus. She had at birth crimson palms and soles, and ten days afterwards bullæ as large as grapes appeared on her hands and forearms,

feet and legs, and were confined to those parts. She was very ill, but recovered under grey powder and mercurial ointment. She also had sores at the corners of the mouth, snuffles and patches at the anus. These facts were supplied to me by the surgeon who had treated her.

Her father had contracted syphilis six months before his marriage, and her mother, after a first miscarriage, had a syphilitic eruption. A previous child was syphilitic. The child born next after our patient had an eruption on the buttocks, and got well under grey powder, but died from tuberculosis and inflammation of the brain at three years of age. The next child, a male, had no symptoms of syphilis. He was at the time of my notes nine months old, and had, I was told, some tendency to rickets, as shown by late dentition and large ends of the bones.

To return to our patient. She was brought to me on account of her failing sight. Her eyeballs were constantly rotating (not oscillating), and there was convergent strabismus. The left eye saw $\frac{20}{200}$; the right saw $\frac{20}{70}$, perhaps more. There were in both numerous very irregularly shaped patches of choroidal absorption. Some of these were small, with black dots in their centre, while others simply showed removal of choroidal pigment. The patches were arranged quite irregularly. The left disc was grey and waxy, and there was much pigment at its edge. The movement of the eyeballs and defective sight had been recognised at the age of two years, so that it is probable that the choroiditis occurred early in life. When I saw the child she was healthy-looking, with no malformation of the head, and with good temporary teeth.

No. XVI.—*Case of Infantile Pemphigus of hands and feet, probably Syphilitic—Death of two children in early infancy with similar symptoms.*

On the 6th of May, 1874, I was called upon to visit Mr. B——'s infant, a seven months baby then twelve days old. It was suffering from spots of erythematous pemphigus on the hands and feet, and a few small excoriations about the anus, not true condylomata.

The father admitted gonorrhœa some years ago, but denied having ever had either sore throat or rash. The mother appeared to be perfectly healthy. There was, however, a statement that some years before, after nursing a syphilitic child of her brother's, she had experienced an inflammation of one eye, which was supposed to be syphilitic, and was cured by mercurial treatment. This was not followed by any symptoms of secondary syphilis. Since that time she had had one other child, which had snuffles very badly, and died with pemphigus when a fortnight old.

The child was ordered mercurial treatment, but died thirty-six hours after my visit.

Comments (written at date of notes, May, 1874).—Though the parental history in this case is too imperfect to justify a positive conclusion as to its syphilitic nature, still the probabilities are all in favour of such a conclusion, for it is certain that the children of syphilitic parents do frequently suffer from pemphigus, and that the disease very usually makes its appearance immediately after birth. Indeed, I should believe that it is often a disease of intra-uterine life, and is a common cause of the death or premature expulsion of the fœtus. And on the other hand, I cannot say that I have ever seen the disease make its appearance immediately after birth in any case where there was no suspicion of syphilitic taint. (This opinion has been since modified.)

No. XVII.—*Congenital Syphilis in a first-born child—No treatment in infancy and but slight symptoms — Very severe Keratitis at the age of twenty-one, with Periostitis and Synovitis of knees—No indications in face or teeth —No relapse, and in good health at the age of forty.*

The first and only child of her mother's second marriage. Sores at the anus were her only infantile symptoms. Her mother died of bronchitis æt. 69. Her father died young after a badly ulcerated throat. Her physiognomy shows nothing obvious: teeth good. In 1896 she was florid and looked well. Suffered from nothing but leucorrhœa and dyspepsia. Much distressed that she had had no children.

In this case although there were extensive iritic adhesions, no recurrence of iritis ever occurred. In 1896 she could see

YEAR.	AGE.	DETAILS.
1877	21	A most severe attack of syphilitic keratitis. Synovitis of knees.
1878	22	A long treatment. Node on tibia: pupils fixed by adhesion.
1879	23	
1880	24	
1881	25	Married: never conceived.
1882	26	
1883	27	Began to suffer from leucorrhœa, possibly gonorrhœa.
1884	28	
1885	29	
1886	30	"Ulcers on the womb" diagnosed, and some operations done.
1887	31	Still much trouble with leucorrhœa.
1888	32	Excepting indigestion and leucorrhœa, in good health.
1889	33	
1890	34	
1891	35	
1892	36	
1893	37	
1894	38	
1895	39	
1896	40	Comes on account of dyspepsia. Teeth are good.

almost perfectly. Her front teeth were of perfect form, and had such good enamel that I mistook them for artificial ones.

No. XVIII.—*Family history in the case of a man who had suffered from Syphilis, and continued to show symptoms long after his marriage.*

I attended Mr. H—— about the year 1870 for severe syphilis. He married within the two years. The disease hung about him for long. He had an attack of hemiplegia with aphasia about a year after his marriage, and much later became the subject of very severe tabetic pains in his legs. He also suffered from hydrocele, which required tapping once a year. In spite of all these infirmities, however, he was a cheerful, happy man, very proud of his wife and family, and never neglecting his business. He finally, in 1896, died, after a few months' illness, of abdominal cancer. I had had many opportunities for seeing his wife and children. The former never ailed anything whatever, and was always the picture of health. She was aware of her

husband's anxiety about their children, and used to smile at his fears. None of their children ever had any infantile symptoms conclusive of syphilis. Their eldest was born at seven months, and was said to have an enlarged liver, and was for some time so delicate that she was not expected to live. She has, however, developed into a fine young woman, now æt. 22, and her teeth show nothing.

No. XIX.—*Hereditary Syphilis—Enlargement and partial displacement backwards of head of each radius.*

David H——, æt. 28. (Sent by Mr. Tay, September 8, 1875.) Has been in London Hospital for some trivial ailment. Considerable haze of each cornea from severe old keratitis. Pupils sluggish, and L. more than R. Slight dots of whitish deposit on each lens capsule, but no synechiæ. Refraction highly myopic in each. Considerable crescent in each. Retinal veins and arteries normal. Abundant peripheric, old choroiditis, large patches of black pigment, a few of atrophy without pigment. Blue irides; darkish brown hair. There are a few dense circumscribed floating bodies in each vitreous. Teeth screwdriver-shaped. No deafness. Physiognomy not characteristic. There is slight enlargement of inner part of R. patella (after a small wound in or close to knee some years ago; the joint was much swelled). The L. outer malleolus is considerably larger than R. No nodes on tibiæ.

He is an only child. There was one miscarriage after he was born. Has never to his knowledge had inflammation of the elbows or ankles. The enlargements at his elbows have been as they are now as long as he can recollect. At each elbow the head of the radius is very considerably enlarged and projects backwards. That of the right radius is the larger of the two.

(*To be concluded.*)

PEMPHIGUS AND ITS VARIANTS.

(*Continued from page 336, Vol. VIII.*)

Before proceeding to make some general comments, I have a few additional cases which must be recorded.

The following letter from Dr. Groome, of New Cross, gives some additional particulars as to the latter part of Miss L——'s illness. Hers was the last case recorded, and was left incomplete.

"My dear Sir,—I attended Miss L—— in June, July, and August, 1895, for a recurrence of the pemphigus, and in September of the same year she had not a blemish on her skin except the staining of the epidermis left after the eruption. She then left for the country and remained clear until December, 1895, when she came to me with the rash developing in the chest and arms. From this time she got from bad to worse, and the rash appeared over the whole cutaneous surface with the exception of the malar portion of each cheek. Her gums, together with the buccal mucous membrane, were extensively involved, as also were the soft palate and tongue. The bullæ were very large, and extended from head to foot; in fact, her skin was virtually one raw surface, covered here and there with large yellowish crusts, the whole exhaling a most offensive odour. As to the treatment, I confined myself to quinine and arsenic in gradually increasing doses, and applied soothing ointments locally, but all to no purpose, for the disease steadily progressed and, as I said before, the patient died in a pitiable condition consequent on the pemphigus and the exhaustion following it. The death certificate contained the words 'Pemphigus foliaceus' and 'Exhaustion.'"

A Pemphigus Eruption affecting only the limbs—Very large bullæ—Inflammation of Conjunctivæ and of Mouth—Partial obliteration of conjunctival sacs and inversion of eyelids.

The subjoined schedule and notes concern a case in which the most distressing condition was the affection of the conjunctivæ. There appeared much reason to fear that the boy might lose his eyes. The pemphigus eruption which

had preceded and accompanied the conjunctivitis had apparently followed typhoid fever, and had been wholly confined to the limbs. My patient was brought to me with an introduction from a physician in Lausanne, which informed me that he had in the early stages suffered from bullæ on the conjunctivæ, and that he could not take arsenic. The diagnosis given was pemphigus of the conjunctivæ, with consecutive atrophy. He was in a most deplorable condition. I advised as a preliminary measure excision of the eyelashes; but I did not see him again, and believe that he left London.

YEAR.	AGE.	DETAILS.
1890	1	Born in Guernsey. He is one of five.
1891	2	Quite well.
1892	3	Was taken to the Riviera, and had a severe attack of typhoid.
1893	4	Very weak, and liable to whitlows, and sores in nose and corners of mouth.
1894	5	Liable to bullæ on face, hands, and feet (sudden). Eyes inflamed.
1895	6	Suffering severely both in eyes and skin.
1896	7	October 30, brought to me.

Additional Notes.

He has never had pemphigus on his body, but his hands have suffered severely. It might be taken for a form of "blistering chilblains." Both eyes are affected, the corneæ being opaque and vascular, and the conjunctival sacs contracted. The right eye has been considered to be lost. He screws the eyelids up and turns the lashes of both upper and lower lids in upon the corneæ, and it is difficult to say how much may be due to this. He is of pale complexion and flabby skin. His skin on the limbs blisters wherever touched. I am told that he has had very large bullæ on thighs as big as eggs.

Acute Pemphigus with Sore Mouth, following a patch of Eczema on the neck—Arsenic disagreeing.

Mrs. R——, aged 35, the mother of three healthy children, was brought to me on April 2, 1897, by Dr. Hampton Brewer, of Dalston. I was told that she had,

some months ago, suffered from hæmorrhage from the bowel, and that in former life she had presented some indefinite nervous symptoms with "paralysis." She had also, in 1895, had an attack of acute general eczema. The first indication of her present skin disease was a rough patch (eczema?) on the back of the neck. Some weeks after the first appearance of this, a general pemphigus eruption appeared on the limbs and trunk. There were bullæ of large size. Arsenic was given from the first, but only with irregular benefit, and finally it had seemed to disagree with the general health. Mrs. R—— had emaciated, and although she had no fresh bullæ when she was brought to me, she looked very ill. The statements as to the disagreement of arsenic induced me to advise its discontinuance, at any rate for a time. We agreed to substitute quinine and small doses of opium. She had complained of sore throat and mouth.

Four weeks later, on April 30th, Mrs. R—— came to me a second time. She had now many bullæ and of large size, especially on the limbs. She said the blebs would rise very rapidly, "often a large one would form in five minutes." They would remain clear for two or three days, and then become purulent. They now occurred on all the limbs, on the abdomen and the back. The mouth and lips showed plum-coloured patches. It was clear that quinine had failed, and I now advised resumption of arsenic. Four days later Mrs. R—— attended one of my Demonstrations. She had still very numerous bullæ on the limbs, but her mouth was better. As she could not be well nursed at home, I asked my colleague, Dr. Stephen Mackenzie, to be good enough to take her under his charge into the London Hospital. This was done the same day.

The date of her admission into the hospital was May 5, 1897. The following notes as to her condition and progress under treatment have been kindly supplied to me, through Dr. Mackenzie, by his House Physician, Mr. Sears.

"*On admission.*—Patient was in fairly good health, but said that she had not slept more than two or three hours on any one night for the last week. She complained of a feeling of 'soreness' of the body and throat

and a general sense of weakness, but was not at all depressed. Her temperature on admission was 99·4° F. and there were no signs of disease in the heart, lungs, or other viscera.

"The entire surface of the body, with the exception of the face and back, was covered more or less completely with a bullous eruption, the bullæ varying in size from a pea to the top of a teacup. The contents were either translucent, opaque, or hæmorrhagic in character, the latter variety being the smallest in number. There was no actual pain, but only a feeling of irritation previous to or during the development of the bullæ. When, however, the bullæ became very distended with fluid, they caused a good deal of pain and had to be pricked, the pain disappearing on the outlet of the fluid. On various parts of the body there were dry, hard scabs which marked the remains of bullæ which had been absorbed, some of which were slightly pigmented, and along the edges of these patches (which were well marked on the hands) small clear vesicles were seen. The glands in the axillæ were enlarged.

"*Progress and Treatment.*—Up to May 11th the patient continued in the same state as before, crops of bullæ appearing on various parts of the body, the temperature, however, rising about half a degree every evening till, at the date above mentioned, the thermometer registered 101·6° F. On the morning of the 12th she complained of feeling ill and very depressed, and could not take solid food on account of a feeling of enlargement of the inside of the throat. A laryngoscopic examination at this date, however, revealed nothing abnormal, and it was not till two days after that a large oval bulla was detected at the junction of the hard and soft palate. The patient was by this time in a very serious state, her condition causing great anxiety, as she was unable to swallow either solid or liquid food, the smallest amount being almost immediately rejected, and showing traces of blood. The temperature at this time varied between 102·4° F. and 99° F. This condition lasted up to May 17th, when the throat symptoms abated, though the feeling of depression continued; the patient being now able to swallow small quantities of milk without vomiting. At this time she was taking Liq. Arsenicalis m. x. t.d., the dose having been increased from the original one of m. v. which she was ordered on admission. During this severe period of her illness crops of bullæ continued to appear on different parts of her body, the character of the eruption not varying in any way; and on May 22nd, when the dose of Liq. Arsenicalis was increased to m. xv. t.d., no improvement of a marked character had taken place, though her general condition was much better. On May 25th the patient was ordered Ext. Opii gr. $\frac{1}{2}$, in pill form, every four hours. No improvement was noticed till the first week in June, when the face became clear and the crops of vesicles gradually became less; and in a few days no new vesicles showed themselves, the last bulla being noticed between the second and third week of that month. Her general condition improved, and she left the hospital on June 25th on account of some family trouble, still feeling more or less

weak and thin. Since then, however, she has been seen and is at present looking remarkably well, and has had no recurrence of the above illness."

This patient attended one of my Demonstrations for a second time on December 7th, five months after her discharge from hospital. It is long since anything has given me keener pleasure than I then received from seeing in perfect health one whom I had believed would die, and who had, I knew, been saved not by the resources of nature but by the timely use of drugs. On the former occasion of her attendance, just before her admission under Dr. Mackenzie's care, Mrs. R—— was a pitiable object, emaciated, covered with bullæ, with a sore mouth, and, worst of all, her symptoms had apparently resisted the influence of the two specifics arsenic and opium. It was this latter fact which made me especially unhopeful as regards her recovery. Yet it was by these drugs, when used with the advantages of hospital supervision, that the cure was effected. Dr. Mackenzie has since informed me that during the first few weeks of her hospital residence she got worse, and that the improvement did not begin until the dose of opium was increased. He credits the combined use of the two drugs with the cure. At the time that she left the hospital the eruption had not quite disappeared, and at this date the opium was left off and arsenic alone continued. I should like to insist on the completeness of the disappearance of the symptoms. Mrs. R—— had, when I last saw her, a perfectly sound skin; she had fattened and looked quite well. This completeness of result is not unusual in pemphigus cases, and is a very important fact. It seems to prove that there is some constitutional element of causation of a very definite kind, the removal of which may permit of return to perfect health. Nor is it very unusual for cases to resist treatment for a while which finally yield to it in this complete manner. Of this the next case which I have to narrate is a yet more definite example, for the disease had lasted longer and had relapsed repeatedly. Yet the patient, after being long at death's door, was finally cured, and has now for nearly three years enjoyed excellent health.

This susceptibility of absolute cure is a feature which pemphigoid dermatitis shares with the malady which we know as Lichen planus. This latter will often for a time resist treatment, and although it does not, like pemphigus, threaten the patient's life, yet it may cause extreme discomfort and much reduce his health. At page 88 of Vol. II. will be found the narrative of a case in which the disease was one of much severity, and in which suddenly under the influence of antimony it began to decline and the skin was soon restored to perfect soundness. It is like pemphigus also in that there is a definite risk that a return of the dermatitis may take place after an interval of some years.

It is much to be desired that those who have the opportunity would put on record their observations as to the permanency of cure in cases like the foregoing. It is unfortunately the fact that many of the case-narratives of pemphigus are only fragments, and do not take us further than the disappearance of the eruption. We know that in many the eruption does relapse, and it can scarcely be asserted that we know for certain that there are any in which, sooner or later, it does not do so. This is really a very important point, and more definite knowledge respecting it might help us much in our endeavour to form correct ideas as to the real nature of the malady. It is, I think, highly probable that some patients who have passed through a pemphigus illness and been cured by drugs do remain well ever after. At any rate I have myself quite lost sight of some patients who would, I think, have returned to me if they had had relapses, and such, I doubt not, has been the experience of other observers.

Pemphigus in a boy—Repeated temporary cures by Arsenic—Severe illness with Ascites—Subsidence of the Pemphigus—Paracentesis six times—Return of Pemphigus—Cure by Arsenic—Recovery and good health three years later.

In my next case, as I never myself saw the patient and have not had any detailed notes supplied, the safest way will be, I think, to let my friend's letters give the narrative.

It will be seen that it is a case of great therapeutical importance.

On March 18, 1894, I received from my friend, Dr. Clement Dukes, of Rugby, a letter, of which the following is an extract:—

"DEAR MR. HUTCHINSON,—I wonder if you can be a good Samaritan and give me a hint on a hospital patient who will die unless I can do something more for him.

"A boy, æt. 6, has suffered from pemphigus on and off for about two years. I got him cured for a time by making his meat and drink of arsenic.

"A month ago, solely from interest in the case, I went five miles to see him as he had ascites, and no pemphigus. I removed him to the hospital, and tapped him three times, letting out 120, 90, and 72 ounces at the three times. Since the last tapping his pemphigus has returned, and he seems very prostrate.

"In addition to the arsenic, I have used mercury and iodide of potassium."

The following note bears date ten days later:—

"*March* 29, 1894.

"DEAR MR. HUTCHINSON,—Thank you for your kind note about the pemphigus boy. I am sorry that I cannot give you complete notes, for I have only seen him intermittently.

"When I first saw him, some two years ago I think, he was one mass of blisters as large as the palm of the hand. It was about a month ago that the village doctor asked me to see him, and take him into the hospital.

"I have again tapped him twice since I wrote to you, and I must do it again to-morrow I fear, as he has incessant abdominal pain unless it is done.

"The pemphigus has now subsided, and he seems better while he fills so rapidly. I thought that the case would interest you. I have not detected any disease of liver."

After that I did not hear anything until, in 1897, I wrote to inquire what had been the sequel, quite expecting to hear that the boy was dead. The following was Dr. Dukes' reply:—

"*December* 6, 1897.

"DEAR MR. HUTCHINSON,—This lad remained under my care from February, 1894, to August of the same year, when he returned home

cured. He was tapped in all six times. I got him nearly black with arsenic. He hovered between life and death for long, often with a temperature of 104°. When he was at last mending, and I had to stop the arsenic, I think because of diarrhœa, I gave him thyroid gland, as he was such a miserable object, and he seemed to thrive on it.

"I have little doubt that he keeps well, otherwise I should have had him in hospital again."

Not feeling quite assured that a good recovery had been established, I wrote again, asking that inquiries might be made as to the lad's present state of health. I had the great pleasure to receive the following reply:—

"*December* 9, 1897.

"DEAR MR. HUTCHINSON,—To-day is the first opportunity I have had to drive out to Easenhall to inquire after Walter W——. He resides in the same cottage with his father and his father's sister. His mother is dead. He left my care in the autumn of 1894.

"In the spring of 1895 he went to Pailton village school. He has attended school ever since (two miles away), has never had a day's illness, is fat, strong, and hearty. Only the other day the aunt said, 'I only wish the doctor could see Walter now; he wouldn't know him, and he wouldn't believe it was the same lad.' He has never had a spot on his skin since he left the hospital."

Most certainly we have here a very remarkable instance of recovery from a very unhopeful condition. The ascites was probably of a more or less inflammatory character, as evidenced by the pain, high temperatures, and the rapidity with which refilling occurred. It was in connection with this diagnosis that I advised my friend to continue the mercury with opium which he was already giving. I have known ascites in more than one case in the late stages of fatal pemphigus, and in one in which the patient had been treated for psoriasis. This latter case led me to entertain a suspicion that possibly arsenic might cause it. On this account I was inclined to advise Dr. Dukes that the arsenic should not be pushed, more especially as the pemphigus had subsided when the ascites set in. A subsequent relapse of the pemphigus made it necessary to give arsenic again. We are obliged to leave it a little doubtful as to what remedy it was that at last brought about the restoration to health,

for several had been tried simultaneously. That the arsenic controlled the pemphigus temporarily there could be no doubt, and probably it had in the end the main share in the cure. The disease had probably been quite conquered at the time it was left off.

Pemphigus with Inflamed Mouth—Partial Cure by Opium.

In the following case the patient had been under careful treatment by opium for some seven months before I saw her.

At the time that Mrs. T—— was with me she had nothing more to show than mere stains. These were visible under her breasts, on her bald scalp, and, to a slight extent, on her face and other parts. She gave the history, however, of having been liable to pemphigus blebs on various parts for the last eighteen months. It began, she said, by a most troublesome "eczema" on the scalp, which proved intractable. The parts next affected were the folds under her pendulous breasts. Her nose and mouth had been inflamed. She counted three definite attacks. She described very sore lips and tongue (with blisters); they used to stick together and were covered with discoloured secretion. The opium had, she thought, cured this.

Additional Memoranda.—Quinine makes her head ache. She has Xanthelasma palpebrarum affecting the right upper eyelid and both outer canthi, but *not* the left upper eyelid. In youth she used to have much liability to "biliousness" in the form of giddiness, for which she used to take calomel by "dipping her finger in it."

She was formerly stout and has lately lost much fat. She inherits gout from her mother, father, and one grandfather.

For two years she has been liable to profuse perspiration, which usually begins about five in the afternoon and affects her head and forehead first and next her trunk.

She menstruated regularly till 54, but, although married at 30, never conceived. She once had a throat which had white exudation and was considered diphtheria, but this was doubted by one observer. This was in August last.

Two years ago she took ether to have her sphincter stretched. She has had constipation all her life. Jerusalem artichokes were her best aperient. Her attacks have occurred at two different places of residence.

A severe outbreak of Pemphigus in a man of intemperate habits for seven years the subject of Albuminuria.

Early in May of '88 I went to Foots Cray to see a gentleman (aged 43) who was in a most deplorable condition from general pemphigus. He was confined to his bed and couch, and covered with bullæ and excoriations. He had for some time been under medical care on account of albuminuria, and he had suffered from epilepsy. His habits had been intemperate. In the October preceding my visit he had suffered from "herpes," which, however, soon got well. In March, during hot weather on board ship at sea, his skin showed an eruption of minute red spots which itched. These were scratched, and, apparently as a consequence, a bullous eruption rapidly developed. This, however, under quinine and iron and the local use of carbolic acid, disappeared to a large extent, and it was only ten days before my visit that a relapse occurred and the disease assumed the severe form above mentioned. The bullæ had been large, and he had rapidly become very weak. No albumen was present in his urine when I saw him, but it had a low specific gravity.

I prescribed arsenic, and a fortnight later I had the pleasure of hearing from his medical attendant, Dr. Fegen (now of Molton, Beds), that from the day that the medicine was begun the production of bullæ had ceased, and that his skin had rapidly got quite well.

Some General Remarks on the Series of Cases and on the Employment of Names.

Just as religious teachers recognise in the human mind a constant proclivity towards idolatry—a preference for the concrete rather than the purely spiritual—so in pathology we have to contend against the tendency to substitute a name or a definition for the perception of essential nature. As it is easier to most of us to worship a personality, a name, or even a book, rather than to conceive of non-material power, so we more readily become accustomed to content ourselves with some euphonious name for a disease rather than acquire

the habit of constantly trying to realise its nature and its relation to possible causes. The concrete has always for the indolent mind—and who in this sense is not indolent—more attractions than the abstract; and not infrequently our minds accomplish for themselves the further feat of giving to the abstract a concrete form in the imagination. Thus in the case in point we assign to the name Pemphigus a definition and give to the group of symptoms which it comprises a sort of individuality, and but too often rest content with our attainment. All that we attempt thereafter is to keep in memory our definition and our name, and to arrange future facts accordingly. Just the same process takes place in reference to such names as "Dermatitis Herpetiformis," and even "Herpes" itself. When once, however, names have been allowed to assume this kind of significance they become a bar to progress, however useful they may be in every-day intercourse with others. Whilst, therefore, it is a matter of necessity that for the sake of conversation and debate a man should make himself familiar with the meanings of the names in common use, I feel sure that he will find it best in the recesses of his own mind to discard names as much as possible and to think only of relationships and causes.

My main object in narrating the cases which have been given as illustrations of the various forms of what is known as "Pemphigus" has been to throw light, if possible, upon their real causes and their relations to other maladies. I am sanguine that this has to some extent been accomplished. It has been proved, I think, that the pemphigus process depends in part and in certain cases upon congenital peculiarity in the structure of the skin. It is only by appeal to such peculiarity that we can explain the occurrence in several members of the same family of children, of a precisely similar tendency to form bullæ on any slight irritation or injury. The peculiarity appears to involve a defective adhesion of the epidermis, and to permit of its easy elevation by fluid secretion under it. It is an element not alone in those cases of pemphigus which occur in childhood, but is met with also in adults in whom the type

of pemphigus does not differ materially from that long known as "diutinus." It has long been known and mentioned as occurring in the latter, although it has, I believe, only recently received the distinctive and convenient name of "epidermatolysis."

Another point which has, I think, been established, and which is an important advance, is that in some cases there is a definite relationship of the pemphigus process to that of herpes. This assertion implies that there is a large neurotic element, and that the vesications are produced in direct connection with the nervous system. These are the cases in which frequent and sudden relapses occur, in which vesications on the lips and in the mouth may have preceded perhaps by years the appearance of any dermatitis, and in which there is burning pain in the part before the bullæ form. Some of these cases never go beyond the stage of affection of the mouth, and in some the dermatitis is not bullous at all but may even be papillary. The alliance is perhaps more close with dermatitis herpetiformis than with any other of the more strictly herpetiform maladies, for, so far as I am aware, there is never any definite deviation from bilateral symmetry, and but rarely any tendency to spontaneous cure. The case narrated at page 128, in which a man had suffered for several years from recurring herpes in the mouth, and subsequently developed pemphigus vegetans, and finally died of the bullous form, is an example of this type of the disease. So also is the case of Miss L—— given at page 333, Vol. VIII., in which attacks of sore mouth preceded by nearly a year the eruption on the skin. In this instance the dermatitis was always a bullous pemphigus, and never attended by vegetations. It was also always under the temporary control of arsenic.

Whilst suggesting that these two essential features of causation—congenital peculiarity in structure and herpetic tendency—should be kept clearly in mind in our discussions as to the nature of pemphigus and our attempts to group our cases, I by no means wish to imply that they suffice to separate them. Many cases appear to partake of both

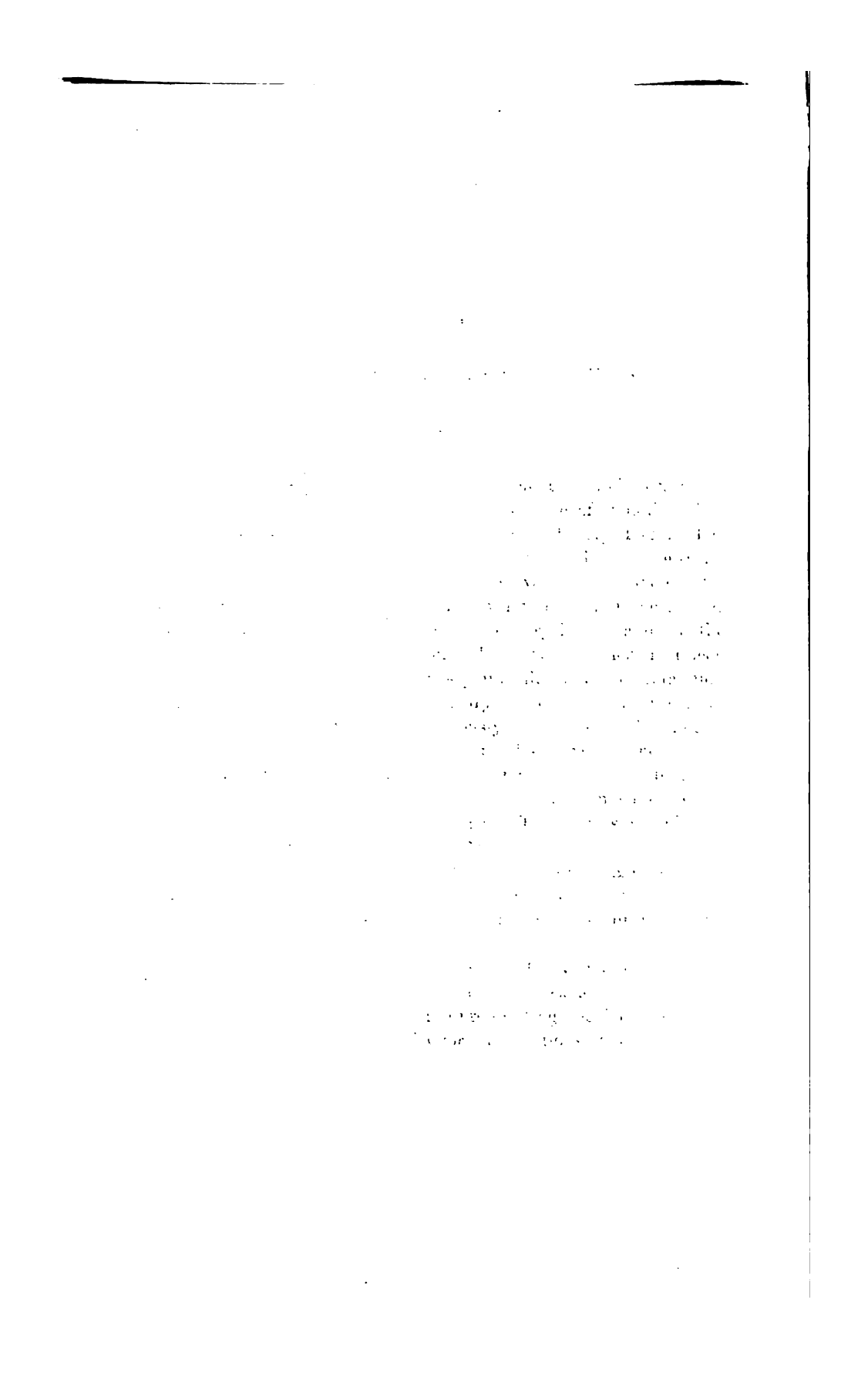
PLATE XCVII.

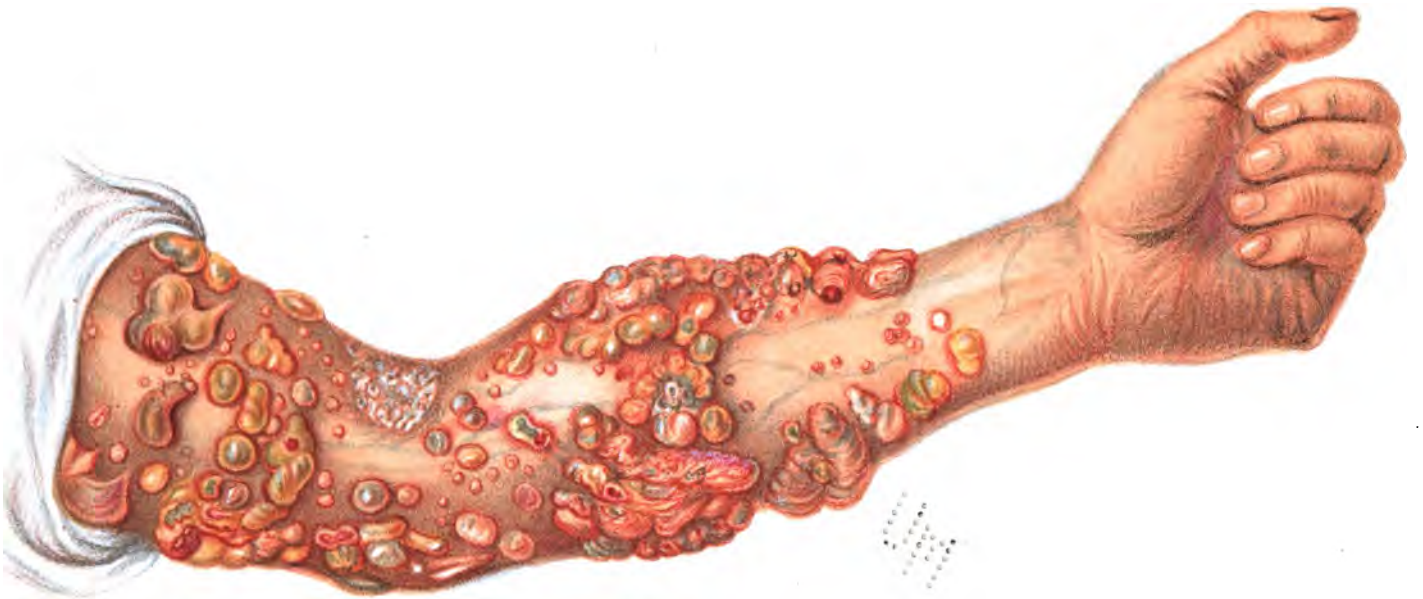
PEMPHIGUS IN SECONDARY SYPHILIS.

This Plate represents an eruption of acute pemphigus, which occurred as the exanthem in the secondary stage of syphilis. The bullæ were exceedingly well characterised and very large. The eruption covered the arms and legs with bullæ, but on the trunk it caused only erythematous patches. It was said to have exactly resembled the chicken-pox at the time of its first appearance. The chancre was still present, as also some very hard glands in the groins, and ulceration of the tonsils. The early treatment had been neglected. The treatment proved very difficult. Iodide of potassium made the eruption worse, and mercury did not cure it. When, at length, arsenic was given simultaneously with mercury, but not in combination, then very satisfactory results were obtained. The patient was, however, still, at the end of two years, not perfectly well. He was in good health, but the eruption tended to return unless the two specifics were continued. The case is recorded in detail in 'Archives,' vol. iv., page 195.

Postscript.—Since the publication of the case in 'Archives,' the patient has remained under treatment, and a perfect recovery has resulted. He has attended several times at my Clinical Demonstrations.

This case and some similar ones which I have published prove, I think, that the special type which the secondary eruption of syphilis assumes depends upon the pre-existing peculiarities of the individual. Hence the necessity for modifications of treatment.





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ılities, and others do not in any appreciable extent dis-
y either the one or the other.

[t may be freely conceded that the two features to
ıich I have adverted by no means cover the whole ground.
ıere still remains much that is unexplained, and for the
esent perhaps inexplicable, as regards the real nature of
·mphigus and its exciting causes. To the two established
cts we may, however, add a third, perhaps yet more im-
›rtant, because of more general application. It includes
›th the others, and is this, that in seeking to explain
emphigus we must look to the idiosyncrasies of the in-
ividual who is its subject rather than to the influences to
vhich he has recently been exposed. Some persons are
›orn liable to pemphigoid dermatitis in any one of its
·arious forms, and others are less so, or not at all. In
›ome of those thus congenitally predisposed the poison of
syphilis may act as the determining or exciting cause,* and
in others other influences which as yet we cannot recognise
may take the same *rôle*. In all instances, however, we shall
probably be safe in supposing a pre-existing proclivity.

For clinical convenience we may perhaps suitably classify our cases of Pemphigus, or better of Pemphigoid Dermatitis, under the following groups :—

GROUP I.—Those occurring in connection with acquired syphilis. In these the whole surface is affected, the eruption is severe and the general health fails, a rapidly fatal course being threatened. Arsenic, and not mercury, is necessary.

GROUP II.—The pemphigus of congenital syphilis. The eruption affects almost exclusively the extremities. It appears within a few days of birth, and is usually followed by death.

GROUP III.—The pemphigus of infants not the subjects of syphilitic taint. This, as in the specific form, is usually more or less confined to the extremities; it begins immediately after birth. It is attended by severe failures of health, but does not lead to death, and may last into adult

* See two most important cases given in ARCHIVES, Vol. V., in which severe general pemphigus occurred as the secondary eruption in syphilis, and was controlled not by mercury but by arsenic.

life. Arsenic exercises a beneficial influence, but does not cure. It may affect several members of the same family; not usually attended by sore mouth.

GROUP IV.—Cases of severe pemphigus beginning in young persons. These may be divided into two sub-groups —those which run a rapidly fatal course uncontrolled by arsenic, and those which, under arsenic, are either wholly cured or lapse into a chronic form. In these the eruption comes out over the whole body.

GROUP V.—Cases resembling the preceding, but with the peculiarity of a sore mouth preceding the pemphigus. These are at times acute and rapidly fatal; see Dr. Penrose's case, ARCHIVES, Vol. VIII. p. 127.

GROUP VI.—Cases in which a sore mouth follows soon after the beginning of pemphigoid dermatitis. A good example of this is given at page 135, Vol. III. (At whatever stage sore mouth occurs it is a complication of bad omen, and implies that arsenic alone will not cure.)

GROUP VII.—Cases of pemphigus beginning in healthy adults. These are almost invariably amenable to arsenic, though sometimes with marked tendency to relapse, or only an imperfect cure.

GROUP VIII.—Cases in which the pemphigoid dermatitis has been preceded by attacks of herpetic inflammation in the mouth. These are far less amenable to arsenic, and more so to opium than the preceding.

GROUP IX.—Cases in which the pemphigoid eruption rapidly passes into a generalised dermatitis without bullæ, and attended by exfoliation. These are for the most part incurable. They are very rare. Pemphigus foliaceus: see portrait in New Sydenham Society's Atlas and one in Hebra's Atlas, representing precisely similar conditions.

GROUP X.—Cases in which a tendency to the production of papillary excrescences is shown ("Neumann's malady," or "Pemphigus vegetans"). In many cases the tendency to vegetations is only temporary, and in the rest of its course the disease conforms to Group VII. Opium is the remedy.

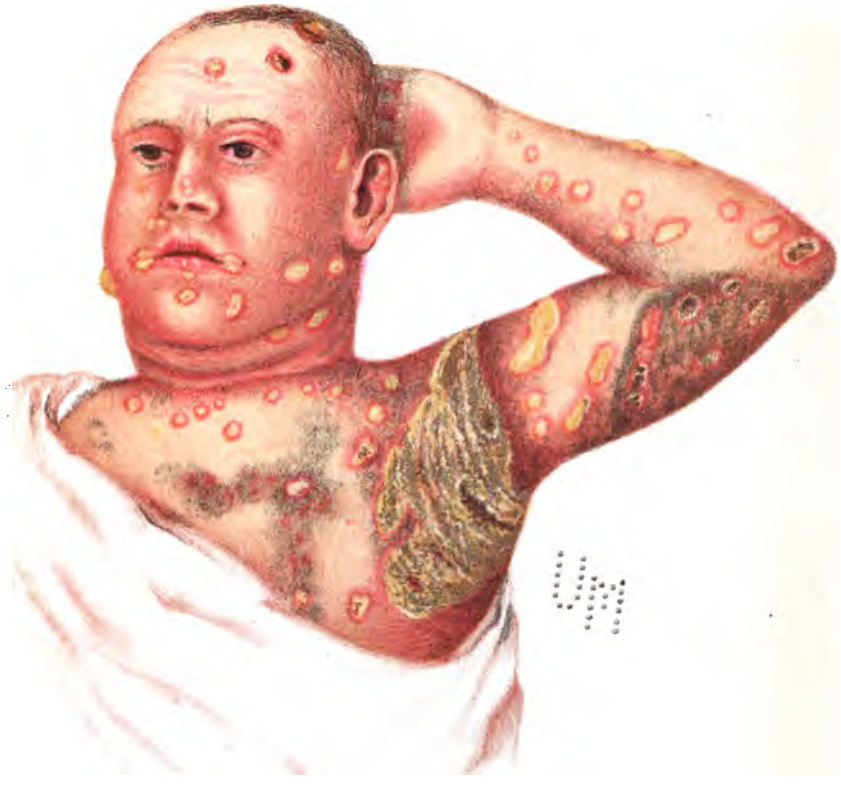
GROUP XI.—Cases in which pemphigoid bullæ remain for a long time restricted to one region.

PLATE CLVI.

PEMPHIGUS VEGETANS.

This portrait shows the condition of the skin in Mr. S——'s case three or four weeks after his arrival in London. The growth of vegetations had already been much checked by local treatment. The portrait was taken under difficulties, as the patient could not bear long exposure. It may suffice, however, to indicate the arrangement of morbid changes and the bulbous character of the greater part of the eruption. Attention is asked to the fact that the corners of the mouth are ulcerated. The vegetations occurred, as usual, with greatest luxuriance in the armpits and groins, but they had been present in an earlier stage over other parts, more particularly on the chest, neck, and arms.

The narrative of the case begins on page 129 of 'Archives,' vol. viii.



West, Newman chromo.

In proposing these Groups, it is clearly to be understood that they are constructed with a full knowledge that they in no sense constitute species. They indicate only variant types of the same malady or of forms of dermatitis which occur in association with causes more or less closely allied in all. It must be expected, therefore, that individual cases will be found to present in different stages the features of more than one group.

POSTSCRIPT.

Although for the most part I restrict myself in the pages of ARCHIVES to the record of my personal experience, and do not attempt any general purview of the literature of the subjects on which I write, yet I cannot resist the expression of pleasure at the rapidity with which our knowledge of Congenital Pemphigus has recently increased. With the exception of one or two examples of that form,—concerning which, perhaps, some doubt might have been felt,—we knew, until a few years ago, nothing as to infantile pemphigus beyond the fact that it might occur in congenital syphilis. Although Dr. Wickham Legge and Dr. Payne had both previously recorded cases, it was a paper by M. Hallopeau published no longer ago than 1890 which first drew definite attention to the malady. The writings of Besnier, Brocq, Beatty, Goldschiedes, Koebner, Valentin, Galloway, Augagneur, and others have contributed to our knowledge of the subject. We now know by the concurrent testimony of these observers that a very peculiar form of pemphigus of the extremities may occur as a family disease and may show itself in the first weeks of infancy. It may affect only one or several members of the same family, and may be inherited from a parent (see Vol. VIII., p. 317). Although usually differing much from the more common forms of pemphigus, yet it may undoubtedly merge into it; that is, the eruption may spread to the trunk and persist for years (see Vol. VIII., p. 321). It does not appear, however, that it is ever attended by the severe constitutional

disturbance and danger to life which acute spontaneous pemphigus involves.

The observation of this group of cases is a most valuable addition to our clinical knowledge. By it a broad ray of light is thrown over the whole subject, and we are made to recognise a congenital peculiarity in the structure of the skin as the predisposing cause to all forms of pemphigus. It is true that this had been suspected before, but it is now a matter almost of demonstration.*

* Koebner of Berlin had in 1886 described "epidermatolysis bullosa hereditaria," and in 1882 Dr. Wickham Legge had published two cases of the same which he had observed in the same family. Dr. Payne, also, in the same year gave an excellent account of a case. It is unfortunate that a new name was coined, and still more so that it was subsequently superseded by that of "traumatic bullous dermatitis." These names have led to the endeavour to separate such cases from "pemphigus," instead of recognising them as being really forms of it. The lesions in these cases are certainly not always traumatic, and epidermatolysis is a factor in all pemphigus. So recently as 1893 Dr. Payne wrote: "It is alleged by some and denied by others that there is a second form of pemphigus neonatorum which is not syphilitic. I have never seen such a case, and am disposed to think that it is extremely rare, if not entirely unknown in this country" (*Lancet*, August, 1893, p. 425). Yet in spite of this statement, to Dr. Payne himself belongs the honour of having observed and published one of the first cases (see St. Thomas's Hospital Reports, vol. xii. p. 187, 1882).

ON THE SO-CALLED RETINAL EPILEPSY.

AMONGST the many items of original observation in disease for which we are indebted to the clinical genius of Dr. Hughlings Jackson is the description of what he once named "Retinal Epilepsy." The name was, I believe, subsequently abandoned as not being strictly appropriate, but no one has found a better, and meanwhile the conditions so designated remain a reality. They consist in the sudden, but quite temporary, loss of function on the part of the retina or some portion of it. It is possible that in some cases a deeper region of the nervous apparatus of vision is affected. At any rate the patient becomes suddenly either in part or wholly blind, and after a longer or shorter time the sight returns again. Thus proof is afforded that the suspension of function is not due to structural changes, but rather to some alteration either in the nervous state or the vascular supply which may completely pass away. Sometimes both eyes are affected, and sometimes only one or a part only of one. As the phenomena are purely subjective, we have only for our guidance the patient's description of them, and as they are often of very short duration the opportunities for observation are often not the most favourable. Many circumstances suggest that they are of reflex origin, for they often occur during attacks of liver derangement, and are followed by other indications of disturbed health. They are very prone to recurrence, and often after more or less regular intervals. Thus in many features they conform to what we know under the name of Epilepsy, and may perhaps still be placed conveniently not far distant from that group of nervous phenomena.

I purpose in the present paper to describe some recent examples of the eye symptoms referred to, but before doing

so may perhaps suitably give a *résumé* of such cases as I have previously recorded.

At page 169 of the first volume of "Clinical Illustrations" will be found the case of a man named S——, aged 45. This man had suffered much from his liver and sick headaches, and had large patches of xanthelasma on his eyelids. He had for long been liable to attacks of temporary blindness, lasting only a minute or two and followed by sick headache. Sometimes both eyes were involved and he was for a time in almost absolute darkness, but more usually it was only one, and the right more often than the left. After this liability had been going on for several years (the eyes always recovering sight after a short time), he one day while at work found a cloud rapidly coming over the right eye, and in a minute or two it was quite blind. After this a headache as usual followed, and he had great sense of pressure on the top of the head. From this attack the eye never recovered. I made an ophthalmoscopic examination a fortnight after its occurrence, and could find no difference between the discs of the two eyes. Five years later, however—the eye being still blind and the other retaining perfect sight—the disc of the right was quite white and atrophic. His general health was much as formerly.

An almost exact parallel to the above is afforded by the case of Miss E——, which I published in ARCHIVES, Vol. VIII., p. 376. This lady was very liable to sick headaches and disturbance of sight. After one of these attacks at the age of 26 she lost the sight of the left eye. This occurred twenty-six years ago. I have seen Miss E—— quite recently. Under continued treatment by nux vomica, &c., she has lost all liability to sick headache. Her left eye remains blind, its disc being now quite white. The other eye is perfect. She is of dark complexion and comes of a bilious family. She is now aged 52.

In the same volume of "Illustrations," &c., at page 171, is the narrative of the case of Miss A——, aged 46, who was

the subject of xanthelasma with serous cysts. She had not menstruated since the age of 25. She did not consider herself "bilious." For many years she had been liable to attacks of numbness during which her hands would become useless on account of inability to feel with them. The numbness would last usually about an hour and then give place to a short sick headache, to be followed in its turn by abnormal hunger. During one of these attacks of numbness she had experienced considerable loss of sight, and her speech had become so thick that she had difficulty in making herself understood. The attack lasted half an hour, and was followed by a bad headache. Her attacks of numbness would usually occur two or three times a year, but she had, I believe, loss of sight on only one occasion. She was quite bald on the top of her head.

In a case of severe and protracted Jaundice recorded by Richter, and which I have quoted in ARCHIVES, Vol. III., p. 6, it was stated that the man had been liable to attacks of transitory blindness with vertigo.

At page 151 of the "Illustrations," I have mentioned the case of a woman whom I saw in Guy's Hospital on the invitation of my late friend, Dr. Hilton Fagge. She was the subject of xanthelasma with jaundice. This woman, a cook, assured me that on one occasion, after her day's work and when dressing for the evening, she had become quite blind. She said that she was in absolute darkness and had to grope her way downstairs by the aid of her hands. When she had got into the kitchen her sight began to return, and after a short time was as good as ever. A severe headache followed. This was one of the most marked and complete cases that I have seen, for the woman's description was very clear. She was not jaundiced at the time, but became so afterwards. I believe that she had had many minor attacks of failure of sight.

At page 75 of ARCHIVES, Vol. III., is a detailed description by the patient herself of very peculiar attacks of defective

sight to which she was liable. In addition to dimness, she had what she described as "kaleidoscopic lights in the eyes." On one occasion she had been much alarmed by the occurrence of total blindness in the left eye, but it lasted only a few minutes. She was the subject of chronic retino-choroidal disease, and had probably suffered from syphilis. She could, however, still manage to read the smallest type.

At page 377 of Vol. VIII. I have mentioned the case of a lady of 30, in whom in connection apparently with liver disturbance, prolonged attacks of dimness of vision were liable to occur. She did not become by any means blind, and probably suspension of the power of accommodation was the main element in her state. There was, however, something much more than what hypermetropics are liable to, for the attacks were sudden, and would last several hours, to be followed by headache.

In my experience the cases of "Retinal Epilepsy" group themselves into two classes. (1) Those which occur in association with definite liver disturbance, and which may happen to persons whose eyes are apparently quite healthy; and (2) those which occur to patients with eyes damaged by previous retino-choroiditis. Of the latter I have just mentioned an example, and shall have to record several others. Most of those which I have seen have been in the subjects of inherited syphilis who had suffered many years before from keratitis and retinitis, and in whom the disc was pale and the central vessels small. It may be plausibly suspected that in these patients ischæmia of the retina is the cause of the loss of function, for the attacks occur to those in whom the structure is very poorly supplied with blood. At one time I was disposed to regard this as a sufficient explanation, but some recent facts have raised the suspicion that the attacks do really partake somewhat of the characters of the petit mal. They occur to patients in whom degenerative changes in other parts of the nervous system are in progress, and who sometimes are liable to other phenomena more or

less allied to those of epilepsy.* I freely grant that I have never yet observed a case in which they occurred in association with ordinary epilepsy. It is not for me to attempt any definition of the term epilepsy, or to say how widely it may be used. Some idea of reflex causation of sudden liberation of nerve force and of temporary suspension of function is, I suppose, essential. It was, I suspect, the belief that the failures of sight referred to were due simply to bloodlessness of the retina, and were unattended by either reflex causation or introductory ischæmia, which led Dr. Hughlings Jackson to abandon his name. Nor is there any doubt that the name had been applied by others to cases of this kind which had probably nothing in common with epilepsy.

Importance of differential diagnosis between the Retinal Ischæmia of Optic Neuritis and true "Retinal Epilepsy."

Cases of "Retinal Epilepsy" must be kept in a wholly separate group from those of the temporary blindness to which those who are suffering from optic neuritis are liable. In

* "No doubt some of the many nervous disorders that result from uræmic poisoning are due to the noxious influence of the morbidly altered blood upon the nervous tissue, while others are more probably explained by sudden partial interruption of the blood-supply to certain parts of the nervous system. This statement may be illustrated by a reference to the two forms of impaired vision which are very frequently associated with advanced renal degeneration. In one class of cases dimness of sight comes on more or less gradually, affecting one or both eyes, and is permanent. This form of impaired vision is found to be associated with peculiar structural changes in the retina, results of the so-called *albuminuric retinitis*. In the other class of cases the impairment of vision may be so sudden in its onset that, in a few minutes or even seconds, there is complete blindness, which usually passes away as suddenly as it came. These attacks of sudden and transient blindness may recur again and again. That they are closely allied to epileptiform attacks is shown by the fact that they are sometimes immediately followed by general convulsions. The most probable explanation of this sudden transient form of amaurosis is that which attributes it to sudden anæmia of the retina, or of the central origin of the optic nerves, the result of arterial contraction, excited by the morbid quality of the blood. It is, in fact, a form of circumscribed partial epilepsy, 'epilepsy of the retina' as it is sometimes designated."—The Lumleian Lectures on "The Muscular Arterioles: their structure and function in health and in certain morbid states." Delivered at the Royal College of Physicians of London by George Johnson, M.D., F.R.S. (*British Medical Journal*, May 12, 1877, p. 577.)

these latter we have no difficulty in believing that interrupted supply of blood is the cause of the loss of sight; and considering the state of the disc as to swelling, &c., the only wonder is that sufficient blood finds its way on to allow of any sight at all. We are here again indebted to Dr. Jackson for the original observation—now universally accepted—that the swollen disc of neuritis is often compatible with good sight. That such conditions involve, however, great liability to its suspension cannot be doubted. Many neuritis patients are blind, and in many who are not so when the head is at rest and in a position favourable to circulation, sight may be lost by stooping or even by suddenly assuming the erect position. The heart is at a great disadvantage and may easily find it impossible to fill the retinal vessels. This is simply a question of hydraulics, whereas in "retinal epilepsy" the hypothesis is that no mechanical causes for the attack are present. In the neuritis cases both eyes are, I believe, always affected (that is provided both are involved), whereas in the epileptic form it is often only one.

A good example of this form of temporary blindness with optic neuritis is recorded in Vol. IV. of ARCHIVES, page 184. In it the patient, a lady whose urine was loaded with albumen, was liable to find her sight leave her if she stood up suddenly or if she stooped. The ophthalmoscope showed swollen discs, but none of the more usual changes of albuminuria. Her attacks of blindness, during which she might be for some seconds in total darkness, were never followed by headache or other symptoms. My comment at the time was, "No doubt the temporary failures of sight are due to the inability of a weak heart to overcome the local impediments to arterial circulation caused by the neuritis."

I will now narrate the histories of some patients recently under observation, and which have led me to write the above remarks.

"Retinal Epilepsy" in a patient whose eyes had suffered severely from Syphilitic Keratitis, &c.—Unusual duration of the attacks—History of other nervous phenomena.

Miss M—— is a lady whom I have known for many years, and who has suffered with very unusual severity from inherited syphilis. Her physiognomy is deformed by the sinking and widening of her nose, and her general growth has been arrested. Her skin is opaque, pale, and earthy. I should much doubt whether the sexual system is well developed. She has had most severe inflammation of her eyes; not keratitis only, but involving the whole organ. Her left eye is lost, and diverges, there being secondary cataract and vitreous opacities as well as choroido-retinal atrophic changes. Her right eye has up to the present time enabled her to read fairly well at times, but in it also there are vitreous opacities and a greyish ill-defined optic disc, with very small retinal arteries. The tension of the globe is perhaps below normal.

The symptom which brought Miss M—— to me in September of the present year was the very alarming occurrence of periods during which she could not discern even the largest objects. These had occurred ten or twelve times during the last year, and were new to her. On more than one occasion the attack had lasted a whole day. During them she was not, she said, in darkness; on the contrary, there was often too much light, "as if a number of lamps were lighted all around me and were dazzling me." Sometimes, however, she was almost in the dark. The attacks had usually been brought on by exposure to strong light, or by fatigue or worry. The eyeball was, she believed, usually a little red during the attack, and felt tender. She is very much afraid of ophthalmoscopic examination, believing that it would bring on an attack. As the attack passes off, which it usually does gradually after lasting a few hours, she is again able to read. She never, however, reads more than a quarter of an hour at a time, as it tires her eyes. Severe neuralgia in the forehead has often attended and followed the attacks.

In looking back to my former notes of Miss M——'s case. I found the following, written, I believe (for it has no date), three or four years ago.

"She describes an attack during which she was quite conscious, but could not move her limbs; she thought she was paralysed, and was much alarmed. She spoke to her friends, was rubbed for some time, and recovered. Her hands were, she says, cramped. She now seems quite well again, but has much headache, and is easily tired. She describes a distressing sensation in her tongue and abdomen. It begins in the tongue and passes downwards, as 'if it were on fire.' She has had violent sickness more than once. Her pupil acts, and there is fair knee-jump; no tabetic pains. Gnawing sensation in the bottom of stomach, and slowness in micturition."

The following are some additional particulars as to her symptoms and present state.

Miss M—— says that she feels a sort of throbbing in her eyes for a day or two before her attacks. Then neuralgia attacks her forehead—not hemicrania, but across her forehead. After this she loses her sight. She considers herself perfectly well except for her eyes. Can see $\frac{20}{100}$. She feels the cold very much, and has had chilblains.

What she terms "loss of sight" involves being in a deep fog so that she could not count fingers. If it is lamplight she is in a yellow fog. More than two years ago she found in her drawing that she could not see so well as formerly. The eye had failed rather rapidly. She went into the German Hospital in 1896, under Dr. J——, and had two months' mercurial treatment without result.

She is now 36, and her attack of keratitis was at the age of 18. When she had recovered from it she could see to do anything with R. until two years ago; read, paint, draw, and sew. The eye then failed rather suddenly. Her left eye oscillates. There is much thinning in the ciliary region in the left eyeball and elongation of globe from this region, the anterior chamber being very deep. She has no perception of light with this eye. She had an operation for her cataract at 21 (Mr. B——). She describes

three needle operations, and says that it was done for appearance sake only.

On October 14, 1897, I examined Miss M——'s left eye with the ophthalmoscope. The pupil had dilated well. There were numerous small films in the vitreous, and a single small opacity at posterior pole of lens. It was not, however, difficult to see the fundus. The choroid was everywhere thin and pale, and showed a few small well-margined spots of absorption near the macula. Near the periphery, on the outer side, was a very irregular area covered with coal-black pigment. The disc itself was pale and waxy-looking. Its margins were indistinct, appearing to merge gradually into the surrounding parts. The central vessels were very small and indistinct, the artery being reduced to a mere thread.

Nervous phenomena in a subject of Inherited Syphilis.

The following description of a nervous attack was received from a young man who was the subject of inherited syphilis, and in whom extensive choroidal and retinal changes were present. He had consulted me respecting his eyes, and mentioned that he had had two of what he called "seizures," attended by failure of sight. I did not feel sure that there were any aggressive or degenerative changes going on in his eyes. One eye had been for years quite disabled.

In both eyes keratitis had occurred some years ago, and in both the periphery of the fundus showed many small patches of denudation with pigmented borders. Nearer to the centre, however, there were many whitish, ill-defined patches which might represent recent deposits. He did not think that his sight was worse than it had been for two years past. He had been treated before I saw him on the diagnosis of acquired syphilis, but he assured me that he had had intercourse only three times in his life, and had never had any local disease. I found no indication of acquired disease, and those of inherited were indisputable. The day after the consultation he wrote me as follows: "I left your house yesterday and came here. I in-

tended to make my preparations for going home this morning, but was taken very strange through the night, sickness and trembling in every part of my body, which lasted a good part of night; and to-day I am like one stupefied, and have not proper control of my legs, and cold shivers passing through my limbs and body. This is the third attack I have had like this. It appears like a form of paralysis; it starts from the forehead and around the heart, and like as if I am passing out of the world."

Although the attacks described occurred to a man in whom syphilitic degenerative processes were present, yet we must not hastily assume that such were really the cause of them. The patient was a young man at an age at which the sexual system often exercises a great disturbing influence on the health. He himself suspected this connection, alleging that he was liable to frequent escape of semen. It may have been the fact that the syphilis had damaged his nervous centres, and rendered him liable to suffer more than usual from sexual causes.

The same suggestion, although the patient was of the opposite sex, holds good as to the case of Miss M——, although I confess with less of plausibility. Both patients may, however, have been under the influence of masturbation or other causes of sexual irritability. It has been seen that the character of the attack, as described in the patient's own words, was very similar in the two.

Hereditary Syphilis—History of severe Keratitis at the age of fourteen—Liability to attacks of "Retinal Epilepsy" at the age of twenty.

Ellen D——, æt. 20. I had attended one of her brothers who suffered severely from inherited syphilis. She had been under Mr. Critchett's care six years ago for "a dulness over the eyes"; the "dulness" being visible to her mother. The affection lasted, more or less, for probably two or three years, and was, no doubt, an attack of syphilitic keratitis. She now sees J. 1 with each eye easily. Ophthalmoscopic examination (after atropine) shows nothing abnormal. For about two years she has been liable to

curious nervous attacks, during which she becomes quite blind for about ten minutes. Generally the blindness is the only symptom, but sometimes (two or three times) she has been giddy, faint, and felt "numb and cold, and trembling," but she never actually fell, or became unconscious. She would fall unless she rested against things.

I regret that my notes of this important case were taken hurriedly, and in only a fragmentary manner. It will be observed that temporary attacks of blindness occurred in eyes which enjoyed almost perfect vision and showed no changes.

Secondary changes in the Eye after Keratitis—Liability to attacks of Epileptic Hemiopia.

The following note concerns a lady, now aged thirty-three, whom I had attended at the age of seventeen for exceedingly severe interstitial keratitis.

"She complains of being liable to attacks of dimness before the left eye. They last a few minutes or half an hour. If both eyes are open she has an uncomfortable feeling before her right, and then on shutting the right finds that she cannot see with the other. She describes an imperfect hemiopia. She does not see distinctly on her left side. The disc of L. is decidedly pale, and its vessels small. It is seen through a certain amount of haze from opacities on the lens. The other disc is seen brightly, and is of good tint."

Pains in Bones, &c.—Doubtful diagnosis of Congenital Syphilis—History of attacks of sudden and quite temporary Deafness—Auditory Nerve Epilepsy.

Miss S——, aged 26, came to me in May, 1887, on account of pain in the right arm of over two years' duration, and for which she had seen several medical men. There were no physiognomal signs of syphilis. Her mother said that she had been a delicate baby and had bad snuffles. At the age of one year an abscess had formed in the thigh. At the age of two, a swelling developed below the knee and the foot

dragged. She had been treated also for thickening of the bones of the legs. Two years before I saw her she had had a bad illness, with pain in the head. I dilated the pupils with atropine, but found no choroiditis. Her mother said that although she complained much of the pain she was quite able to throw it aside. Her younger sister had had inflammation of the eyes when a year old. There had been several miscarriages between the two. This sister had also suffered from neuralgia and a peculiar form of deafness. It would come on very suddenly, and at times she would become "stone-deaf" during a drive, and then the hearing would return suddenly. One ear was worse than the other. The father was gouty.

Comments.—Although in this case the diagnosis is not fully established, I yet think it highly probable that both the patients were really syphilitic. I am induced to record it on account of the parallel which the attacks of temporary deafness afford to those of so-called "epilepsy of the retina."

ON INFECTIVE DISEASES OF THE LYMPHATIC GLANDS.

(*Continued from Vol. VIII., p. 294.*)

The starting-point for almost all forms of gland disease is probably to be found on the surface either of skin or mucous membranes. Scarcely ever is the gland affection really primary. Yet in a large majority of the infective forms no primary source of irritation is to be found. This is true even of the more malignant forms. Two explanations may probably be offered of this fact. First, that in almost all the primary sources of irritation the condition is one only of non-specific inflammatory action, which may pass away and leave no trace, and next that it is not infrequent for the glands to have received their infection at a long period prior to the manifestation of disease in them. Both these hypotheses are fully supported by facts. It is very common to be told of a transitory sore throat as having preceded gland disease which proves persistent and infective. It is also very common to learn that a gland has been in a quiet state of enlargement many years before any aggressive development. Some change in the mode of growth—as inexplicable as that which occurs when leucoma on the tongue passes into epithelial cancer—takes place, and at once that which was hitherto purely local and quite quiescent becomes infective and generates a plasma which will produce its like in all structures of a similar character to its own. If the infection has started from the mouth, nose, or throat, and the cervical glands have been first affected, it will spread downwards on the neck, thence to thorax, taking the axilla in its way; from the thorax, through the abdomen in the

chain of glands clinging to the great vessels, and so from the pelvis out under Poupart's ligament to the glands in the groin. The whole affair is one of infection in continuity of structures; and if the source of irritation have been on one of the lower limbs or in the pelvis, the infection will travel in the opposite direction, and the neck be the last to suffer. According to the pre-existing proclivities of the individual will be the precise histological character of the growth. If the tuberculous tendency be strong, crude tubercle may result and suppuration may follow, with the beneficial sequel of arrest of the infectious process. If, on the other hand, the scrofulous proclivity be but moderate, we may then have the chronic inflammatory hypertrophy, without obvious tubercular deposits and without the tendency to suppuration, which characterises Hodgkin's disease or lymph-adenoma. Although tubercle may not be demonstrable, no clinicist can doubt that lymph-adenoma is essentially scrofulous. If the patient's inherited proclivities be towards cancer rather than tubercle, he may then become the subject of one of several modifications of lympho-sarcoma. In some cases an enormous local growth may develope with tendency to inflame and suppurate, and there may be little evidence of spreading to more distant parts. In others, the original gland mass may remain but slightly developed and quite free from irritation, whilst other growths are being produced in distant glands or even in cellular tissue and skin. The ability to leave the glandular system and to grow in the subcutaneous cellular tissue, or even in the skin itself, which is witnessed in these cases and constitutes their characteristic feature, although very rare in lymph-adenoma, is not wholly unknown in it. I have in more than one instance seen growths in regions where no glands exist. Probably in all these cases the infection takes place in lymph channels instead of in glands, and thus their peculiarity is not so great as at first it appears.

The case with which I concluded the last part of my Report was one in which inflamed toe-nails caused enlargement of the glands in Scarpa's triangle, which was quickly followed by infection of the pelvic glands and by a very malignant form

of lymph-adenoma. The patient, previously a strong, healthy man, was dead within twelve months of the first injuring of his toe-nails. The case is of great value as giving support to one of the chief propositions with which I set out, namely, that as regards their initial stages no distinction is to be drawn between inflammatory and malignant affections; or, in other words, that the cancerous process is only a modification of that of inflammation. The case which I have now to adduce is perhaps a yet stronger fact in the same phalanx. In connection with a diseased tooth, a gland became enlarged; it remained quiet but swollen for ten years, and then began to grow. A rapid sequence of lymph-adenoma and secondary sarcoma of the skin was the result.

CASE XXVII.—*Enlarged Gland in the Neck secondary to inflammation in the mouth—Quiet condition for ten years — Sudden development of infective qualities — History of Cancer in family.*

In the following remarkable case we have an inflammatory process appearing to be the exciting cause of a malignant one, as in the case already recorded at page 293, Vol. VIII.

The history was as follows. Ten years ago, in connection with a decayed and painful tooth, a gland enlarged under the angle of the jaw on the right side of neck. It gave no trouble for seven or eight years, when it began to increase in size and to be more or less tender. From this other glands in the same side of neck enlarged, and then some on the other side and in both armpits.

His mother's sister had died with cancer in liver, æt. 66. Before her death she was covered with secondary growths in skin. No history of tuberculosis in family.

When Mr. H—— was brought to me (by Dr. Douglas, of Newbury), he presented some very peculiar conditions. The mass of glands in the right side of his neck was of considerable size, and extended from the angle of the jaw to the clavicle. There was a considerable fulness under the clavicle, evidently due to glands concealed by the great pectoral muscle, and from these a chain passed down into the armpit.

On the opposite side the conditions were similar, but the gland masses were not so large. On both there were some enlarged veins coursing over the clavicular regions. The affected glands were for the most part of almost stony hardness, and they adhered to each other and to the surrounding tissues, but there was no tendency to inflame or suppurate. Over the larger glands were a few very small, hard, movable lumps, not bigger than currants. The most curious feature was, however, the condition of the skin. It did not adhere to the glands, but presented a considerable area of isolated little patches of infiltration. These were quite movable with the skin—indeed, almost superficial in it—and they were attended by a slight blush of congestion. They were exactly like what we often see when the skin is affected at a little distance from a scirrhus of the breast. One of these patches, flattened and thin, occurred just over the upper part of the sternum. It would not have been noticed by the eye, but was distinctly perceptible to the finger. I had no doubt that these skin patches were due to secondary infection from the glands. They showed a tendency, though as yet on a small scale, to the production of the *en cuirasse* condition.

Nothing definite could be proved as to the presence of gland disease in the chest. The patient had a certain amount of difficulty of breathing in exertion, and the breath sounds were very feeble on the right side. Judging from the conditions elsewhere, it was exceedingly probable that the mediastinal glands were involved. There was as yet no affection of the inguinal glands.

It will be observed that the secondary infiltration of the skin occurred only in proximity to the affected glands. There was no tendency to generalised production of skin cancer.

The important fact that one of the patient's aunts had died with her skin covered with nodules of cancer might very nearly have escaped record. The patient himself did not know of it, and, as is not unusual, strongly denied that any relative of his had ever suffered from cancer; his surgeon, however, was better acquainted with the family history.

CASE XXVIII.—*Very large Lymph-adenomatous Tumours rapidly developed in an elderly man—No hereditary history.*

Amongst the patients who attended my Demonstration on November 24, 1896, was a man aged 66, who had been sent by Dr. Stocker, of Forest Gate, with large glandular masses in his neck. On the right side there were two chief masses,

each made up of distinct glands which had adhered together. The lower mass completely concealed the clavicle. The skin over them did not adhere, but it was somewhat reddened. The congestion of the skin, attended by slight thickening, extended in a large and definitely bounded area upon the chest and over the upper parts of sternum. There were enlarged glands in the right axilla and also in the left side of the neck. In both positions they were non-adherent. The

patient, a very intelligent man, was very weak and ill, but had no enlargement of the spleen and no indications of leucocythemia. He said that he knew of no history of either tubercle or cancer in his relatives. He thought that he had first observed the enlarged glands on the right side about a year ago, and those on the left soon afterwards. They were increasing rapidly, and with some pain. I could see no indications of primary disease in the mouth, nose, or throat. He had formerly suffered from nose-bleeding, and had had an attack of hemiplegia. The accompanying wood-cut illustrates this case.

The large size and rapid growth of the gland tumours in this case induced a strong suspicion that they must be of a malignant nature, and secondary to some central growth in the nasal passages or sphenoid cells. There was, however, no evidence of the existence of such, and the fact that the axillary glands were also implicated showed that the malady was conforming to the type of acute lymph-adenoma. I wish to ask special attention to the congestion and slight infiltration of the adjacent skin, which was exactly like what is so often seen in cancer of the breast, and is introductory to what is known as scirrhus *en cuirasse*. The same condition, but in a yet more definite stage, was present in the preceding case.

CASE XXIX.—*Lymph-adenoma Tumour in the Neck—Excision—Subsequent development of sarcomatous growths in the subcutaneous cellular tissue of various parts.*

I have recorded at page 208, Vol. VIII., the case of a medical man past middle age in whom, secondary to a gland tumour in the neck, a great number of growths were produced in the subcutaneous cellular tissue. Death occurred about three years after the beginning of the illness.

There is at present in the Cleveland Street Sick Asylum a man whose case is almost an exact counterpart of his. Through the courtesy of Mr. Hopkins, the medical superintendent, I have several times presented this patient to my clinical class. He is about fifty years of age. His first ailment was a gland mass in the right side of his neck.

This attained a considerable size, and presented, as he describes, a congeries of firm but loose glands when it was excised at Charing Cross Hospital. His neck shows a very long scar left by the operation, which must have been an extensive one. This was now three years ago. My friend Dr. Abercrombie, physician to Charing Cross, has kindly taken much trouble in the endeavour to find for me the description of the tumour and its microscopic examination, but without success. The wound healed well, and there has been no extensive recurrence in the neck. All that is now present are a few loose glands as big as grapes under the scar. They show no tendency to grow. There are a few small, hard glands in the other side of the neck, and some in other positions, but none of large size. In the subcutaneous cellular tissues, however, all over the trunk, hard, isolated growths have occurred, and there are some also in the abdomen. Very slowly the man's strength has failed, and he is now confined to his bed. When I last saw him, in the early part of December, he had drooping of one eyelid, an indication not improbably of some growth implicating the third nerve. There can be little doubt that he is the subject of generalised sarcoma, but it began in glands.

(To be concluded.)

ON CERTAIN FORMS OF PSORIASIS-ECZEMA CHIEFLY AFFECTING THE HANDS AND FEET.

Severe crippling of the Hands from Psoriasis-Eczema—An acute attack of General Dermatitis—Partial recovery—Death from Cancer of Œsophagus after having taken much Arsenic.

I saw at Barnet, with my friend Dr. Thyne, an old gentleman named C——, who had been for many years a sufferer from an almost universal form of dermatitis. He was 70 years of age, and had quite recently become the subject of a stricture of the œsophagus which was probably malignant. I was told that I had myself seen him for his skin disease many years ago, and that it had then been called "psoriasis." It was believed that he had in former years taken a good deal of arsenic. He said that he had never been quite free from the skin affection since it had first attacked him; but it had varied a good deal at different times. He had been liable to what he described as severe attacks of it, during which his hands had become especially severely affected. Dr. Thyne told me that during one of these attacks, about two years ago, the whole surface had been affected, and that he had been at a loss whether to call it "diffuse eczema" or "pityriasis rubra." The term eczema seemed justified by the fact that there was moist discharge which stiffened his bed-linen. When the more severe attacks subsided there was always very profuse desquamation, so that his bed every morning would be full of scales. During the attack to which Dr. Thyne referred, Mr. C—— had been so ill that it was feared he would die. I found Mr. C——, at the time of my visit, confined to his bed by debility and much emaciated. He had retired from business fifteen

years before on account of the state of his skin and especially of the disablement of his hands. During the greater part of that time he had been unable to use his hands for any purpose. They had been constantly affected by a diffuse exfoliating dermatitis, under which the fingers had wasted and become much distorted. The digits were as thin as they could possibly be—mere skin and bone, and the skin atrophied and covered with dry flakes of peeling epidermis. The digits were bent backwards at the metacarpo-phalangeal joints, and forwards at all the others, giving them a claw-like appearance. The nails were somewhat thickened and rugged, but there was no large accumulation of epidermis under them.

Mr. C——'s face, at the time I saw him, was scarcely affected, and he was florid and of a thin transparent skin. He retained his hair, which was white. So far as anything was shown in his countenance he might have been supposed to be a healthy old man. He told me, however, that his face had often suffered with the rest of his skin, and I found a good deal of scaly accumulation over the whole of his scalp at the roots of his hair. He had a clean, red, and somewhat glazy tongue. Over the whole of his body and lower extremities the skin was atrophied, very dry, and covered with peeling flakes, a condition suggestive of diffuse psoriasis. My visit to Mr. C—— at his own house was on March 2, 1893. On returning home I was fortunate enough to be able to find my original notes of his case, Sept. 23, 1876. I had then diagnosed his disease as "a peculiar form of psoriasis," and had written against my notes "an important case." The following is almost a verbatim transcript of my notes :—

"Mr. C——, aged 53, was sent to me by Mr. Crowfoot of Beccles. He has recently been for some time under Mr. Naylor's treatment, and has just returned from a long stay at Harrogate without any benefit. He is in excellent health, and tells me that he never needed a surgeon until the last two years. In boyhood he had no skin disease whatever, and his present affection began only two years ago. It commenced in the palms of his hands. He has taken much

arsenic, and it has not disagreed in any way. He is covered with scaly, peeling inflamed patches, which are located with accurate symmetry. Both his hands are very severely affected. The patches on them are abruptly margined. There is considerable contraction in the skin of the palms. The eruption occurs both on his elbows and legs; but there are no spots on the fronts of his knees. On the legs the patches are large, ill-margined, all of them eczematous, but never actually moist. His trunk, with the exception of the buttocks, is exempt. His nails are severely affected, being rough and thickened. Their disease appears to begin at the lunula and not, as in true psoriasis, at their free edges; indeed, some of the nails have fallen and grown again. On his hands cracks are liable to occur."

Although Mr. C—— believed that he had been taking arsenic under Mr. Nailor for two years, I could yet see nothing more hopeful for him than to prescribe it in a fresh combination. I accordingly ordered Pearson's Solution in m. xii doses. A month later I saw him again. He was then worse, his fingers more contracted and talon-like, red, tender, tense, and covered with scales. His hands were quite useless, and he was in a most distressing condition; * the backs of his fingers solid, but not the backs of the hands. He told me that in boyhood he had a dry skin, but that of late he had perspired profusely. He believed that his mother, an old woman of 80, had two or three dry patches on her skin; and one of his sons had once had a few patches. The condition of his feet was similar to that of his hands, but they were much less severely affected.

It will be seen that this case belongs to the group in which eczema-psoriasis begins on the hands, and continues throughout to affect them with excessive severity. Of this I have not seen many examples; but a few very definite ones. Miss C——'s case is probably one of the same group, and another is Mrs. ——, who was temporarily cured by opium (see Clinical Society Transactions and Atlas Plate XXII.). I have also preserved a portrait in the collection of the College

* I have written against my description of his hands, "I have never seen hands so bad."

of Surgeons, which shows a very severe and disabling form of psoriasis of the hands. Most of these cases were liable to very severe exacerbations, and in several attacks of universal dermatitis occurred much resembling pityriasis rubra. These attacks equally merit the name of "diffuse eczema." They differ in no respect from those seen in the workhouse epidemics. It does not seem very probable that the contraction and crippling of the hands was in any way due to arsenic, but this is a possibility which must at any rate be kept in mind. Not long after my visit the patient died, his death being caused by the malignant stricture of his œsophagus. We have here another instance of cancer in a patient who had taken much arsenic.

Congenital Ichthyosis limited to the Palms and Soles occurring in many members of the same family in several generations.

On Oct. 31, 1877, Mr. Tay showed me at the hospital an exceedingly interesting series of cases of hereditary ichthyosis of the hands and feet. The mother, a woman of near 40 and in excellent health, was herself the subject of it, and she brought her infant and two boys, all of whom had exactly the same conditions. In all of them the whole palm and the palmar aspects of all the fingers were affected. The condition was uniform, not in patches, and the epidermis was accumulated in thick, rough layers of a yellowish colour, which were crossed by the natural creases, the latter being much deepened. The parts were not sore, and there were no fissures, but the thickness of the crusts interfered with pliancy of the hands, and the mother said that in herself it quite prevented doing needlework. The condition ceased abruptly where the palm joins in the wrists. The backs of the hands were free, but on the fingers over the last two phalanges and about the nail roots there were thin scales. The hands of all four patients were exactly alike, and we were told that the feet were so also. In all it had been present at birth, and no alteration had been observed subsequently. In none was there any skin disease of other parts,

and in none was there the slightest tendency to general ichthyosis.

The condition was known to have occurred in four previous generations, and in several families three or four individuals had been affected.

In the facts as regards inheritance and in the circumstance that it affected several members of a family and was present at birth, this malady fits with what we know of ichthyosis and differs from what is usual in psoriasis. There can be little doubt that its real affinities are with ichthyosis. Yet the entire exemption of all the rest of the skin is remarkable. There was no evidence that ichthyosis had ever occurred in relatives.

Case of Psoriasis (Qy. Ichthyosis) limited to the Palms and Soles in a boy.

I brought before my class at the London Hospital, at the same time that this group of cases attended, a boy who was then in the hospital on account of another disease, but whose palms and soles were in almost the same condition. He was about nine years old, and asserted that the condition had been developed only recently. This was perhaps doubtful. In him the condition was limited to the palms and soles, with the exception that the tip of each elbow showed an ill-defined scaly patch. These patches on the elbows were not exactly like those of psoriasis, because there was no thickening and no abrupt borders, only a slight desquamation. Still, their position was probably sufficient to denote an alliance with psoriasis.

In some minor features the conditions differed from those present in the cases just described. Thus on the backs of the hands and fingers there were separate scaly patches over all the knuckles and over all the phalangeal joints. The skin over the phalangeal bones and that over the backs of the hands was quite free. These patches were like those on the elbows, without thickening or congestion, being simply scaly. In the palms there was much less of epidermic accumulation than in the other cases, but just as in them the entire palmar aspect from finger-tips to beginning of wrist

was uniformly involved, and there was no tendency to cracks or fissures. He was in fair health, and there was no history of importance.

A reason for calling this psoriasis rather than ichthyosis is that it was (as is asserted) not present at birth. Another is the existence of the elbow patches. Yet the close similarity in the conditions to those present in the congenital cases is most remarkable.

Case of severe dry Eczema of Palms and Soles only after general Eczema in childhood—Influence of local causes.

A robust sailor, aged 24, who came to the Skin Hospital in October, 1875, presented an example of severe dry eczema of the palms and soles. The entire palms and the palmar aspect of all the fingers were dry, hard, red, and fissured. In front of some of the finger joints the skin was raised and so hardened as to prevent complete extension of the fingers. There was no tendency to the formation of patches, and the peeling was in irregular flakes. On the soles the same conditions were present, but much less severely. The dorsal surfaces were not affected, nor did the nails suffer.

The question arose as to whether the condition should be regarded as a dry eczema or as xerodermia. The man said that in boyhood his skin had been dry and rough all over, but this state had now wholly passed away, and his skin was quite supple in all parts excepting the palms and soles.

In favour of its alliance with eczema were the facts that he had been told by his mother that in infancy his head was broken out very badly for a long time and that he had scabs over him, and that he is still at times liable to an eruption on his cheeks which is "watery."

He suffers very much from his hands when at sea, in consequence of large, deep cracks forming. This is especially the case when exposed to wet and cold. His feet also become worse if he goes about in the wet without his shoes and stockings.

It seems, therefore, clear that the eruption is an eczema which has become localised by local irritation. Probably the effect of the sea air has been good as regards his skin gener-

ally and has helped to cure the diffuse eczema, but the wet and cold handling of ropes, &c., has kept his palms bad.

He stated spontaneously that whenever he was using fresh tar his hands got better. No other application did any good. He was almost driven to abandon his occupation.

Dermatitis of the Hands and Feet—Cure.

Mrs. S——, aged 54, was sent to me by Dr. Martin, of Huddersfield. She was in good health, but of a very dark bilious complexion, the xanthelasma positions and the parts beneath the lower eyelids being extremely dark. In early life she had suffered from sick headaches, but not much since her marriage. She had twelve living children, and her menstruation had ceased comfortably some years ago. Above the left inner canthus in the xanthelasma position were some little spots and cysts which no doubt showed a tendency to that disease.

Mrs. S—— consulted me on account of very severe chronic inflammation of her palms and soles. This had troubled her for eighteen months, having commenced between the toes and next in the palms of her hands. The disease had progressed to such an extent as to almost disable the hands, and to render walking very painful. The influence of walking in aggravating the disease was well shown in the soles of the feet. She had a high arch, and the part immediately beneath it was consequently quite exempt, and here the skin was quite natural. There were painful cracks both in the palms and soles. Her nails were not affected, nor was there any eruption on her face or head. There were, however, a few peeling patches on the backs of the hand, and on the legs and forearms there were ill-marked groups of irregular spots quite dry and much scratched. During the last week or two there had been much tendency to dry eczema in the axilla. She had been liable to cramp in her calves before the eruption appeared. She had not used her hands for any particular purpose or in any manner which would explain the location of the disease on them.

Mrs. S——'s case is interesting as an example of chronic dermatitis beginning symmetrically on the four extremities

without any obvious predisposition, and without exposure to any local cause. It shows also the tendency to gradual implication, possibly by infection, of other parts of the skin. It is similar to some cases which have been claimed as having alliance with pityriasis rubra, and showing a tendency to terminate in that malady. It is not wholly unlike the remarkable case which I published in the Clinical Society's Transactions, in which a remarkable recovery took place under the use of opium internally, after all other measures had failed. In connection with this latter point I am glad to be able to record the interesting results of treatment, although at the same time I must admit that my measures were too complicated to admit of any safe inference as to the degree of credit to be assigned to any one of the drugs used. In the case of Mrs. F—— just alluded to it was different, for in her almost all local and constitutional remedies had been tried before the opium was used.

Treatment.—On March 25, 1890, I ordered for Mrs. S—— a mixture containing min. v. of Pearson's solution of arsenic, min. iii. of liq. opii sedativus, with a little nux vomica and cascara to prevent constipation. She was to use an ointment containing a little chrysophanic acid with ammoniochloride of mercury in lanolin and lard. She returned to her home in Yorkshire, and remained under the care of Dr. Martin, her medical attendant. I did not see her for six months, and during that time she had steadily continued the prescription. She returned to me on October 26, 1890, with her skin quite well, but somewhat out of health generally.

(*To be continued.*)

ON CANCER AND THE CANCEROUS PROCESS.

A Cystic and Hæmorrhagic form of Sarcoma commencing in the vagina and spreading with extreme rapidity in the cellular tissue of the pelvis and abdominal wall—Death within four months from its beginning.

I saw with Dr. Elam, at New Barnet, in January, 1896, a married woman, aged 35, concerning whom I had been told that she had some peculiar and very suspicious growths in the vagina. Just three months before our consultation an operation had been done for the removal of "cysts" or soft growths in the vaginal wall, near to the urethra. On this occasion two quite distinct tumours, described to me as about the size of cherries, had been dissected from the vaginal wall. One of them contained "grumous fluid," but the other was "like blood clot in a loose tissue." Unfortunately no microscopic examination was made, as the portions removed were accidentally thrown away. The parts healed well, but there was soon evidence of return. A florid mass, as big as a cherry, would become prolapsed from the upper wall of the vagina in the erect position, receding when the patient was recumbent. At this time the patient became the subject of a very severe eruption, a sort of bullous urticaria. This confined her to bed, and for some weeks absorbed attention. The general health now failed very rapidly, partly from the irritation of the eruption and partly from repeated hæmorrhages from the growths.

It was under the circumstances described that I was asked to see the case. I found Mrs. C—— in bed, very pale and very thin. She was still covered with the eruption, but it was said to be fading fast. On exposing the vagina the first object attracting attention was a smooth,

pale swelling, the size of a half cherry, just to the left of the meatus and below it. It was soft, and might have been supposed to contain fluid. The mucous membrane over it was quite sound. On passing the finger into the vagina I found two rows of soft, partially pedunculated growths running up from the sides of the urethra, crossing the bladder, and almost reaching the cervix uteri. These were very soft and much lobulated, and together constituted two parallel ridges, each as thick as the thumb. From the lower end of the right ridge it was easy to bring down into view a mass which looked like a livid pile and at least as large as a cherry. The growths did not bleed much on pressure. Although very near to the meatus, they did not actually involve it. The urine, which easily escaped during the examination, was quite clear, and there had never been any difficulty in micturition. There was no enlargement of glands. On examining the abdomen above, I found in front of the bladder and crossing the supra-pubic regions a large, soft, cake-like mass as big as an outspread hand. This mass was distinctly circumscribed at its sides, but not below, as it passed under cover of the pubic bones. It was apparently in or adherent to the parieties of the abdomen, but the skin was quite loose over it. The patient's attention had never been drawn to the presence of this growth. There were no indications of growths elsewhere. We could only advise palliative measures. I did not see the patient again, but Dr. Elam was kind enough subsequently to furnish me with the following particulars:—

After the consultation the growth extended, as it had done before, with most astonishing rapidity. Only a week before the consultation the abdominal wall had been carefully examined and nothing found. On January 5th, date of consultation, it was very obvious and extended a hand's-breadth above the pubes. A week later it was higher than the umbilicus, and at the time of death (January 17) it nearly reached the epigastrium. It apparently extended between the peritoneum and the abdominal wall. The growths in the vagina did not increase perceptibly. The patient suffered much pain and became rapidly exhausted,

and so sank. Unfortunately no post-mortem could be obtained. From the date of the first operation (October 7) to that of death (January 17) was little more than three months, and the growths removed had been recognised by the patient only about six weeks prior to the operation. It should be added that Dr. Elam had excised a mucous cyst from the vulva four years previously, and on two occasions abscesses in the vulva had occurred.

The patient had lost a maternal aunt from cancer. She had been married five years and had borne three children.

I append a description of the original growths and of the operation in Dr. Elam's own words.

"On October 9th, 1895, I removed two growths from vulva; one she had noticed about one month and the other rather longer. There had been profuse hæmorrhage from both. That in the left labium was smooth on its surface except at one point, from which what was apparently a blood clot projected. It was freely movable and painless. This was clearly encysted and was easily dissected out. The other was situated partly in the right labium and partly in the vestibule to right of the urethra. It was not well circumscribed, and was bleeding on its surface. It was partly cystic and partly made up of large venous spaces. It was with difficulty dissected out. The wounds healed in two or three weeks. When the growths recurred, then rapidity of growth was more remarkable than anything."

Keloid recurring in the Scar of an Excision.

I have just seen again the young man whose case, as illustrating the association of keloid with inherited liability to cancer, I have recorded in the *Edinburgh Medical Journal*. His keloid in the first instance developed in his vaccination scars, but subsequently it attacked almost every abrasion that he received, and at present he has on different parts of his limbs more than a dozen separate growths. Many years after their first formation a surgeon excised one of the vaccination keloids, and subsequently did skin grafting to complete the healing. The scar of the excision developed a keloid plate far larger than that which had

preceded it, and in addition the sites of the suture wounds and that of the skin graft (in the shoulder) all formed little buttons of keloid. It was with this experience to warn me that I yet felt obliged to advise the excision of a growth on the shoulder opposite to that of the vaccinated arm. This growth was not smooth and glossy like keloid, but dusky and superficially ulcerated. It had formed from some abrasion so slight that it had never been noticed, and it had become very painful. Its conditions were such that I much feared malignant ulceration, more especially as many of the lad's relatives had died of cancer.

A Case of Arsenical Cancer.

Dr. Bullock, of Notting Hill, brought to me on October 9th a very important example of the evolution of cancer in a man who had taken arsenic for long periods. The cancer had developed, as was supposed, in the site of a patch of psoriasis a little above Poupart's ligament on the right side. When I saw the case it was a sore as large as a child's palm, with rolled everted borders and a red granulating surface. Portions of the edge had been excised and submitted to an expert for microscopic examination, with the result that nothing implying cancerous growth had been discovered. As a consequence of this verdict, the man had been subjected to a long and rather severe treatment on the hypothesis that the disease was syphilitic. No benefit had accrued, and in the meantime the glands in the adjacent groin had enlarged and suppurated. The man denied all history of syphilis, and the naked-eye aspect of his ulcer was characteristically that of cancer.

Mr. F—— thought that it was as much as three years since he first noticed that the patch of psoriasis was ulcerating, but it was only during the last year that it had attracted much attention. Quite recently it had spread rapidly, and the implication of the glands had been rather sudden and attended by much inflammatory swelling. The structures around the enlarged and suppurated glands were glued together and adhered to the abdominal wall. It was impossible to ascertain whether or not the glands within the

brim of the pelvis were implicated. The conditions, taken altogether, appeared to me to forbid any operation.*

Mr. F——, the patient, was a man of 46, very thin, and almost cadaverous looking. He had suffered from psoriasis from boyhood. At the age of 14 he had been taken to Mr. James Startin, subsequently to Sir Erasmus Wilson, and lastly to Mr. Milton. Arsenic had been given by all, and he had repeatedly taken it to definite disagreement. His skin generally had become dry and of a light brownish tint. The palms of his hands had become harsh and dry, but had never developed definite corns.

* This was exactly what had occurred in my first case of arsenical cancer. See Pathological Society Reports, vol. xxxix. p. 352; and I may add that the appearances of the ulceration were in some respects exactly similar in the two cases.

DISEASES OF THE NERVOUS SYSTEM.

(*Continued from Vol. VIII., p. 378.*)

No. XCVIII.—*On subjective Numbness unaccompanied by any demonstrable Anæsthesia.*

This peculiar symptom, one often mentioned by patients, was present in the case of Mr. P——, whom I saw several times in consultation with the late Dr. Ramskill. Mr. P—— had had syphilis twenty-five years ago, and had for about five months been the subject of complete paralysis of the left sixth nerve. Not long after the failure of his external rectus the skin of his chin on the opposite side became numb. From his description, I should judge that the mental branch was first affected. By degrees it spread over the whole right half of face, including the forehead and side of nose. On October 15th, when the symptom had been present two months, I carefully tested by pin-pricking, pulling hairs, &c., and could not prove any loss of sensation. He thought that if there was any difference he felt his moustache pulled on the right side more acutely than on the left. Yet he still insisted that the whole right side of face was "numb." He had no "pins and needles," but "a general perception of stiffness, as if the cheek, &c., were of wood or leather." The pupils showed nothing peculiar; they were sluggish, but still acted, and were of equal size. He had no headache and no other symptoms except the two mentioned, of numbness of the whole right side of face and paralysis of left external rectus. Possibly an exception ought to be made in that he was a little hoarse.

No. XCIX.—*Threatened Paraplegia with pupil symptoms eleven years after Syphilis—Recovery under Mercury.*

The following note is of much interest in reference to the diagnosis of syphilitic affections of the nervous system, and also as to the use of mercury during long periods of time.

A married man, aged 33, was brought to me in April of 1893. Great anxiety was felt as to his spinal cord. His legs had become weak, so that he was unable to walk more than a few yards, and micturition was so feeble and uncertain that he was compelled to use the catheter habitually, though not quite invariably. He had pain in the middle of the back, and there was a girdle of hyperæsthesia around the chest. On one occasion he had had retention of urine. His left leg was more weak than the other. In both the knee-jerk was exaggerated, but especially so in the left. He had suffered from neuralgic pains of great severity in his chest—"fearful pain, as if red-hot needles were being pushed in." There had been no pain in his limbs. His sexual vigour had almost ceased. It was eleven years since his syphilis, and during the whole of that period he had been taking iodide of potassium, although not quite continuously. His pupils were almost motionless, the right very small, the left of normal size.

My advice was that he should avoid the iodide of potassium and take mercury with nux vomica. I did not see him again for four years, but he was meanwhile under the observation of a very careful surgeon.

In November, 1897, he called on me for a second time, and chiefly to report his cure. His only remaining troubles were a certain amount of chronic cystitis and entire loss of the sex-function. I made the following note of his condition.

On April 13, 1893, I ordered a pill containing half a grain of calomel, a fifth of a grain of opium, and a third of extract of nux vomica. These pills he took regularly without intermission for two years, and since then less

regularly. He omitted the opium after a time because it caused constipation.

He has steadily improved. Within six months after beginning the treatment he was able to disuse the catheter, and has never employed it since excepting for washing out. For the latter purpose it is still needed. The urine still smells badly. The pain in the chest also ceased. He now looks robust and well. He can now walk "as well as ever he did in his life." Has been shooting on the moors. His only remaining inconvenience is mucus in his urine, with proneness to decomposition. Salol makes the urine dark and removes all odour, but it is very uncertain in its action. He is still costive. As a rule he is obliged to go to the closet to relieve his bladder, as he cannot make water standing; sometimes, however, he can pass it without effort when standing. He walks well with the eyes shut.

For the two years whilst taking the pills he never had a pain or ache. The pupils are still all but motionless, and the right one twice the size of the left. The right dilates a little when shaded, the left scarcely moves. They do not act in accommodation. He can read easily, and as long as he likes. His sexual function is in abeyance, and he never attempts intercourse.

The fallacies as to therapeutics are many, and they are by no means absent in this case. That the patient has, with certain persisting disabilities, recovered from a very threatening group of symptoms is undoubted. It is also certain that during the period of his improvement he was taking half a grain of calomel three times a day. We must remember that he took also nux vomica and opium, and that he abstained from the idiode of potassium which he had taken far too freely before. It may be that the latter drug had much to do with the loss of sex-function. On the other hand it may be the fact that the result simply proves the superior efficacy of mercury.

No. C.—*Epilepsy after Syphilis—White Atrophy of optic discs—Complete recovery of health, with blindness.*

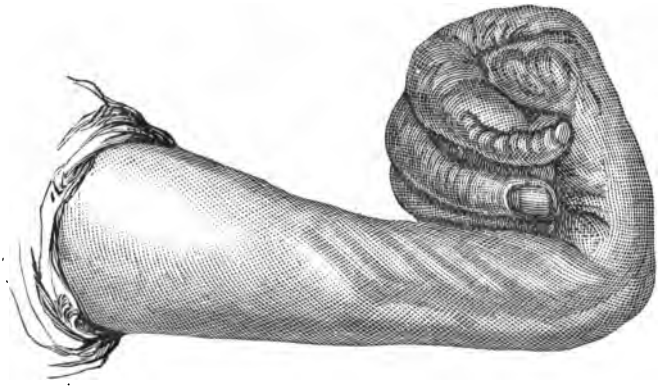
The following fragment, although disgracefully incomplete, may be useful for purposes of prognosis. Mr. B——, aged 42, came to me first in June, 1887. He was blind, and had suffered from epileptic seizures. The discs were in a state of white atrophy. Twenty years previously he had contracted syphilis. I advised him to continue specifics which he was already taking. In May, 1891, I saw him again, and advised that mercury should now be given up. He had been very busy during the intervening three years, and had had much excitement. His health had, however, been very good, except for an attack of sleeplessness. There had been no sign of syphilis for several years. No fits had occurred since 1874, except one or two after long intervals. Previously he had one, two, or three a day for four or five months. Mercury and iodides had effected the cure. There was no knee-jerk. There were no pains in the legs; and although they felt tired he could walk well. The pulse was very soft. The pupils were rather large and fixed, and the eyes diverged. The hearing was good, and there was just perception of light.

No. CI.—*Severe Contusions (two occasions) of one thumb—Amputation of terminal phalanx, and subsequently of the proximal one—Neuralgia and contraction of all the digits into the palm—Amputation through forearm—Cure.*

The following notes refer to the case which the appended woodcut illustrates. I have recently had a report of the patient, and am assured that since the amputation through the forearm, now five years ago, the man has had no return of pain. He has been able to use his stump freely, and has enjoyed good health. The question of exaggeration and of feigning had been freely discussed during the whole course of the case. The patient's sex, and the fact that he was a married

man engaged in business and with every motive for avoiding the rôle of a valetudinarian, seemed to negative such a supposition. In support of it, however, were the entire absence of lesions of nutrition in the skin and the maintenance of muscular health. The man was himself always ready to consent to amputation, but his surgeons were of course very unwilling to remove a hand which, except for the contraction, appeared perfectly sound. Finally, however, this *ultima ratio* was resorted to with complete success.

Mr. S——, aged 25, who had been married three years, was sent to me in February, 1891, by Dr. Thyne, of High Barnet, for an affection of the hand. The condition was the result of two accidents, both nearly five years before. At that time he was acting as third mate on board



ship, and on two occasions, with about one month's interval, he had had his thumb end crushed. It never got well, and the whole hand became painful. In April, 1888, Dr. Thyne amputated the last phalanx. He was subsequently under Dr. Hughlings Jackson at Queen's Square Hospital, from the middle of 1888 to the end of 1889. Whilst there I was invited to see him. The proximal phalanx of his thumb had been removed by Mr. Victor Horsley some months after Dr. Thyne's operation. When Mr. S—— was sent to me in February, 1891, the fingers were bent strongly into the palm, and the wrist was flexed, as firmly as if made of wood. They had been in that position for three years, and any attempt to straighten them caused pain. The tendons of the forearm did not start forward, and the extensors were not atrophied. The nails were grown like claws. There was not the slightest defect of nutrition in the skin. Mr. Horsley had tried, under ether, to straighten the wrist, but did not succeed. I was told that Mr. H. had wished to cut the

posterior roots of the nerves. The patient had a peculiar staring look and nervous manner, and I found that he had been an opium eater before his accident. He was a bad sleeper.

On February 26th he complained of pain in the left side of his head. There appeared to be hyperæsthesia of the skin of the hand and forearm. When it was touched anywhere, however lightly, *e.g.*, by pulling a hair, &c., fibrillation was produced in the small muscles of his thumb. Nutrition of the skin still remained good; and there was no atrophy of the forearm, nor of the small muscles of the hand. The girth of the forearm was nine inches, as compared with ten inches in the other limb. In March of 1892 Dr. Thyne amputated through the forearm. The neuralgia and insomnia which had been so troublesome immediately disappeared, As already stated, the patient has during the last five years remained quite well.

We have had two other cases recently under notice which may suitably be mentioned in connection with the above narrative. In one the facts were very similar. A woman had had all her fingers amputated in succession on account of pain and disability which had followed an injury to one of them. She still retained her thumb, but she could make no use of it on account of pain. It was not contracted, but it was atrophied, and the skin was glossy and shrivelled. I advised amputation through the forearm, and this was done by my son in the London Hospital. It is only six months since the operation, but thus far the stump is quite free from irritability.

In the other case a young woman was sent up from Devonshire with her fingers contracted into her palm, much as shown in the woodcut, but with the difference that the whole hand was much swollen, and covered with excoriations. It had for long been disabled, and she was desirous of amputation. On baring her upper arm I found evidences of constriction, there being a deep furrow. She was subsequently detected, by an unexpected visit in the night, with a cord tied tightly round the arm. After this complete exposure she desisted from her practices, and before she left the hospital she could use the hand well, the œdema having to a large extent disappeared.

DISEASES OF THE SKIN.

(*Continued from Vol. VIII., p. 369.*)

No. XCIV.—*Lupus Sebaceus occurring as a single patch—Its association with family history of Tubercle.*

I have recently had under treatment two examples of the single-patch form of lupus sebaceus. This disease is of course a variant of lupus erythematosus, but with some peculiarities. One of these is that it not unfrequently remains for a long time, possibly through the whole of its duration, a solitary patch.

In the instance of Miss C——, a lady of 40, whose brother had died of phthisis, came to me with a patch on one cheek the size of a shilling. She thought that it had been gradually spreading from a small point which showed itself nine years ago. I applied fuming nitric acid very freely over its whole surface, and a month later repeated the cauterisation to one small spot which did not look healthy. It is now four months since the first application and nothing remains but a smooth, pale scar.

In the case of Mrs. T——, my patient was an old lady of 71. Mrs. T—— came under my treatment for a well-characterised patch of lupus sebaceus in the middle of her forehead. It was as large as a shilling, and had been present six months or more. I destroyed it with fuming nitric acid, and it healed with the florid scar which is not unusual. Mrs. T—— had lost three of her sisters in phthisis, and in early life had herself been considered delicate on the chest. She had, however, regained good health, and had borne fourteen children. She showed no signs of delicacy at the time the lupus began.

No. XCV.—*A somewhat peculiar form of Psoriasis of the Nails in association with Psoriasis patches on the Scalp.*

Mr. T——'s nails are peculiar. In many the sides are becoming discoloured and loose from the nail-bed. At the free borders this has only proceeded to a very slight extent, but under one there is an abruptly margined patch of discoloration as big as a threepenny-bit. It is of a brownish tint, the border being more discoloured than the centre. It is clearly spreading, and is much like the patches on his scalp. This patch does not touch the borders of the nail, and is easily seen through its transparent structure. Some of the other nails show brownish discoloration running in ill-margined streaks. The nails are brittle and split up. On the scalp are large scaly patches, as big as the palm of the hand, of deep-red congestion and with scaly surfaces. They have been present four years. He has only noticed the patches under the nails for a few months. He has been drinking whisky too freely.

No. XCVI.—*A Comedonous and Spinous form of Lichen spreading over the whole trunk and limbs of an adult Woman.*

Mrs. H——, a lady of about 46, consulted me on September 3, 1897, at the suggestion of Dr. Blair, of Kew. I was told that her eruption had begun in April as a patch near right axilla, and that from thence it had spread over the whole trunk and limbs. It had never affected the face, but was plentiful on nape and to some extent on scalp. It was very abundant on back. Mrs. H—— said that she had never before suffered from any eruption, and that her skin was usually smooth and quite free from spots. She was covered, when I saw her, with small lichen papules, many of which were little black comedones, and from some of which distinct little sebaceous spines projected. These latter could be easily picked out, and the plugs of sebum beneath them could be ejected as in those of acne. The

eruption was general and diffuse, not being in the least arranged in patches. I was, however, assured that in the first instance there was a single patch, and that it was from this that the spots had spread. Mrs. H—— was not out of health, and the eruption had caused but little inconvenience.

At my suggestion, Dr. Blair removed some of the little sebaceous plugs and sent them to the Clinical Research Association for examination. The report returned was negative. No parasitic elements could be discovered.

Three weeks after our consultation I heard from Dr. Blair that the eruption was receding, more especially on the chest near to the parts where it had first appeared. A month later the patient was good enough to attend at one of my Demonstrations in order to show her very peculiar eruption. It was then still demonstrable on the shoulders and some other parts, but in the main it had disappeared, and the skin had resumed its healthy condition. No spines could then be shown, but there were still some small comedones. The face had remained quite free. The principal measure of treatment had been the free inunction of a weak ammonio-chloride of mercury ointment.

No. XCVII.—*Pigmented stains on the Abdomen of a middle-aged woman.*

I recorded some years ago the case of a lady, whom I had in the first instance seen with Dr. Buzzard, who had an eruption of brown spots over the trunk which had excited a suspicion of syphilis, but which persisted unchanged for years. She was past middle age, and my diagnosis was, in the end, a form of family freckles. I have just seen another case which may, I think, be very fairly placed in company with it. L— H—— is a remarkably well-preserved woman fifty-eight years of age, but looking like forty. She has lived many years in India, and was, indeed, born there. In early and middle life her skin was healthy and never gave her any trouble. Her complexion is that of a blonde, with brown sandy hair. About three years ago, in her bath, she observed that she had some dark spots "like freckles" in groins, but

beyond a thought that it was an odd place for freckles she gave them no attention. They continued, however, to increase in size and number, and spread over the whole lower part of the abdomen, and she began to imagine that the skin felt hot and irritable. She had much advice for them, took a long course of arsenic, much iodide of potassium, and was also sent to Buxton. No great change resulted. She thought it probable that some of the many applications which had been made had irritated the patches and made them spread.

When on Sept. 23, 1897, I was consulted, her abdomen at its lower part was covered with dark brown, almost black, stains. Some in an early stage were not bigger than pins' heads, others might have required the end of one's thumb to cover them. Some were ill-defined, others presented a more or less definite ring with a paler centre. None were raised or perceptible to touch, but scattered amongst them were a few small comedones around which there was staining. A few of the stains passed as high as the chest, and under the breast on both sides there was an intertrigo patch of slightly thickened skin, upon which were many little indolent lichen spots with some diffuse yellow-brown discoloration. These patches were not actually eczematous, but threatened to become so. There were no "freckles" on the face or arms, and scarcely any on the back. A few small lichen acne spots might, however, be found on the face and shoulders on careful inspection.

L—— H—— was not out of health, and although her eruption had caused her great annoyance, it had not much interfered with her comfort. She inherited gout, and I had myself prescribed for one of her sisters for eczema.

I thought it possible that the arsenic which she had taken had deepened the colour of the blotches, but it was certain they were not caused by it, nor was there any general pigmentation of the skin. No history of cancer was known in the family.

I prescribed some applications for the submammary intertrigo, and as regards the stains advised that they should be let alone.

No. XCVIII.—*Aggressive Pigment Patches on the Glans Penis and Prepuce.*

Repeated references have been made in ARCHIVES to the remarkable cases in which pigment staining of an aggressive form is occasionally the prelude to malignant growth. In most of the cases which I have described the disease was placed either on the eyelids or on the lips. I have, however, recorded other cases in which the same process occurred at the roots of nails and in association with sarcomatous growths in the sole of the foot and other parts. I have at present under observation a remarkable example of pigmentation, of patches on the glans penis and in the scar of a circumcision done thirty years ago. The patient is a man of 64, and the disease has been in progress three years. He was in the first instance (two years ago) sent to me in the fear that the condition was malignant, but excepting increase of pigmentation nothing further has been developed.

No. XCIX.—*Type-Case of Severe Urticarious Dermatitis induced by Food Poisoning, and recurrent on the slightest possible provocation.*

The following case may stand as a good example of that form of urticaria which occurs suddenly to a person who has previously not shown any special proclivities. Such outbreaks are probably almost always evoked by dietetic poisoning, but they leave the skin susceptible for a considerable period after the special cause has been wholly removed.

Mr. ——, a robust Scotchman, was sent to me by Mr. Drummond, of North Shields, in October, 1897. He had suffered from nettlerash for six weeks, and at times most severely, although a rigid dietary had been enforced and he had taken saline aperients freely. His age was 45, and he assured me that until the present attack his skin had never shown any irritability whatever. No change of underclothing ever caused him the slightest trouble, nor had he

been liable to suffer in any special degree from the bites of insects. On the morning that Mr. —— came to me he had been three days in London, and his urticaria had wholly left him. I made him strip, and found his skin pale and quite free from all traces of irritation. He told me, however, that he had often been covered over his limbs and trunk with large red wheals, which he described as having been raised as thick as his finger. He said that the medical men who had seen him had said that they had never seen so severe a case. The eruption had not been persistent, and had often left him for a few days at a time, but never quite so completely as during the last few days that he had been in London. He assured me that his underclothing did not irritate him in the least, and it appeared quite evident that the exciting cause was from within.

I asked Mr. —— to tell me in detail how his first attack had been developed. He said that he had one night found his skin irritable, and had scratched a good deal, and that in the morning he had found himself covered with red wheals. The next day he saw his doctor, and he had been under treatment ever since. "Had you taken fish for supper?" "Yes, in all probability, for I usually do; but there had been nothing particular. I never take shellfish. A day or two before I had eaten mackerel, and this was what Dr. D—— blamed." "You have been forbidden fish since?" "Yes; I have taken none. I have been put on a low diet, and had no salt meat, no stimulants, and no beef or mutton. Milk I have taken freely and cocoa, but no tea or coffee." "Have you been able to observe that any article of food brings it out?" "No; it has come without anything to explain it. I have been covered in the course of an hour or two without knowing what had produced it." "Has it itched much?" "Oh, yes, intolerably. I have often been scratching half the night." "Does the scratching make it worse?" "No, it relieves it. I often scratch till the blood comes." "And yet the eruption goes away and leaves your skin sound?" "Yes, most completely; my skin the next morning often looks as if there had been nothing there."

PLATE LXXVI.

MULTIPLE LUPUS VULGARIS.

PORTRAIT of a boy the subject of multiple lupus in the early stage. For the later stage, after an interval of five years, see Plate LXXVII. For further particulars see the description of Plates LXVII. and LXVIII.

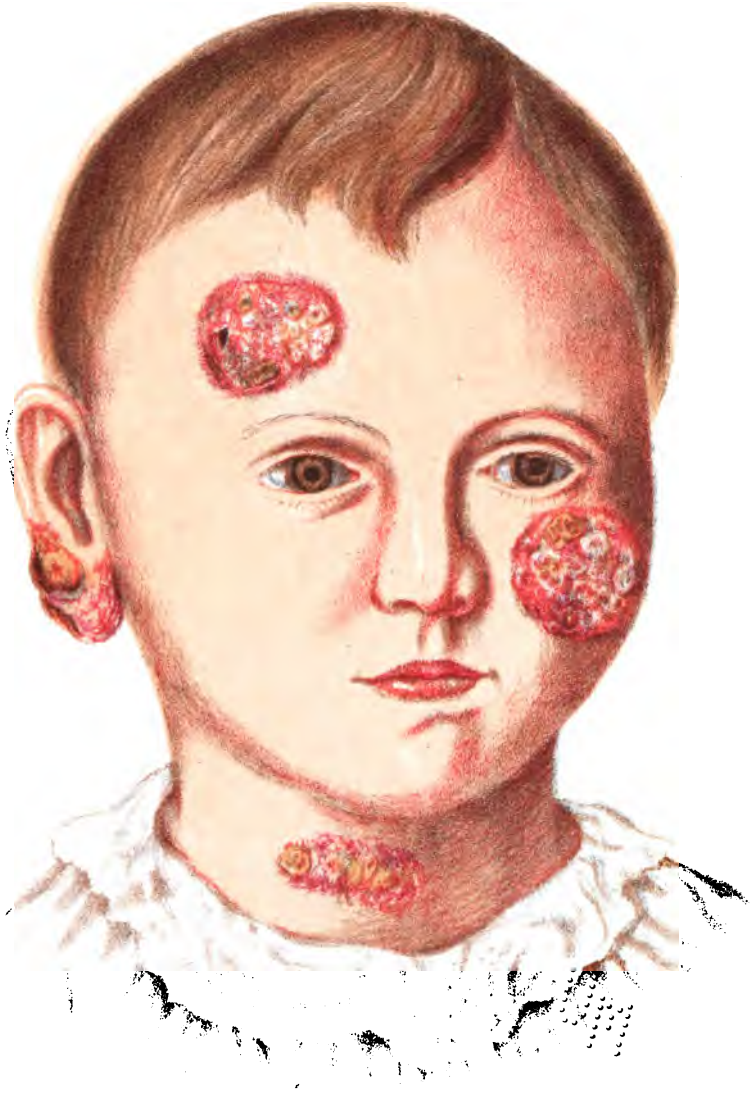


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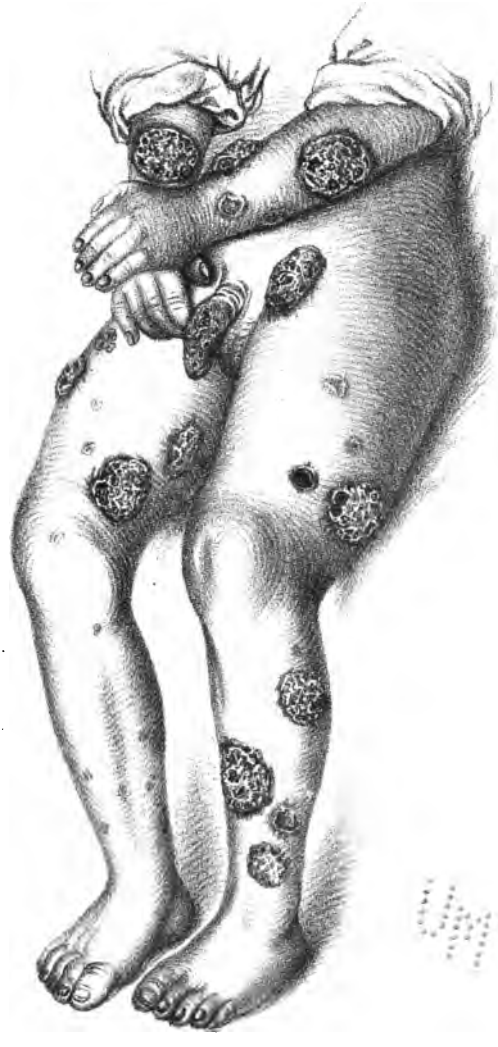
PLATE LXVII.

MULTIPLE LUPUS VULGARIS.

This portrait shows the earlier stage of the same case as that depicted in Plate LXVIII., the interval being about five years. The patient was a healthy boy, in whom, at the age of about three, an acute general eruption occurred, the nature of which was not easily recognised. Some of the patches were almost rupial, whilst others were lichenoid or pustular. At a later stage, however, many of the smaller spots had disappeared, whilst the larger ones had extended into patches characteristic of lupus vulgaris. It will be seen that the individual patches in Plate LXVIII. are very much larger than those in LXVII.

In Plate LXVII. it will be seen that the whole of the prepuce is involved in a lupus patch. In Plate LXVIII. this had been removed by excision. A full narrative of this case is given in my Harveian lectures on lupus, which will shortly be reprinted. The boy when about twelve years old was well grown, and in fair health, but was almost covered by huge patches of exfoliative lupus. He died, as narrated at page 77, with albuminuria and pulmonary disease, probably tubercular, at the age of fourteen.

Coloured portraits representing the face of the same patient in the two different stages of the disease will be found in Plates LXXVI. and LXXVII.



West, Newman, lith.

No. CI.—*Conclusion of a remarkable example of Multiple Lupus Vulgaris.*

A case to which I have many times referred as my best illustration of multiplicity in the manifestations of lupus vulgaris and of the peculiar phenomena which attend its outbreak has recently ended in the death of the patient. Portraits in illustration of its different stages had been taken and are now reproduced (Plates LXXVI. and LXXVII., LXVII. and LXVIII.), the originals being preserved in the Museum.

It is now ten years since Master L——, then a healthy boy, developed a general eruption of pustules and lichen papules, many of which inflamed and became covered with crusts. The diagnosis was in doubt for some time, but after a while much of the eruption disappeared, and what remained settled down into patches of lupus vulgaris in its exfoliative form. These were so numerous and soon became so large that it was impossible to subject the poor boy to efficient measures of local treatment, and after many trials the disease was allowed to run its course, excepting as influenced by attention to the general health. Amongst other measures, Koch's fluid had a full trial at the time when it was in vogue. The patches increased steadily in size, but caused but little discomfort. In the end, probably a full third of the patient's surface was occupied by them. My object in now recurring to the case is to record the fact that the boy has died with albuminuria and tubercle of the lung. He had enjoyed fair general health until the last six months of his life.

SYPHILIS.

(*Continued from Vol. VII., p. 177.*)

No. LXXIX.—*A peculiar form of Induration in Sub-mucous Tissue ten years after a chancre near the same site.*

Mr. B—— contracted syphilis in 1872, followed by palmar psoriasis, &c. He was treated with mercury, but not for long, and got quite free from symptoms. In May, 1883, aged 35, he came to me with a sub-mucous collar, almost as hard as bone, in the prepuce, close to the corona, in the middle line of the dorsum. There was not the least soreness or congestion. The mass was rather deeply placed, as big as a horse-bean, but flattened and abruptly margined. It was not like a chancre in the absolute absence of congestion, and I thought it was a gumma. Mr. B—— thought it was not exactly where the original chancre had been, but was not far from it. He admitted repeated recent exposure to contagion. The induration subsequently disappeared under treatment.

No. LXXX.—*The course of Secondary Syphilis unusual and precisely parallel in two Brothers.*

A very demonstrative illustration of the influence of individual idiosyncrasy upon the development of syphilis has recently come under my notice. Two brothers contracted sores from the same woman, and nearly at the same date. They consulted me ten months later for a peculiar form of eruption which was exactly alike in both. It had been modified in both by treatment already adopted, and in each it had assumed the type of an urticaria in wheals and

PLATE LXXVII.

MULTIPLE LUPUS VULGARIS.

PORTRAIT of a boy the subject of multiple lupus in the later stage. For the earlier stage see Plate LXXVI.; and for further particulars see the description of Plates LXVII. and LXVIII.

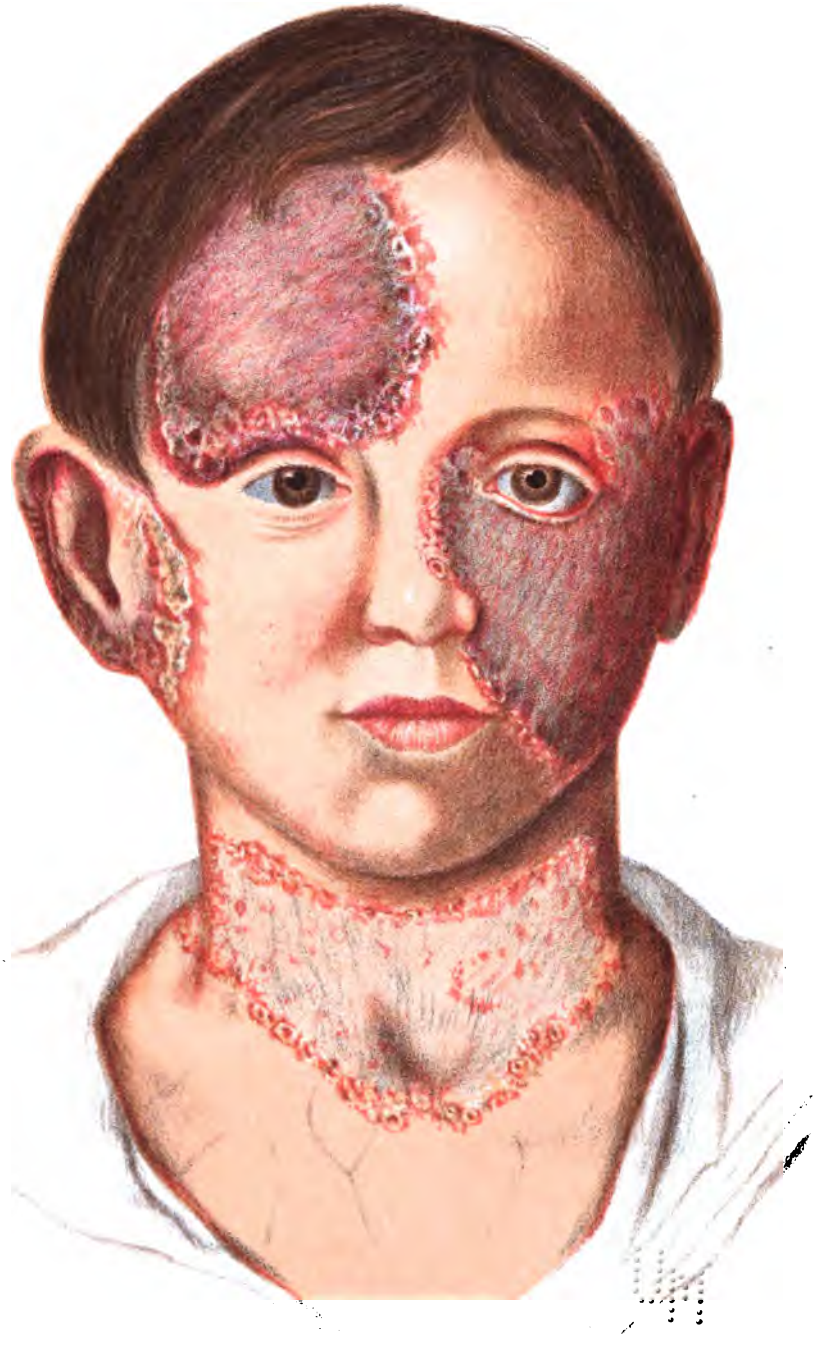


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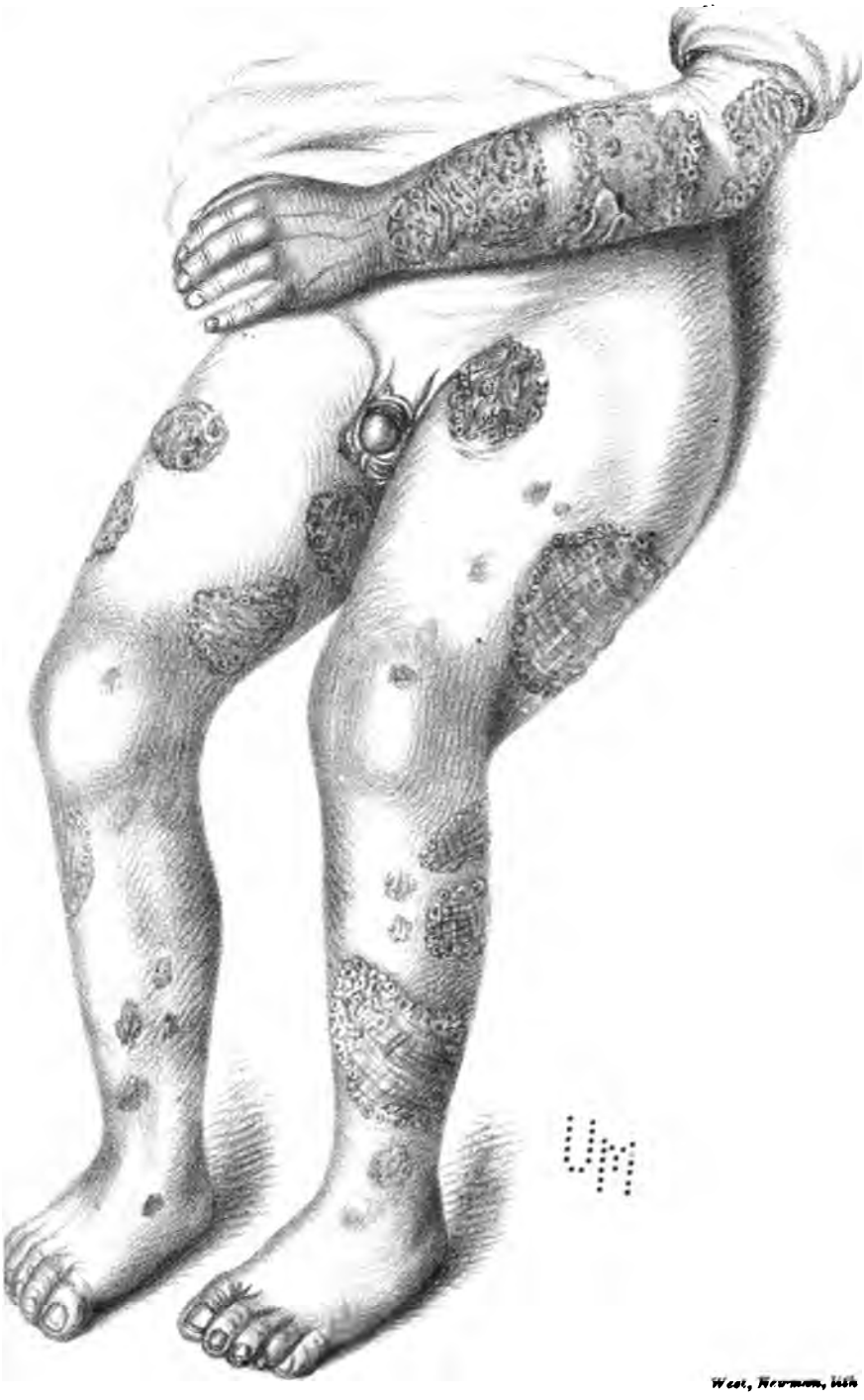
PLATE LXVIII.

MULTIPLE LUPUS VULGARIS.

This portrait represents the condition of the Lupus patches in the boy Ll——n, who was also the subject of Plate LXVII. A comparison of the two Plates shows the extent to which the disease has advanced during the four years which had intervened between the dates at which they were taken. It will be seen that all the patches are much larger in size, and that in some places several have coalesced. The prepuce, which in the first Plate is seen to be involved in lupus, has in the second been removed by circumcision. The Plate is not to be regarded as anything more than a map indicating the size of the patches.



West, Newman, lith

rings. In both it was wholly free from irritation, and both stated that it became much more conspicuous after a warm bath. In both patients the original chancre had, after lasting about three weeks, healed and disappeared spontaneously, and in both the sore throat had been very slight. In both the original eruption had been, I was told, quite different from that which now persisted, and was described as a roseola. It will be seen that the eruption presented by these two men when they came to me in the tenth month of treatment was precisely that which I have described as occasionally occurring at that stage, and which is, I think, never seen unless mercury has been used. It is by no means common, and its development in the two brothers is therefore the more remarkable.

No. LXXXI.—*Primary Syphilis in Hindoos.*

It is very desirable to collect trustworthy information as to racial peculiarities in reference to disease. As such I record the following fragment:—

I am at present seeing three Hindoos for primary syphilis. In all the chancre has been a very large induration. In one the sore became phagedænic after induration and required cauterisation. All the three had large tonsils, and in all superficial sores showed on their surfaces.

No. LXXXII.—*Syphilis from a Finger-Chancre which was ill characterised in its early stages.*

A surgeon has just been with me who has a chancre on the side of his forefinger and is covered with a syphilitic eruption. His case presents some features of special interest. In the first place, he has, in addition to a considerable mass of glands in his armpit, enlargement also of those under the clavicle. This is just what happens in infection of the lymphatics from cancer of the breast, but I do not remember to have seen it before in the axillary bubo of syphilis. The latter usually restricts itself to one or two isolated glands in the armpit itself. The next point is that, although my patient is an observant man, he cannot offer the slightest

conjecture as to how he got infected. He says that he never recollects any prick or scratch on his finger. He is not to any great extent exposed to risk, not seeing many syphilitic patients and not doing much midwifery. What he first noticed on his finger was a little pustule, which he pricked with his scarf pin to let out a small quantity of matter. It was somewhat painful from the first, and latterly has been very much so. No one of his medical friends to whom he showed it would at first admit that it was suspicious, and as a consequence he got no treatment until the eruption came out, and this was five or six weeks after the first observation of the pustule. The sore meanwhile had inflamed, and had come to present a hard, raised margin as far round as a sixpence, with an ulcer in the centre.

No. LXXXIII.—*A healthy infant nursed by a syphilitic mother—No contamination—Urticaria pigmentosa mistaken for a syphilitic eruption.*

A married lady (Mrs. K——), aged 27, consulted me in February, 1892, she being then covered with a syphilitic eruption. The disease had not been diagnosed, and no treatment had been adopted. I found that she was nursing an infant seven months old, and of course told her that she must at once wean him. A year later she brought the infant to me because he had an eruption which she had assumed to be syphilitic. I found not the slightest indication of syphilis, and the spots appeared to be flea-bite urticaria. They were said to come out at intervals, now on one part and now on another, and were attended by excessive irritation. A year later still I heard that the child was in good health, but still liable to the eruption, which was reported to leave brown stains. His mother still held that the child must have suffered from her "blood poisoning." Three years later the boy was again brought to me, the belief being that I should now be forced to admit that he was syphilitic, as his hair had begun to fall off in patches. He was the subject of well-characterised alopecia areata. The patches were large, and perfectly

smooth. There was no history of ringworm, but I was told that in an early stage the patches had been scaly. The boy showed no indications of syphilis. He had his twenty milk teeth, all still quite white, and none showing any caries.

The facts which this case seems to prove are that an infant may be nursed by a woman suffering most severely from secondary syphilis without receiving from her milk any taint and without contracting any chancre on the mouth.

DIET AND THERAPEUTICS.

(*Continued from Vol. VIII., p. 384.*)

On the use of Indian Hemp.

I have of late years used Indian hemp freely for the relief of chronic rheumatism, and often with very good effect. I fear, however, that it cannot be denied that it is a very variable remedy, and that the prescriber is much at the mercy of the dispenser. This applies especially to the fluid forms, which, unless carefully made up, may easily concentrate into one dose the quantity which should be divided into many. For this reason, having been warned by a case in which dangerous symptoms occurred, I now never prescribe it otherwise than in pills. Even in pills, however, it is variable. A patient who had some months before taken the extract in grain doses, was made so ill by doses of one-third of a grain that he had to keep his bed several days. His symptoms were mental confusion and inability to walk straight. He did not know what he was saying. He persuaded his wife to take three or four of his pills, and they had the same effect on her. I have just received the following from a patient: "The last prescription you gave me with the small pills seems to affect my nerves so much that I really cannot take it any longer. It makes me tremble all over." The dose in this instance was only a third of a grain, with a grain of quinine.

Another patient wrote: "Your quinine and Indian hemp pills quite paralysed my speech when I had taken only four. I was very ill, and had to remain in bed some days." In this instance the dose was only a third of a grain.

Opium in Raynaud's Disease.

I have just heard from Dr. Clarke, of Upper Clapton, that Mrs. W——, whom I saw with him three years ago, when she was the subject of Raynaud's phenomena in a severe form, is now "quite well." Small doses of opium have, I believe, been the main influence in her recovery. Her case is published in the *Medical Week*.

The following letter from Dr. Clarke gives more details. It was written in reply to one of mine in which I inquired whether it could really be said that the patient was "cured," and also asked him to bring her, if possible, to one of my Demonstrations.

"*Nov.* 4, 1897.

"DEAR MR. HUTCHINSON,—I have deferred writing, hoping to persuade Mrs. W—— to visit Park Crescent, but in vain, or to bring her myself; thus far my efforts have failed.

"I consider the case a cure, and so do the patient and her family. The fingers have been well *for a year at least*—no *further michief at those extremities*. Feet and toes entirely free; but some six months ago (I suspect from over-walking) superficial ulcerations—three or four small but deep ulcers—formed in the triangular space above the os calcis. The pain was most acute, as she described it, exactly like that in the tips of her fingers when the disease was active. This was relieved by a 10 per cent. solution of cocaine, and the ulcers locally treated with boric acid lotion and carbolic acid, and support by bandaging. The internal treatment was solely pulv. opii gr. i. in pill twice or thrice daily. *She is now quite well*, only suffering from time to time from dyspepsia, relieved by ext: nuc: vom: gr. ¼ ter die in pill. *This suits her best.*"

A case illustrating the Treatment of Psoriasis—Arsenical Zoster.

I prescribed for a boy aged 14, who was the subject of severe and extensive psoriasis, an ointment of chrysophanic acid ʒi ad. ʒi) and Fowler's solution of arsenic in four-minim doses, three times a day. The effect of the ointment was to cover him with erythema, which was for some days thought to be scarlet fever and which was followed by peeling. About a month after taking the arsenic he came out in herpes zoster on the left side of the trunk. It was well marked, but not a severe attack. As a result of the combined influence of the arsenic and of the acute dermatitis

produced by the chrysophanic acid, his skin was at the end of a month almost entirely free. His father thought that the so-called scarlet fever did it, for after the peeling the spots of psoriasis were all gone. It is worthy of note that the ointment, although continued afterwards, did not irritate again. It was my usual ointment, which twenty years ago obtained, I believe, some little reputation in the profession as a compound petroleum ointment. When the boy was brought to me a month after his first visit he had the zoster still out, but with this exception his skin was everywhere pale and soft.

Carbolic Acid as a Topical Remedy in Lupus Erythematosus.

A lady who recently consulted me for rheumatoid arthritis of her knees told me that I had cured her of "Batswing Lupus" some years ago. On inspecting her face I could find only the faintest traces of scar on the nose and cheeks. At first glance, indeed, I did not see that there was anything. She told me that she had consulted me only once, as she lived at a great distance, but that she had continued my treatment for nearly a year. She was exceedingly pleased with the result, having been told before she saw me that the disease was almost incurable. On turning to my notes I found her diagnosis confirmed by a brief entry on December 12, 1893: "Mrs. E——, aged 48. Lupus erythematosus spreading symmetrically from the nose over both cheeks; sunburn on the nose the beginning of it." I was naturally anxious to know what the measures were which I had advised, and a week later at my request her husband forwarded to me the prescription with a letter, from which I extract:

"I beg to enclose you the prescription you gave Mrs. E—— in December, 1893, for Batswing lupus, and which, as you saw, entirely cured her. She was obliged to continue the use of it for a lengthened period, but she was most careful and persistent in doing so; indeed, continued it for some time after the disease appeared to be cured."

The prescription was for a mixture containing tincture of nux vomica with one minim of Pearson's solution of

arsenic in tincture of orange-peel. The more important measure was, however, the topical use of undiluted carbolic acid. The written directions were: "With a bit of wood paint this acid over the edges of the patches once or twice a week." A boracic acid ointment (a scruple to the ounce) had also been given for daily use, and especially after applying the acid.

As regards the use of carbolic acid, I believe that I have repeatedly published the opinion that for patients who wish to carry out treatment at home and cannot see their advisers often, it is by far the safest and most effectual form of caustic. Some of the best and most complete cures of lupus vulgaris which I have ever seen have been under its persevering use. It has also the great recommendation of leaving very healthy and supple scars. It is necessary that the patient should be persevering, and make the application freely once or twice a week. In lupus erythematosus, of which the present case is an example, I have been less commonly successful, but this case is certainly one of the best cures of a formidable example of it which I have ever witnessed.

Alcohol as an Hypnotic.

I was urging very strongly on a man who well knew his failing that he should reduce his quantity of whisky. In giving a reluctant assent, he remarked: "But, you see, it gives me such sound sleep. If I do not take my usual allowance at bedtime, I dream dreadfully all night; but if I have had it, why I sleep like a child and never dream at all." "But," I suggested, "do you not wake with a dry mouth and a headache?" "No," he said, "I wake as bright as possible and enjoy my breakfast." His assertion on the latter point was confirmed by the fact that he had a perfectly clean and soft tongue. He had, as he well recognised, been on the verge of delirium-tremens more than once, and was anxious to amend his mode of life. What made it especially difficult for him was that alcohol always seemed at the time to suit well, and never gave him any immediate discomfort. There are many who are, I believe, in the same position as

my patient, and those may be thankful in whom indiscretions and excesses are followed by prompt and well-recognised penalties.

Leprosy and Fish-eating in Persia.

The highlands of Persia are one of the districts which have often been quoted as affording an objection to the acceptance of the fish-theory of leprosy. It has been said the leprosy prevails there, and that the inhabitants, owing to their position, can get no fish. I have before me a reprint, from the Geographical Journal, of a paper by Capt. Vaughan entitled "Journeys in Persia." For my benefit Capt. Vaughan has been good enough to add some notes as to the diet and food, from which I extract the following:—

"The chief diseases are—

"1. Ophthalmia very common, and probably due to dust and glare. The inhabitants attribute it to a diet of dried fish and dates.

"2. Skin diseases.

"3. Some form of venereal disease. I saw no true syphilis.

"4. Fevers are rare.

"I do not remember having seen any lepers. The diet of the people all over the country consists largely of dried and salted fish imported from the Persian Gulf and the Caspian Sea."

Although Capt. Vaughan saw no leprosy, yet the testimony of others establishes the fact of its occurrence. Probably it is not common. Capt. Vaughan's evidence entirely overturns the assertion of those who say that fish is not obtainable. Clearly it is obtainable, and that in its most dangerous state, salted or dried. Very probably it is eaten uncooked.

Zosteriform pigmentation of Skin as a consequence of the medicinal employment of Arsenic.

It has been well established respecting arsenic that it may produce diffuse pigmentation of the skin and also that it may cause herpes zoster, a malady which affects the areas of distribution of individual nerves. I have now to offer a

connecting link between these two different classes of phenomena, and to suggest that this remarkable drug may produce pigmentation which is not diffuse, but which is arranged in streaks like those of herpes. In other words, it would appear probable that the pigmentation may be caused or permitted by special nerves. Three, if not four, cases illustrating this fact have come under my observation, but for the present I shall record the details of only one, as the facts respecting the others were somewhat less conclusive.

Mr. S. A. C——, a single man aged 44, was sent to me from Yorkshire on account of an eruption which was suspected to be in connection with syphilis, from which he had suffered ten years before. When he was stripped, I found that his "eruption" consisted only of brown stains, without the slightest thickening or surface change. These stains were arranged in long streaks curving forward on the sides of the chest and abdomen. There were also streaks down the inner aspects of the upper arms (in the district of the humeral branch of the intercosto-humeral). A long streak passed vertically up his back over the vertebral spines. The "eruption" caused him no inconvenience, and he would not have known of its presence if he had not seen it. He had no other indications of syphilis, and the history of the primary disease was, as I have said, ten years ago.

The appearance of the stains roused my suspicions as to arsenic, and on inquiry I found that he had been taking that drug on account of deafness. He was clear in his statement that he had no stains before the arsenic was given, and that he was in his usual health when he sought advice for his hearing. The medicine which was given him made him, he said, feel very ill. After taking it for about a month he could not sleep, and had difficulty in walking. He was breathless and had much palpitation. It was in October that the arsenic was prescribed, and it was left off, I believe, in December. If was in February that he came to me for the stains, which had then been present six weeks or more. The other symptoms of arsenical poisoning had then for the most part passed away. There had been no disturbance of the nutrition of the skin in his palms or soles.

MISCELLANEOUS.

(*Continued from Vol. VIII., p. 288.*)

No. CCLXXXIX.—*Frequent recurrence of Raynaud's Phenomena with Hematuria in an otherwise healthy man, and in connection with exposure to cold.*

A somewhat remarkable narrative illustrating the paroxysmal form of Raynaud's malady was given me by a gentleman from Lancashire, Mr. B——, of T——. Although looking very well, and accustomed to vigorous exercise in hunting, &c., Mr. B—— told me that he had for years been liable to bloody urine if he was exposed to unusual cold. During his attacks he became, he said, quite blue, and had most severe backache. It was necessary to put him to bed and wrap him in blankets, &c. The attacks always began by shivering. The backache was often very severe. He did not, however, refer the pain to the region of the kidneys, but rather to the sacrum. It was, he said, always relieved as soon as blood appeared in the urine. Some of the attacks had been so severe that he had expected to die, and, according to his account, large quantities of blood had been passed. Sometimes a paroxysm would occur every day for a week, but more usually they were only once a week or once a month. They occurred only in winter, and he could always trace them to exposure. He had been obliged to be most careful as to exposure to risk, and during the last year had managed to almost wholly avoid attacks. The first attack occurred after a long drive in an open gig in very cold weather. Although florid and looking well, Mr.

B—— had a very feeble pulse. He had suffered from syphilis many years ago, but had never lived in an ague district.

No. CCXC.—*On the relative frequency of Baldness in the two sexes.*

A distinguished author on skin diseases writes:—"Females are more liable to alopecia than are males; their susceptibilities are greater, and they are more open to the influence of disturbing causes. In one hundred cases, sixty-three were females and thirty-seven males."

Now I cannot but think that there is a great fallacy in this statement of fact, and if so, in the inferences. I do not believe that loss of hair depends upon "susceptibilities," or that "disturbing causes" have much to do with it. Nor do I believe for a moment that females are more prone than males to become bald. The author quoted seems to have trusted to his "statistics" rather than to his common sense. The susceptibilities of women lead them to be very sensitive as to loss of hair, and they naturally seek help under circumstances which a man would probably disregard. As a rule, indeed, men accept the beginnings of baldness as inevitable, or they have something more important to think about. Possibly they even do not notice it until some friend makes a kind remark. A woman's long hair enables her to observe at once if it is falling unduly, and she takes alarm and will often assert that she "is losing all her hair" at a stage when no one else can see anything peculiar. There are, I admit, a few men, mostly young, who are as sensitive as women on this matter, but they are fortunately exceptional.

In spite of Sir Erasmus Wilson's statistics, I have no hesitation in believing that loss of the scalp hair is really far more common amongst men than women. If there were as many bald women as there are bald men, wig-making would be a very profitable trade. One of the reasons, and perhaps the chief, of the frequency of baldness in men is, that the free growth of sexual hair on the

face, and sometimes on the trunk as well, competes with that of the scalp.

No. CCXCI.—*Description of the condition of the limb many years after detachment of the Upper Epiphysis of the Humerus, with great displacement.*

A gentleman of thirty, who consulted me about his right shoulder, remarked casually that the left was permanently damaged by an unreduced dislocation which had occurred in boyhood. He added that his surgeons had at the time repeatedly put the bone into place, but that it would not remain there and was still out of its socket. I requested leave to examine the shoulder, and found that so far from there being any hollow under the acromion, there was a lump of rather rough bone projecting strongly in front of it and almost on its level. This bony mass was almost under the skin, and was easily seen and felt. It concealed the coracoid, and was close to its inner side. It was not difficult to recognise in it the upper end of the shaft of the bone from which the epiphysis had been detached. Its upper surface presented the uneven ridges which are so characteristic of that part. On further examination it seemed almost certain that the epiphysis itself remained in the glenoid cavity, and that the upper end of the shaft displaced forwards was united to its front aspect. There was nearly an inch and a half of shortening, and although the acromion did not project much, there was a hollow behind and at a little distance below it. The movements of the joint were fairly free, and my patient said that he could do almost anything with the limb. He could not, however, easily get his hand behind him so as to button his braces, and was accustomed for this purpose to use his other hand. The accident had occurred in the hunting-field at the age of fifteen, when the bone had probably attained almost its adult length. Had it occurred earlier the shortening would probably have been greater.

I have seen, and have recorded some years ago, several examples of detachment of the head of the humerus at the

epiphysal line, but I have never met with an instance of a similar displacement to that in the present case. I have had but very few opportunities for ascertaining the state of parts long after an unreduced displacement. It is not common for the displacement to be complete, that is, for the surfaces to so leave apposition to each other as to permit of overlapping and real shortening. The large size of the surfaces involved will easily explain this. When complete displacement with shortening does occur, it is probable that there is fracture of the end of the shaft as a complication of detachment at the epiphysal line. Such it may be supposed had probably occurred in this instance. If a fragment had been broken from the posterior border of the upper end of the shaft the kind of displacement which had occurred would have been more easy of production, and the difficulty encountered in keeping the bone in place more easy to understand.

It is hardly necessary to ask attention to the almost complete recovery of the movements of the joint, and consequently of the usefulness of the limb, in spite of the unreduced and very considerable displacement. Injuries to the epiphyses of the long bones are often very difficult to treat, and in some instances, as in this, it is found impossible to keep the bone in the position of perfect reduction. They often cause much undeserved loss of reputation to the surgeon concerned. It is satisfactory to be able to assure parents that however great may be the seeming deformity at first, there will be in the end, after the lapse of years, almost complete restoration of usefulness.

No. CCXCII.—*Usefulness of the Hand after Anchylosis at Elbow.*

Mr. W——, 52, has an anchylosed left elbow (from boyhood), with scars in front of radius and much shortening of bones of forearm. Pronation and supination absolutely lost, the palm of hand looking downwards. He can do almost anything with the hand.

No. CCXCIII.—*Anchylosis of Patella on inner Condyle—Useful limb.*

In Mr. W—— the left knee has the patella on its inner side and there quite fixed. The quadriceps is wasted so that I cannot discover it. Yet he has walked well all his life on the limb. He can flex it a little.

No. CCXCIV.—*A peculiar form of Lupus resembling Psoriasis.*

Mr. W——, æt. 52, has a very peculiar form of psoriasis-lupus. Some of the patches are exactly like serpiginous lupus, others like psoriasis. There are none in the psoriasis regions.

No. CCXCV.—*Sclerosis of Tongue in a non-smoker—Syphilis doubtful—Xanthelasma of Eyelids in a mother and son.*

Mr. H——, aged 50, a stout man in good health. In very early life he remembers to have had a small chancre, but he does not think that he had secondaries. He took medicine for some time. He does not appear to have had any reminders. His father had diabetes, and died of heart disease and apoplexy æt. 56.

Mr. H—— has a sclerosed tongue with many little abrasions at the sides, and over the whole surface a thin "white paint layer." Yet he has not smoked. He has been fond of painting, and was accustomed to suck his brush constantly. I can find no other local cause, and he has not a single stopped tooth nor any artificial ones. He habitually uses a gasogene.

He has xanthelasma in the usual situations, thick yellow patches. His mother had them in middle life also. Both were very bilious. He has been married twenty years, but has no children. Lately has been out of tone; easily tired. Is very thirsty, and often wakes with dry tongue.

No. CCXCVI.—*On the influence of Paralysis of Muscles upon the circulation in the affected limbs.*

The influence of motor paralysis upon the circulation of the blood and the nutrition of tissues was illustrated in a very instructive manner in the case of a man who had been twelve months hemiplegic. His hemiplegia had been in the first instance complete, but had implicated the muscles only, there having never been any degree of anæsthesia. At the end of the year he had regained the power of walking, but his upper extremity was still to a large extent paralysed, and he could not move his fingers in the least. All the muscles of his forearm were somewhat wasted, and those of his hand yet more so. His fingers were habitually curved into his palm, but there was no fixed contraction and they could be easily straightened. The difference in the strength of the pulse at the two wrists was most remarkable. He was a vigorous, well-nourished man, and his pulse in the unparalysed arm was full and strong, whilst that of the affected one was feeble, soft, and small. The capillary circulation of course shared in the peculiarities. His hands were of a dusky red tint, cold and flabby. He was obliged always to keep a glove on this hand, whilst not needing one on the other. In a warm room the hand soon became warm and at the same time more florid and less dusky. The circulation was much at the mercy of the external temperature, for on going into the cold again the duskiness and objective coldness soon returned. No lesions of nutrition had occurred, nor had there been any pain excepting a dull ache when very cold. It is, I suppose, to be held that the main influence in causing the defective circulation is the loss of functional use on the part of the muscles, thus bringing on a large reduction in the *vis a fronte*. Some share may perhaps also be due to interference with the vaso-motor nerve supply.

No. CCXCVII.—*Death of Sterne—Catarrhal Pneumonia during Chronic Phthisis.*

Laurence Sterne died rather suddenly in lodgings in London at the age of 55 (1768). He had been suffering from a chest ailment for several years, and had been sent for long periods to the South of France. He was liable to attacks of what he termed "my vile influenza." It was from one of these that he died—no doubt intercurrent catarrhal pneumonia.

No. CCXCVIII.—*Death of George II. from Rupture of the Right Ventricle of the Heart.*

On the 25th of October, 1760, at his palace at Kensington, King George II., without having complained of any previous disorder, was found by his domestics expiring in his chamber. He had arisen at his usual hour, and said to his attendants, that as the weather was fine, he would take a walk into the gardens. "In a few minutes after his return, being left alone, he was heard to fall upon the floor. The noise bringing his attendants into the room, they lifted him into bed, where he, with a faint voice, desired that the Princess Amelia might be sent for; but before she could reach the apartment he expired. An attempt was made to bleed him, but without effect. Upon opening the body, the surgeons discovered that the right ventricle of the heart was ruptured, and that a great quantity of blood had been discharged." The king was seventy-seven years of age.

No. CCXCIX.—*Last illness of Lorenzo the Magnificent (Son of Il Gotoso).*

Lorenzo the Magnificent, the son of Lorenzo il Gotoso, died at the early age of forty-eight. The cause of his death is doubtful. He had long suffered from ill-health, and had frequently had recourse to the baths of Siena and Porrettana. He was, however, looking forward with confidence to the enjoyment of rest and literary pursuits when his fatal illness

seized him. I extract the following from Roscoe's life of him :—"Politiano describes his disorder as a fever, of all others the most insidious, proceeding by insensible degrees, not like other fevers by the veins and arteries, but attacking the limbs, the intestines, the nerves, and destroying the very principle of life. On the first approach of this dangerous complaint he had removed from Florence to his home at Careggi, where his moments were enlivened by the society of his friends and the respectful attentions of his fellow-citizens. For medical advice his chief reliance was upon the celebrated Pier Leoni, of Spoleto, whom he had frequently consulted on the state of his health; but as the disorder increased, further assistance was sought for, and Lazaro da Ticino, another physician, arrived at Careggi. It seems to be the opinion of Politiano that the advice of Lazaro was too late resorted to; but if we may judge from the nature of the medicine employed by him, he rather accelerated than averted the fatal moment. The mixture of amalgamated pearls and jewels with the most expensive potions might indeed serve to astonish the attendants and to screen the ignorance of the physician, but were not likely to be attended with any beneficial effect on the patient. Whether it was in consequence of this treatment, or from the nature of the disorder itself, a sudden and unexpected alteration took place, and he sank at once into such a state of debility as totally precluded all hopes of his recovery, and left him only the care of preparing to meet his doom in a manner consistent with the eminence of his character and the general tenor of his life." After this followed the celebrated interview with Savonarola, and others with his son and friends. Although no definite diagnosis appears to have been arrived at, it is clear the symptoms were held to preclude all hope; it is further clear that the patient retained his faculties to the last. The malady, having regard to the antecedents, may not improbably have been disease of the kidneys and bladder.

No. CCC.—*Syphilis in the Sixteenth Century.*

The father of Catherine de Medici (the wife of Henri II. and Queen-mother during the reigns of Francis II., Charles IX., and Henri III.) is stated to have died of syphilis a few days after his daughter's birth.* Catherine was an only child, and her mother died at her birth (1518). Her portraits, which are numerous, show no evidences of inherited taint. At that time syphilis was a new disease in Europe, and, as it had not then been in any way associated with sexual habits, no disgrace was supposed to be attached to it. Historians felt no delicacy in recording the fact that any one of whom they wrote had suffered from it. Many deaths of ecclesiastics as well as civilians were attributed to it.

* See vol. ii. Roscoe's "Life of Lorenzo de Medici."

ARCHIVES OF SURGERY.

APRIL, 1898.

ON SYMBIOSIS IN REFERENCE TO HUMAN PATHOLOGY.

RECENT observations in what is known under the name of Symbiosis are likely, if I mistake not, to throw light on many of the problems of pathology. By this name is designated a peculiar form of parasitism, in which one organism lives in the tissues of another, but without necessarily causing any damage to them. The two thrive together in a sort of partnership which may or may not be disclosed. There is nothing to prevent the one becoming inimical to the other, but at the same time there is nothing to necessitate it. Sometimes indeed the intruder—or shall we say the visitor?—is actually beneficial to the host. This may occur, for instance, when a vegetable organism, living in the tissues of an animal, actually decomposes carbonic acid and sets free oxygen.

The intimate and seemingly permanent union in which two vegetables live into each other in the case of lichens is one of the most startling examples of symbiosis. Almost all our more advanced physiological botanists now admit that lichens do not constitute a separate family of plants, but are produced by the structural union of an alga and a fungus. The two plants which habitually live in this close union may be artificially separated and cultivated apart. It is not easy to say which is the host and which the parasite. The two

are in structural union and thrive together without undue preponderance of either.

A more simple example of symbiosis occurs in the instance of the green sea anemone (Anthea viridis). It is known that the green colour of this cœlenterate is caused by the presence in its structure, enclosed in its outer tissues, of an alga of unicellular form. Many others of the same class of animals—corals, jelly-fish, and anemones, are known to be coloured either green or yellow by the presence of similar algæ; and according to the researches of Mr. P. Geddes these algæ remove carbonic acid from starch and give out oxygen, being in this way distinctly advantageous to their fortunate possessor.

Now in reference to human pathology I would venture to suggest that although we have arrived at the crude fact—a very important one—that bacilli are present in many more or less specific forms of disease, we as yet know but little as to the possibilities of their intimate relations with the tissues in which they dwell. It may be that they are often present in a sort of symbiotic relationship and without evoking any obvious disturbance of nutrition. It may be that they are only liable to be excited into states of disease-producing activity by influences which are by no means universally present. Thus the bacillus lepræ may possibly have been present quietly in the tissues of the subject of leprosy for years, awaiting the stimulus of salt-fish diet to rouse it into activity. There is nothing in the present condition of our knowledge to exclude the possibility that the dormant form may be one of considerable difference as regards size, &c., from that finally produced when it assumes activity and causes the phenomena of disease.

Some such conjecture as this seems to me essential in order to the explanation of inheritance, latency, and recurrence in reference to many specific forms of the inflammatory process. Those of scrofula, tuberculosis and leprosy are perhaps the most important, but we have others in erysipelas, elephantiasis, some forms of eczema, and possibly in psoriasis. It is even possible that the tertiary

stage of syphilis may depend upon the persistence of parasitic organisms which have passed into a symbiotic state of existence and are no longer capable of leaving the cell structures in which they dwell and of becoming infective to others. In order to explain the local origin of a gumma we must, I think, invoke the hypothesis of either a chemical or vital element which has been left behind in the tissues. There must have been some residuum which determines the peculiar type which the local inflammation or growth finally assumes. That residuum is incapable of originating a specific contagium which may be transferred to other persons or to other parts, but it is not incapable of causing cell-contagion in the affected part. Infection spreading by continuity of tissue is one of the best characteristics of the gumma, and it is more easy to explain it on a theory of symbiosis of living organism than by one of a chemical ptomaine. So also I think is the fact that tertiary gummata, however long may have been the interval between their formation and the original disease, and however complete the proof of their non-contagiousness, are still amenable to the influence of the specifics for syphilis, mercury and iodides.

It will, I know, be objected to all suggestions of symbiotic parasitism in human disease that they lack objective demonstration. To this I reply that the microscope has never yet shown us the organic element of syphilitic contagion, and that in a disease so definitely tuberculous as lupus erythematosus it has not as yet found a bacillus. We are merely on the threshold of our knowledge in these matters, and although I admit that what I have suggested is mainly conjectural, yet there is so much of *a priori* probability about it that I feel sure that it is worthy of our attentive consideration.

ON SUDDEN OCCLUSION OF ARTERIES BY COAGULATION.

REFERENCE has been repeatedly made in the pages of ARCHIVES to cases in which large arteries had become obliterated without obvious disease, and in some instances quite suddenly. In one of these a man in apparent health had fallen unconscious on his own hearth, and had on recovery remained hemiplegic with complete obliteration of the opposite carotid. He had also obliteration of one femoral. I have also asked attention to two valuable case-narratives, one by Sir William Gull and the other by Sir W. Savory, in which one or other of the large arteries of the neck were found (post mortem) to be quite obliterated. In one of these the opening of the innominate from the aortic arch was smoothed over and the vessel itself was a solid cord. In these cases there was no evidence of preceding arterial disease, nor was there any explanation forthcoming of the cause of the obliteration. One if not more of the patients was under middle age.

At the date of the above reports, and, indeed, until the other day, I was unaware of the existence of a most valuable paper from the pen of Dr. Dickinson in the St. George's Hospital Reports which supplies a sort of complement to them. In all my cases, and those which I quoted from others, the condition was of old standing and the account of the original symptoms somewhat imperfect. Dr. Dickenson deals with recent cases which had been treated in the wards of St. George's Hospital, and in which autopsies had been obtained. His facts go to establish the proposition that it is possible for the blood to coagulate almost suddenly in large arteries, and thus produce paralysis and obliteration of the vessel concerned and corresponding paralysis. It implies,

although this may be considered as less assured, that this coagulation may be quite independent of embolism and of disease of the walls of the vessel and of any special form of dyscrasia in the patient. The subject is one of so much novelty and importance that I must give abstracts of his cases.

In Case I. the whole length of the left internal carotid and all its branches, as far as they were traced, was filled by a black coagulum. Outside the skull the vessel was empty and natural. Nothing abnormal could be discovered in the walls of any of the cerebral vessels. There were no coagula in the heart or in other arteries, and no vegetations in the valves. The subject of the case was a coachman, aged 39, who until within twenty hours of his attack had been supposed to be in good health. He had fallen in a fit quite unconscious, and with foaming at the mouth, whilst in the act of hanging up his harness after having been out during the greater part of a June night. His symptoms, in addition to the unconsciousness, had been loss of sensition, motion and all reflex action in the right limbs, with slight ptosis on the left side. About an hour and a half before death there was an accession of symptoms, with slight convulsions and much foaming at the mouth, after which the breathing became stertorous. It should be added that the right lateral ventricle was full of fluid, whilst the left was empty. This, however, could have nothing to do with the hemiplegia, since it was on the same side.

This case is not unlike the one which I have recorded at page 36 of Vol. VII. The only differences are that in my case the patient survived, and that not only the internal but the common carotid was obliterated.

In Case II. the circumstances which preceded the attack were not known. The patient was forty-three years old and the mother of six children.

"The attack, which was the first that had occurred, was preceded by a feeling of giddiness. She only lived a few hours after her admission. There was no return of consciousness. The left side was palsied; the

right leg was frequently drawn up, and with her right hand she was for ever wiping and rubbing her face. She swallowed with difficulty. Before her death there was much foaming at the mouth."

The following is the account of the condition of the cerebral arteries:—

"The arteries at the base were obstructed in many places by recent coagula; these were most abundant in the right hemisphere; the end of the right internal carotid was filled by a plug an inch and a half in length, which was slightly attached to the wall of the vessel. The surface had become slightly decolorised. Many similar plugs were found in the smaller arteries. They were generally about an inch in length, and manifested a tendency to place themselves on the cardiac side of a bifurcation. The left posterior cerebral was one of the vessels affected. There was no difference in consistence between the two sides of the brain."

All the valves of the heart were the seat of fibroid thickening, and the mitral orifice was contracted to the size of a button-hole and quite rigid. There were, however, no vegetations or fibrinous concretions.

The subject of the third case was a young woman of 23, who had long been the subject of heart disease and was liable to attacks of vomiting. She was admitted into the hospital, and it was noted that her face was bluish and flushed and her pulse indistinct. She was, however, up and about. One morning, whilst washing her face, she became suddenly faint, and died quickly without having spoken. Dr. Dickinson writes: "Death was almost the first symptom" of the coagulation. "The patient must have expired almost on the instant of its formation." In this instance coagula had formed in both internal carotids. The plug on each side measured two inches in length, and extended from the bony canal up to the smaller divisions of the vessels. Many of the smaller vessels contained detached coagula. Outside the skull the internal carotids were empty, but on the right side the external carotid was plugged.

In the fourth case, a man aged 36, who had tramped from

Leeds in July weather, was seized by a fit on his arrival in London. There was partial paralysis of the left arm and inability to speak, although consciousness was not lost. He sank on the third day after his attack, having had a very rapid pulse, profuse sweating, and incontinence of urine. Long black coagula were drawn out of both carotid arteries from the base of the skull. They were not adherent. All the larger arteries at the base were similarly occupied, but the coagula were not quite continuous. The heart and arterial walls were healthy.

This case would appear to have been one not improbably of only partial obstruction. The clots were still loose, and did not fill the vessels. Some circulation still went on past them, and thus the patient escaped the sudden fate which occurred in the preceding one.

In the fifth case it was the basilar which was obstructed. A firm buff-coloured coagulum distended its whole length and also the adjoining quarter of an inch of the right vertebral. The clot was an inch and a half long, hard, and somewhat adherent to the walls of the vessel. It was more perfectly decolorised in its outside than in its centre. There were no coagula in other vessels and no trace of atheroma anywhere. The valves of the heart, especially the mitral, were thickened and leathery, but there were no vegetations. The other organs were healthy. Dr. Dickinson points out that a coagulum large enough to distend the basilar artery could not have passed upwards through either of the small vertebrals, but must have formed *in situ*.

The patient in this case was an intemperate carman aged 26. His first symptom had been giddiness, which began suddenly late one night. After this for two days he went to his work, but was eventually obliged to take to his bed. Four days later he suddenly lost his speech and had pins and needles in his right arm, followed by loss of power. He did not lose consciousness, but subsequently became delirious. His pulse became very rapid, and he died on the second day after admission and the ninth after his first symptom.

This very remarkable group of cases appears to afford conclusive proof that coagulation of the blood in the cerebral arteries may take place suddenly and independently of disease of their walls. In no one single instance was atheroma noted, and in none was there any indication of embolism. The occurrence indeed of coagulation simultaneously on both sides, and in one instance in the external carotid independently, put the probability of embolism out of question. In four out of the five cases—and this is a point to which Dr. Dickinson draws especial attention—the circulation was placed at disadvantage by the presence of obstructive disease in the central organ. In only one case was the heart free from disease, whilst in several the mitral orifice was very definitely contracted. In one, however (Case IV.), the heart was normal. This was the case in which the man was probably much exhausted by a long tramp in hot weather. In no single case is any suspicion of syphilis recorded, but indeed in the entire absence of evidence of disease of the arterial coats it is difficult to see how syphilis could contribute to the conditions under consideration.

Dr. Dickinson's paper refers only to the cerebral arteries. It is my wish to extend the conclusions deducible from his facts to the rest of the arterial system, and to suggest that what has been proved in the case of the intra-cranial vessels may occur in any of those of the limbs, and that it is not very infrequent. Naturally we do not get many opportunities for post-mortem demonstration in the case of the latter. It is only the vessels of the brain the sudden occlusion of which endangers life. Surgeons are, however, familiar with cases in which patients have experienced sudden pain in a limb, and that pain has been followed by peripheral gangrene and other symptoms of arterial obstruction. We have been accustomed to assume that these are instances of embolism or of occluding arteritis, but the not infrequent suddenness of onset would suggest coagulation of blood as a much more probable event.

During the last few months I have seen two such cases. In one the toes had become gangrenous, and in the other

there was sloughing of the skin of the leg. In the latter the femoral artery could not be felt, but in the other the obstruction was probably lower down. Both were remarkable for the suddenness with which the symptoms of obstruction had developed.

In amputations for gangrene it is not uncommon to find the arteries plugged. I remember well one in which the hand had suddenly passed into gangrene, and in which I found the brachial artery as high as the axilla stuffed with firm coagulum; and in several in amputation through the thigh, a similar condition in the femoral has come under my notice. Hitherto it has been the custom to regard arterial thrombosis under such circumstances as being probably secondary to other changes, but in the light of present facts it may reasonably be suggested that it is primary.

In strong contrast with what usually occurs in syphilitic occlusion of arteries we have in these cases a remarkably sudden onset. In the syphilitic cases the obstruction is commonly somewhat slowly produced outside the vessel, and if thrombosis finally occurs it is usually consecutive. In the present group there is no external obstruction, and there are no premonitory symptoms.

Left Hemiplegia occurring suddenly in the night in a healthy man who had suffered from Syphilis twenty years previously—Diagnosis Arterial Thrombosis not due to Syphilis.

In the following case, a year after the attack the loss of muscular power is still almost absolute in the hand and foot, and much less so in the face, thigh, and upper arm. Thus the man can walk but cannot move his toes, and can to some slight extent move his upper arm and bend his elbow, whilst he cannot stir a finger. As regards his facial muscles he can both frown and close his eye, but cannot whistle, and his mouth is drawn to the opposite side. He has control over his sphincters, and can protrude his tongue straight. In all these points his case conforms, I believe, to what is usual in patients recovering from almost complete

hemiplegia. His account of the seizure which produced the paralysis is that exactly a year ago, when he was feeling quite well and was wholly free from discomfort in his head, he one night went to bed as well as usual, but half tipsy. He woke at his usual time with a call to make water, and on attempting to get out of bed found that he could not use the left limbs. He was quite alone. He could not speak, and had no alternative but to lie still till his housekeeper came to know why he did not get up. He was then obliged to make signs for his pencil, for he could not articulate. He was perfectly conscious and wrote a request to fetch a certain doctor. After this he remained in bed three months. During that time he had constipation, but no trouble with his bladder. His face was, he says, so completely paralysed on the left side that he could not move it, and his tongue was pushed over to the left side so strongly that he frequently bit it.

On the day following the attack he began to be able to speak, but it was only very indistinctly. During the next six months his speech continued gradually to improve, and he can at the present date talk well if he does so deliberately.

This case appears much more like one of sudden thrombosis than of hæmorrhage. I do not see any reason to suppose that the previous syphilis had anything to do with it. Neither before or since were any indications of syphilis present.

I have recently seen another very similar case as regards the suddenness of the attack. The patient was in the second year of syphilis. Death followed after about ten days of hemiplegia, with intervening symptoms not unlike delirium tremens. As we did not get a post mortem it is not worth while to record details.

THE SEQUEL OF A CASE OF OPHTHALMOPLEGIA.

By the courtesy of Dr. E. J. Cross, of St. Neots, I have just been supplied with the details respecting the death of a patient whose case I had recorded in 1878. B. B—— was the subject of Case VII. in my original paper on Ophthalmoplegia Externa in the Medico-Chirurgical Transactions (see vol. lxii. page 15). He had then recovered under iodides from almost complete paraplegia after syphilis, and was at that date slowly improving under similar measures as regards the partial paralysis of the muscles of his eyeballs.

The case is of importance as an example of complete recovery, without relapse, in the first place from paraplegia, and, secondly, from ocular conditions which more usually prove aggressive. He took pills containing a third of a grain of calomel three times a day, with iodide of potassium in scruple doses for, I believe, at least two years. From 1878 to 1895 he enjoyed good health, and had no tendency to relapse. In the latter year he had, in addition to considerable dyspepsia, some return of diplopia, and again on his own responsibility took iodides. His death was attended by symptoms which might not improbably indicate an abscess in connection with the gall bladder. There was slight jaundice and clayey stools, and finally sudden profuse vomiting of foul fluid. The symptoms were suggestive rather of an abscess which had given way into the stomach than of any form of syphilitic disease. Unfortunately there was no autopsy.

Schedule of the Case of Mr. B. B——.

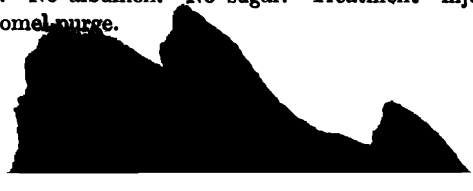
DATE.	AGE.	DETAILS.
1869	26	Syphilis complete. No record of treatment.
1870	27	
1871	28	
1872	29	
1873	30	Threatened paraplegia, and for a time confined to bed.
1874	31	Recovered under iodides, &c.
1875	32	Paresis of ocular muscles. Ptosis and diplopia.
1876	33	Under my observation with ophthalmoplegia externa.
1877	34	Still under treatment (mercury and iodides).
1878	35	In January attended at Med. Chir. Society.
1879	36	Well.
1880	37	
1881	38	
1882	39	
1883	40	
1884	41	
1885	42	
1886	43	
1887	44	In good health. Married. In constant occupation as a butler.
1888	45	
1889	46	
1890	47	
1891	48	
1892	49	
1893	50	
1894	51	Dyspepsia and flatulence.
1895	52	Died on August 17th. Abscess about gall bladder?

The following details as to his fatal illness have been supplied by Mr. Cross:—

"*Present illness* (August, 1895).—For the last two years he has had pain in the stomach, a great deal of flatulence and some indigestion; has noticed that he has been getting gradually larger round the waist. Two months ago he noticed that he began to see double again, and had an old prescription of Mr. Hutchinson's made up, and now he sees quite well again.

On examination.—A well-nourished (fat) man, complaining of intense pain over region of liver, which is considerably enlarged and very tender. A distinct lump may be felt at the level of the umbilicus, and about two inches to the right of it. Tongue furred. Bowels constipated. Conjunctivæ slightly yellow. Temperature 100°.

Urine.—Acid 1020. No albumen. No sugar. Treatment—injection of morphia and a calomel purge.



August 9th.—Pain much easier. Has had a fairly comfortable night. Bowels open twice. Motions clay-coloured.

August 10th.—Rather more comfortable.

August 11th.—Abdomen less distended. The lump is not nearly so distinct nor so tender. Temperature 100°.

August 12–14th.—Much the same. Fairly free from pain.

August 15th.—Rather more pain. Bowels not open since 12th. A calomel purge.

August 16th.—Diarrhœa very profuse.

August 17th.—Sickness has come on. About 12.30 patient raised himself, vomited about three pints of very foul fluid, and expired almost instantly. (I was present at the time.)"

From this narrative of the symptoms which attended the fatal illness, there does not appear any reason to suspect syphilitic mischief. A gumma would have developed much more quietly. The symptoms were those of an acute inflammatory process, and the matters vomited were most likely the contents of an abscess. I have recently seen two cases illustrating similar conditions. In one a lady vomited the contents of a very large swelling which had formed in connection with the stomach or liver, and nearly died at the time. In the other a man who was extremely ill with symptoms supposed to denote suppuration in the liver was found at an operation to have a large abscess containing grumous fluid behind the liver. It was on the point of giving way into the peritoneum.

ON THE NATURE OF GUMMATA.

It is very necessary in order to a clear understanding of tertiary syphilis that we should know what we mean by a gumma. This word, which has come down to us from very ancient times, was, I believe, originally applied to a soft, indolent swelling occurring in association with a syphilitic taint. More recently its meaning has been somewhat extended, and it has been recognised that a gummatous process may be present although little or nothing that can be called a tumour is ever produced. It would perhaps assist our comprehension of the matter if we were to speak rather of "the gummatous process" than of a gumma. Under that term we should include all forms of chronic inflammation attended by chronic swelling, and tending to break down, which occur in connection with a syphilitic taint. I do not know that we gain much by calling a gumma a "granulation tumour," it is rather a somewhat peculiar form of chronic inflammation. Its peculiarities consist in an indolent character, a tendency to produce swelling, and but little liability to suppurate. A gumma may break down and soften, or it may slough, but it does not as a rule form an abscess containing pus. We must not, however, push these distinctions too far. Between syphilitic inflammations in which the swelling is from the first attended by considerable increase in vascularity and in which there is a decided tendency to suppurative ulceration, if not to the formation of a circumscribed abscess, and the more characteristic gummata, we have all gradations. As a rule, however, gummata resemble new growths rather than inflammations in that they are not very vascular, are not very painful, and are in all stages slow and indolent. The cellular tissue is probably the invariable site of the gumma-

tous process. An indurated chancre is an example of one form of gumma. The lumps which sometimes form in the substance of the tongue or in other muscles, and which are sometimes very hard and closely resemble new growths, are our best examples of tertiary gummata.

Just as definitely as primary indurations melt away under the influence of mercury, so do these muscular gummata under that of the iodide of potassium. It is, indeed, this easy amenability to specifics which chiefly distinguishes these "tumour-gummata" from independent new growths. When a gumma breaks down there is often disclosed a sloughy mass of cellular tissue, and when this separates, which it does very slowly if specifics have not been efficiently used, an unhealthy base will be exposed, and there will be a tendency to peripheral spreading, with induration of the walls which may constitute a very close resemblance to cancer. There are few more difficult problems in diagnosis than to distinguish certain forms of open gummata of the tongue from cancerous sores. The degree and quality of the induration, and frequently the flabby state of the overhanging borders, are amongst the most useful signs.

Something of the gummatous process probably attends many forms of syphilitic inflammation which yet do not earn the name of gumma. Such, for instance, are many examples of syphilitic lupus and of the ulcerative destruction of the soft palate and adjacent parts which occur in the tertiary stage. In these the tissues inflame and ulcerate before any appreciable tumour has formed. The chronic infective inflammations of the subcutaneous cellular tissue, which ulcerate to a slight extent whilst they undermine widely, are also gummata. These are often seen about the knee in women. Some of these subcutaneous gummata are often very like sarcomatous growths. A very remarkable illustration of this is recorded at Vol. VIII. p. 221. In this instance a tumour gumma, which had been once cured by iodides, relapsed, and was (by another surgeon) excised as a new growth. It relapsed again and was again cured by iodides.

The gummatous process is certainly attended by the development of cell elements which are infective. Whether

ulcerated or not, gummata tend to spread by "the contagion of continuity." They need to be destroyed just as do cancers. The least bit of gummatous tissue left living will reproduce the whole thing. On the other hand, if once a sound scar have replaced the gumma in every part there is but very slight risk of relapse.

Gummata are very rare in the secondary stage of syphilis, and the longer the interval since the primary disease the greater is the probability that the peculiar features of a gumma-tumour will be well shown. Under these conditions they are to be regarded as local, just in the same sense as a cancer is local. They differ, however, from cancer in having no power of infection, either to the lymphatic system or the blood. Their infection is, like that of the rodent ulcer, limited to the tissues in continuity with them. In these, however, it is often very strong, and repeated recurrences after partially successful treatment will be witnessed.

The treatment of gummata should be based, as just hinted, upon the same principle as that of malignant new growths. They should be utterly destroyed. Fortunately it is not needful to excise them. Their vitality is low and is easily influenced by several different remedies. The local use of iodoform will often remove those which are sufficiently superficial to give it adequate access. Iodide of potassium reaching them through the blood will have the same effect. An attack of acute adventitious inflammation artificially induced, as for instance by a free application of nitric acid, will often succeed, and that even when the internal use of the iodide has partially failed.

The important point to bear in mind is that every particle of the morbid tissue must have been brought into a normal condition, or the process will be reinitiated. There is no more tendency to the spontaneous cure of tertiary gummata than there is to that of cancers. In some desperate cases scraping, excision, or even amputation of the part may become desirable.

As regards the theory of tertiary gummata, they are, I think, clearly residual in their nature. Something has been

left behind in the tissues from the date of the secondary or blood phenomena which originates these peculiar forms of cell-growth. It does not seem probable that the "something" is of a merely chemical nature. If it were so its action would probably be more widely manifested. I incline rather to suspect that a process of the nature of symbiosis must be taken into account, and that in a state of modified vitality the specific germs of the syphilitic fever must be regarded as having entered into a life-partnership with the cell-structures of the part concerned. There are plenty of collateral facts in pathology to justify such an hypothesis. It would also explain what the chemical theory would fail to do, the fact that a drug which certainly possesses some power over the inflammations of secondary syphilis is also a specific for these, and further that their type is often remarkably like that of the primary sore.

One of perhaps the very best illustrations of the gummatous process is to be met with in the "recurred chancre." Here we may have, after the lapse of many years, during which the part has appeared to be in a state of perfect health, a new induration form of large size, and exactly like a primary Hunterian sore. The chief difference is, that whilst the one begins by an ulcer which indurates, the other begins as an induration which ulcerates. These gummata are almost always exactly in the site of the original sore. They are not contagious to other persons, nor do they infect the lymphatic glands or the blood of the patient himself.

CASES ILLUSTRATING RECURRING HERPES OF THE MOUTH, TONGUE, &c.

THE Herpetic group of affections assumes year by year increasing importance. More and more clearly do we accept, in all that we name as "herpes," illustrations of what the nervous system can effect in inducing local pathological changes, and in proportion as we perceive this does our interest increase in the examination of the facts. Herpes zoster and herpes labialis still remain for us, as they were for our ancestors, the two type forms; the one of the single attack, the other of the frequently recurring form. We recognise, however, a number of eruptions which do not conform closely to the ordinary laws of either of these, and which yet clearly belong to the group Herpes. Thus we have cases in which a zoster form is frequently recurrent, and we have cases in which the labialis form recurs so quickly that it is almost persistent. We have also certain generalised eruptions on the whole body, or large parts of it, which appear to partake of the herpetic type, but which sometimes approach so closely to pemphigus that we are puzzled how to classify them. An unexpected observation has also recently accrued, to the effect that certain forms of severe pemphigus of the limbs and trunk are preceded by months, or it may be years, of liability to recurring herpes in the mouth.

The collection of cases which I now propose to record will comprise illustrations of many of the more infrequent forms of Herpes. In the first place, however, I purpose to deal with those just alluded to in which severe, and frequently recurring, attacks occur, affecting the mucous membrane of the mouth. It is not all of these that end in pemphigus; or perhaps it would be safer to say—since the

development period may occupy several years—it is not in all that the pemphigus stage is attained. It is, however, a matter of great importance to determine, if possible, what the nature of the relationship between the two really is. The cases which I have now to record are remarkable examples of herpes of mouth without pemphigus of the body, but in former papers I have given several of the latter class. Thus in the case of so-called pemphigus vegetans, given at a former page (Mr. S——), a liability to herpes of the mouth, frequently recurring, had been present six years before the pemphigus was developed on the skin (Vol. VIII., page 130).

In the case of Miss L——, given at page 333, liability to herpetic sores in the mouth had preceded by one year the appearance of pemphigus on the body.

The conditions presented in these cases of severe and almost persisting herpes of the mouth so closely resemble those of syphilis, that in almost all cases they are at one or other period so diagnosed and so treated. This occurred in my first case of "Inflamed mouth with eruption," published in the Medico-Chirurgical Transactions, and has happened in almost all examples of "pemphigus vegetans." It will be convenient, therefore, if I first deal with this part of the subject.

ON THE LIABILITY TO MISTAKE RECURRING HERPES INSIDE THE MOUTH FOR SYPHILIS.

Herpes of the Mouth recurring with increasing frequency during fifteen years—No previous Syphilis.

As I have said, the diagnosis of herpes of the mouth is important on account of the risk of those not familiar with the malady mistaking it for syphilis. The mistake is indeed one of very frequent occurrence. It is especially likely to happen in cases where the patient has really had syphilis, for in such cases the patient himself abets the error. In some sense such cases are perhaps syphilitic, but, like recurrent herpes on the penis after chancres, they are not

to be cured by mercury or iodides, but by arsenic. Occasionally, however, we may encounter recurring herpes of the mouth in which there has been no antecedent syphilis whatever. Of this the following is an example.

In 1889 Dr. Daly, of Amherst Road, sent to me a gentleman of thirty-two, who was in excellent health, had a healthy child, and who declared that he had never in his life had a chancre. He showed me inside each cheek one or two oval, greyish, superficial ulcers, and along the right side of his tongue several little similar spots which were all but healed. He said that they were going away, and the result of his experience was that they would be gone in the course of another week. The spots on the cheeks were exactly like what are generally believed to be characteristic of syphilis. He assured me that he was liable to them, and had been so for fifteen years past. They had of late so much increased in severity and frequency that he was scarcely ever free from them. He was quite clear, however, in his statement that no individual spots lasted long; in a week or ten days they would heal, and others would come. With these facts the diagnosis of herpes was clear.

The diagnosis being made, I was interested in examining the facts as to the history in a little more detail. Mr. F—— told me that he had never had the eruption on his lips, and he did not think that as a boy he had been liable to it there. It had always come on the insides of his cheeks and sides of his tongue. Sometimes it would be restricted to one side, and sometimes to the other, and sometimes, as on the occasion when I saw him, it would be on both sides at the same time. As far as he could remember, when he first became liable to it, ten or fifteen years ago, it was a slight matter, and did not come very often. His first attack occurred after a visit to the seaside, and after he had bathed on a cold morning. His tongue and cheeks became covered with sores, and the former much swollen. He was for the first time obliged to consult a medical man, and placed himself under the care of a very intelligent friend of my own, who quite refused to believe his story that he had never had syphilis. The attack, however, passed quite away in the course of ten

days. This was in July, 1888, and he did not have another severe one until October of the same year, when he was obliged to place himself under the care of Dr. Daly. Since that to the present time, March, 1889, he had never been free for more than a week or two together. He had not been able to trace the attacks to the influence of any article of food, or to any special derangement of health. He always, he said, felt chilly and creepy before they occurred, and during the last six months he thought that he had felt a little nervous and low. He still, however, had the appearance of excellent health. Since October, the almost constant soreness of his mouth had compelled him to desist from smoking.

In June, 1890, he was very much better, after having taken arsenic quite regularly for a whole year. Although he was never more than a few days without the herpes, yet it was not nearly so severe as formerly. I found on examination only a single sore on the right side of the tongue, near the tip.

Recurring Herpes of the Palate—No Syphilis—Arsenic given —Immunity from the Herpes of Palate—Very severe Zoster from the Arsenic.

Captain C——, aged 50, formerly accustomed to go to sea, but for six years residing on land, consulted me in June, 1883, on account of liability to herpes in the mouth. He was in excellent health, and had never had syphilis. For the last two years he had been liable to attacks of herpes on his palate once every month or two; they had often been slight ones, but on the present occasion it was very severe; his whole palate was covered with little ulcers, which also extended down the sides, and he was hoarse to a degree which suggested some implication of the larynx. The attack had lasted two weeks, and was now passing off. I could find no cause for his liability excepting that he had some bad teeth. For the prevention of his attacks I ordered, as usual, arsenic. He took the liquor sodæ arseniatis m. iii three times a day from June 14th to August 23rd, and had complete immunity during that time. Six weeks from the

beginning of the arsenic, however, he had a very severe outbreak of zoster in the lower dorsal region; the spots were gangrenous, and when I saw him three weeks later they had not quite healed. On account of the shingles he left off the arsenic for about three weeks, but afterwards resumed it. He subsequently became again liable, although continuing it, to recurring attacks on the pillars of the fauces, but they were on a much more limited scale and did not last long. On September 22nd of the same year I saw him for a slight attack of this nature. I advised him to continue the arsenic, and I believe that he subsequently got quite well.

Recurring Herpes in the Mouth—No Syphilis—Resistance to Arsenical treatment.

The case of Mrs. W—— is an example of great distress caused by the very frequent recurrence of herpes in the mouth. It is also, I am sorry to say, an instance in which arsenic did not cure. She came under my observation on June 2, 1890. She was a married lady of fifty, and had suffered from acne rosacea on the face. Her chief trouble was, however, that for several years she had been liable to recurring herpes on her tongue and lips. The attacks came so frequently that the sores had scarcely time to heal in their intervals. She said that the individual spots were always well in two or three days, but that fresh crops came every few weeks. It appeared that they were seldom non-symmetrical, but on the day when she came to me the right side of the tongue and the right side of the lower lip were the only parts affected. I ordered her liquor arsenicalis in two-minim doses three times a day, and gave her a sulphur wash for her acne. She came to me again six months later, February 10, 1891, with her face very much better, and stating that she had had very few and very slight attacks of herpes. She was much pleased with the result, and I thought that by persevering with the arsenic it would prove a cure. She came again, however, on February 13th, saying that her herpes had recurred, and that she was now scarcely ever free from it. It made her mouth so sore that

she often could scarcely eat, and was obliged to keep to fluids. She assured me that she had taken the medicine steadily. The usual position for the herpes spots was on the sides of the tongue and near to the frænum. She thought that as a rule both sides were affected at the same time. At the time of her visit to me there was a single large and much inflamed sore on the inner side of her lower lip. She complained much of feeling out of tone, saying that she could not give attention to things and could not remember. It appeared possible that some of the benefit in the previous autumn had been in connection with the visit to Wales. I advised that she should increase her dose of arsenic and get another change of air. I do not know the ultimate result. There was no reason whatever to suspect syphilis.

Herpes of the Mouth recurring with extreme frequency and following Neuralgia—No Syphilis.

In the following narrative we have an example of recurring herpes consequent, in all probability, upon persisting disease of the nerve centre. It had been preceded by severe neuralgia. The patient, an old woman of sixty, was sent to me by Mr. Waren Tay on February 1, 1872, when the notes were taken which are subjoined.

The attacks recur so frequently that she is seldom quite free. Its present stage is, she says, the best that it ever gets into. She expects that in a few days a new "crop of blisters" will make their appearance. At present she has merely a number of superficial ulcers, most of them of oval form; some are three-quarters of an inch long, others smaller. They occur in the inside of left cheek, upon both sides of hard palate, and upon the front gums. On the hard palate and front gums they are placed almost symmetrically, but there are none whatever in the right cheek. Some of them are distinctly pellicular, and from one I peeled a membrane three-quarters of an inch long and a third broad, firm and coherent. It left a clean red surface which bled slightly.

She is a stout old woman of six[illegible] nearly two years

since the eruption first came. It first showed itself on the left gums, and in the cheek and on the tongue. At first she used to have intervals of two or three weeks, much longer than she now has. She had been liable to neuralgia in the face, always on the left side, for many years. Since the eruption appeared she has had less neuralgia. Never had shingles; never any eruption on cheeks or lips. The pellicular character of the eruption is a very marked feature.

In this case, as in the preceding, I lost sight of the patient. Both were cases in which there was much reason to fear that the herpes might prove introductory to pemphigus.

Recurring Herpes of the Throat—Intervals very brief—Remote history of Syphilis.

The case of a gentleman aged 63, named S——, afforded a good example of recurring herpes of the palate. He consulted me in July, 1886, on account of sore throats, which constantly varied in severity, but hardly ever left him. He had been liable to them for three years, and before that he had had what he described as an abscess in the root of the tongue. His first attack of herpetic throat was the worst that he had had, and occurred at Cape Town. He was then a week in bed. Mr. S—— had lived much abroad, and had in a general way enjoyed good health. He had been told that his throats were syphilitic, and was curiously anxious to believe them so. His syphilis had occurred, however, at the age of twenty-one; he had never since had any reminders, and his children were in sound health.

My next case is a very important one, and must be given in detail.

A very severe case of Recurring Herpes of the Mouth, Lips, and Tongue—Suspicion of Syphilis, but no other symptoms—Temporary benefit from Arsenic but relapses.

Mr. T—— consulted me on account of a liability to herpes, which had persisted for four years. The eruption came out symmetrically on the tongue and lips. I pre-

scribed arsenic, and under its influence he became for a time quite free from the attacks, and gained a stone in weight. I asked him to write me out the details of his illness, and the following are his notes :—

"*February* 5, 1889.—A little over four years ago I first remember the ulcers on my tongue and throat. The ulcers would disappear after taking medicine, and reappear again about every two months. I was under this treatment for two years, when my medical attendant was also treating my wife for ulcerated womb, and he said that my ulcers were caused by my wife being in that state. He changed my physic, but still ulcers came. He ordered me away on the moors, but had to come home again, as old complaint came on more severe. I then consulted one of the leading allopathic physicians; he also said it was liver complaint, and he treated me for twelve months, but to no purpose. I then went to another physician, and he examined me and pronounced it to be syphilis. Treated me for same for fourteen months. I have continuously taken the medicine, and have been most careful in my mode of living. But still the ulcers came on about every four or six weeks, would stay about a week, and then disappear gradually. During the period of my mouth being bad I always lose my appetite, and am unable to put anything inside my mouth except liquids, as the tongue is so sore I cannot bear it. I also lose from seven to ten pounds in weight every time I have an attack, but when I get well I pick up the weight again, and am as well as ever. Until lately I have always had a slight thin running from the nose of the influenza kind accompanying my mouth. I generally get an irritable itching all round the bag of the testicles a few days before my mouth gets bad. Since taking the iod. pot. and mercury the attacks have not been so severe as they were before, neither have the ulcers remained as long on my tongue. The itching of my testicles has always been an attending symptom of a recurrence of my tongue. I always lose the saliva from mouth at these periods, and my tongue and mouth get parched and dry. I have been very ill two summers running, and have taken a trip to Jersey for fourteen days, and have come back thoroughly well, and generally remained well for twice the length of period to what I do when at home. A friend of mine at Christmas (a medical man) told me to discontinue taking the last physic, as he said I was not suffering from syphilis. He has treated me for disordered stomach, and I have been worse since then, having had two attacks in a month, and being very bad each time. If I have a cold when I am bad it thoroughly upsets me, and makes me feel very ill. Of all the physic I have taken, I have felt better when well when taking the kind prescribed for syphilis. It has driven spots out all over my face, and greatly disfigured me. When well I am generally very windy, wind sometimes belching up from the stomach, other times passing freely

through the bowels. But when I am bad this disappears, and I get more costive."

When I first saw Mr. T——'s lips I made not the slightest doubt that it was a case of syphilis. His tongue showed a number of red abrasions scattered on its surface, and there were some also under its tip. His lips on their inner aspect showed many sores, which, although quite superficial, were much inflamed. Some similar ones were seen on looking into the pouches of his cheeks. I had rather hastily told him that it must be syphilitic, when he at once led me in a different direction by saying that he had had it over and over again, and that he expected it to get well of itself. He said that he had already had much advice about it, and that some had assured him it was syphilitic, others not. On inquiry there did not appear to be much reason to suspect that he had had syphilis. I may briefly state that his history pointed to the conclusion that the disease was recurring herpes, and that it probably had no connection with syphilis. I sent him to Mr. Burgess to have a sketch taken. This sketch does not show the disease in its early stage, but only the condition of the ulceration left nearly a fortnight after the outbreak. There was nothing at that time distinctive of herpes; in fact, as just said, the abrasions looked like those of secondary syphilis. The portrait was taken at the College of Surgeons on Monday, February 4th; and on Wednesday, the 6th, there was no trace remaining of the sores on his tongue, and little or nothing of those on his lips. I had some difficulty in believing that he was the same patient. The following are some of the particulars as regards his history.

It was four years since his first attack. It used at first to come on the back of the throat, and was referred to the drains by his medical man. At first it used to recur every two months, but of late every month. He was accustomed to experience itching on the penis for a day or two before the herpes showed itself. He had seen several physicians in Plymouth, and had different opinions given him. One thought it syphilitic, and gave iodide of potassium and liq.

hydr. bichloridi, which he took regularly for fourteen months with bark. He thought his health better under this treatment, but the herpes still returned. He nearly always had a sort of influenza cold, and felt chilly, especially down his back, when the herpes was coming. The attacks were attended by temporary dryness of the mouth, and it became dry and parched. He had had much eruption, but it appeared to have been due to the iodide. He was rather thin and pale, and he counted each attack as causing a loss of half a stone weight, which he regains in their intervals.

Six months later I received by letter the following report. I had, of course, prescribed arsenic.

"DEAR SIR,—On the 4th day of February I came to London to see you about a very obstinate ulcerated tongue, which I had been suffering from for four years. Perhaps you will remember sending me to the Royal College of Surgeons to have my tongue and lips sketched. You at first sight thought it syphilis, but afterwards said it was not so, and gave me a prescription. I have been taking the medicine regularly ever since, and I am pleased to tell you I have not had any serious return of my old complaint. Last week I had one ulcer on my tongue, which I attribute to my smoking cigars. I have felt so well that I smoked a little too much, which I think brought on the ulcer, but having put aside the smoking, the ulcer soon disappeared. I have regained my usual weight, 140 lbs. (which is 11 lbs. heavier than when I saw you), and am well in every respect. It is now over three months, and before your treatment I never went longer than a month or six weeks."

After this, Mr. T—— once came up to see me and I found his mouth well, and he was much pleased with his almost complete immunity.

In July, 1893, not having seen or heard anything of my patient for two years, I wrote asking for a report. The following letter was received :—

"*July* 21, 1893.

"MY DEAR SIR,—In reply to yours of yesterday respecting the sore mouth and tongue you treated me for in February, 1889, I beg to say that I frequently get relapses of same, but have not taken the medicine regularly for two years, and have only had one bottle since Christmas. I find a change of air does me most good. I was in London a month ago, and my tongue was very bad then, and I intended to have called upon you, but the day after I arrived I was so much better that I did not

call, but if you think I ought to see you when I am in town again I will call. I have never been free longer than three months at a time, but when I take the medicine it does me good again. If I catch cold the ulceration on mouth or tongue generally accompanies it."

After this letter I never saw the patient. In the present year, wishing to publish the case and having heard that the man was dead, I wrote to my friend Dr. Clay, of Plymouth, to ask if he could ascertain for me the subsequent history. Dr. Clay unexpectedly replied that the patient had originally been under his own care, and that he well remembered the case. He told me further that the man had lived intemperately, and that he had died of rupture of an œsophageal varix in connection with cirrhosis of the liver. Respecting the latter, Dr. Clay was good enough afterwards to procure for me full details, and these I shall make the subject of a separate notice. It will be convenient here to deal only with the herpes. Dr. Clay assured me that there were good reasons for believing that the man really had suffered from syphilis, and he thought that the sore mouth had at various times been benefited by specifics, especially iodides. We must therefore leave this question in some doubt. It remains quite certain that at the date of my being consulted there were no other indications of syphilis, that the stomatitis was herpetic in nature and prone to spontaneous cure, that specifics had not prevented it, and that arsenic did, for a time at least, most definitely restrain it. It is very possible that syphilis may have been a predisposing cause, for we know that it often takes that *rôle* in reference to recurring herpes. At the same time it is quite clear that the herpes of the mouth was not syphilitic in the sense of being amenable to anti-syphilitic treatment, and that it did conform closely to the type displayed in other cases in which specific history is wholly absent. It must also be left an open question whether the patient's habits as regards alcohol had exercised any influence in aggravating his herpes. He had not, so far as I observed, any of the usual indications either of intemperance or liver disease. It is to be observed, however, that a period of six years elapsed between the date of my seeing him and his death.

He appeared, when he called on me, to be in good health, excepting his liability to sore mouth, and he so considered himself.

My next two cases are examples of recurring herpes of the pharynx, but were probably in more close connection with syphilis than any of the preceding.

Persisting but variable Eruption in the third year of Syphilis —Repeated attacks of Herpes on Penis and in Throat.

Mr. M——, a young man of florid complexion and good health, had chancres two years ago. A year later he had a gonorrhœa. I saw him for the first time on April 19, 1891. He had then herpes on the under surface of his prepuce, some spots like herpes on his soft palate and tonsils, and an eruption of ill-defined and inconspicuous yellowish-brown stains on his thighs. A few of the latter stains occurred on other parts of his skin and body. He told me that they were liable to come and go, and that he thought their increase generally preceded an attack of herpes in the prepuce. He had been taking mercury in pills for the last six months, and could not get rid of the liability to his herpes, nor of the sore throat and the blotches on the skin. His gonorrhœa had for long been quite well, and there was no tendency to recurrence of his chancre, nor any enlargement of lymphatic glands. The herpes on his prepuce was quite definite, and he described his attacks as occurring about once a month. The eruption on his thighs, although much worse at some times than others, never quite disappeared. It consisted of patches which were not abruptly margined but of rather oval form, and were little more than yellow stains. He was very confident in his statement that this rash varied in severity with his preputial herpes. Concerning the latter he volunteered the statement that it was sure to come out after a nocturnal emission.

I was interested in the speculation as to whether in this case the whole of the phenomena were of herpetic or, in other words, of neurotic nature. It was certain that the

long-continued use of mercury had not cured it. That part of them were herpetic there could not be the slightest doubt.

Epilepsy eighteen months after Syphilis—Recurring Herpes of Pharynx.

Mr. R. H. S——, a gentleman aged 34, had primary syphilis in May of 1888, for which he took mercury. Subsequently he had herpes of the pharynx, and several times after taking cold had sore throats, probably of an herpetic character. For these he was under my care in November of 1889, and he then gave me the history which chiefly makes his case of interest. He had been suffering, he said, from headache, and had had an epileptic fit. The fit occurred when he was in the water-closet. It came without warning, and was attended by tongue-biting. He had been feeling unwell for some little time previously. Thus his hands used to shake, and he had frequently a feeling of giddiness, and at other times of sleepiness. It will be seen that this fit occurred within eighteen months of the primary disease, and the question was whether it should be regarded as in connection with the syphilis. His syphilis had in the first instance not been very efficiently treated. I did not see him until seven months after the chancre, and he then still had his eruption out. The eruption quickly disappeared under the mercury which I ordered, but even whilst taking it he had a sharp attack of iritis in one eye. Of the latter he got quite well, and I did not see him for nearly six months, when he came with the history of his epileptic attack and headaches.

In the cases of herpetic pharyngitis which occur, not infrequently, soon after the secondary stage of syphilis, the vesicles are, I think, usually seen on one side only. In these cases recurrences not unfrequently occur, but the liability to them does not last very long. In such as those just quoted, in which the recurrences are very frequent and persist for many years, all tendency to unilateral development is, I believe, lost. It is seldom that any differ-

ence can be detected between the two sides, and if it be so it is seldom maintained in different attacks. These cases stand apart from those to which I have next to ask attention, in which groups of herpetic vesicles, like shingles on a small scale, recur repeatedly on or near to the same region of the skin. These cases occur in my experience almost always either on the face or neck or near to the buttocks. They are exceedingly rare on the limbs or on any part of the trunk. The subjects of recurring shingles on the face or neck are usually females and young children, and there is no association with syphilis. Those who have these attacks on the buttocks or upper part of thighs are, on the contrary, usually adult men who have suffered from syphilis. My next group will refer exclusively to the latter.

GROUP OF CASES IN WHICH HERPES RECURRED REPEATEDLY ON THE THIGH AND BUTTOCK.

Herpes recurring on the Thigh—Syphilis two years before.

Of this patient, Mr F——, my notes under date March, 1880, record:—He has had four attacks of herpes on the right buttock. He now shows me his fourth eruption, three long oval groups of abortive vesicles sloping down the buttock. He thinks that he feels rather ill whenever it comes, and the right leg feels weak and there is some tenderness in the inguinal region of right side. He never has herpes on the penis, and he never had ordinary shingles. His first attack of herpes was a year or more ago, and he has had three since last Christmas. He had syphilis two years ago.

Recurring Herpes on the Buttock, with history of former Shingles.

Dr. P——, aged 45, first consulted me in the spring of 1881. He had had half a dozen attacks of herpes on the right buttock during the preceding four months. As usual, I prescribed arsenic.

He told me that he had had a fearful attack of shingles

on the chest twenty years ago, and also herpes on penis several times.

In April, 1882, he reported that he had got rid of the herpes on leaving H——, but he had taken arsenic as well.

Herpes recurring on the Thigh.

The following letter from a surgeon in the country describes his own liability:—

"DEAR MR. HUTCHINSON,—Can you tell me what is the reason of my having two or three times a year one single patch of herpes on the outer and posterior side of right thigh, about two inches or so above the bend of the knee? It has come out pretty steadily two or three times every year for some years now, and I have taken no particular notice of it. Is it due to some local nerve influence? It is confined to the right thigh. During the intervals nothing is to be seen or felt. I should be glad of any hint or advice. I have the notes of your Lectures on Skin Diseases at Blackfriars, but don't find anything referring to my case."

Recurring Herpes on the same spot on the skin of Buttock.

The case of Sir H. M. T—— offers us another example of recurring herpes. He is a gentleman of forty years of age, in good general health, liable to gout. It is possible that he had syphilis many years ago, and it is certain that he has had gonorrhœa on many occasions. Formerly he was under the care of the late Sir William Gull on account of recurring herpes preputialis. His liability to this ceased after a long course of arsenic. His present trouble is the repeated recurrence of a patch of ordinary herpes, exactly like zoster, on the back of one buttock, midway between the crest of the ilium and the great trochanter. During the last three or four years he has had ten attacks, always in the same place. One for which he came to me on April 9, 1881, was, he said, the worst he had ever had. The patch was as large as a crown-piece and of oval form. As is, I think, usual with recurring herpes, the eruption seldom gives him much pain. He told me that its outbreak was usually attended by a sense of chilliness and general discomfort, as if he had caught a cold. On the present occasion it was accompanied by a distinct attack of nasal catarrh.

Recurring Herpes on Sacral Region and on Penis after doubtful Syphilis — Hyperæsthesia of whole back of Thigh—Ten years later tingling in skin of Lip, &c.

Dr. W—— came to me in September, 1877, on account of very troublesome herpes in the sacral region, which had recurred over and over again. The eruption usually came out on an area as large as the palm of a hand on the upper part of right buttock. It sometimes crossed the middle line in the cleft, but was always chiefly on the right side. It ran the usual course of herpes and subsided quickly, but recurred every two or three weeks. At the same time some herpes spots often came also on the penis, but this did not always happen.

Dr. W—— attributed his herpes to syphilis, but his history was not conclusive. Three years previously he had contracted a chancre. He described the sore as "punched out," and said that he was sure that it never hardened. It lasted only a fortnight, and he was assured by the surgeon whom he consulted that it would be followed by nothing. Six months later, however, he had a sore throat, and, three months later still, some eruption under each arm. At almost the same date he began to be liable to the attacks of herpes on the two parts mentioned.

I saw Dr. W—— again two years later, in July, 1879. He was then very anxious as to loco-motor ataxy, and consulted Dr. Hughlings Jackson also. He had suffered from vague pains in various parts and was still liable to herpes. He was now 28 years old. He told me that the outbreak of herpes occurred usually every six weeks, and that it was attended by hyperæsthesia of skin of buttock, extending down the back of thigh to knee (small sciatic). Sometimes the skin would be actually painful as well as over-sensitive, and now and then this hyperæsthetic state of skin would occur without any herpetic eruption. Respecting the latter, he said that it now occurred sometimes on one side of the coccyx and sometimes on the other, but never on both sides at the same time. He was rarely more than six weeks without it, but he did not now have it often on the penis. I did not find

any definite signs of ataxy. His pupils acted tolerably well.

Nearly ten years later still I again heard from Dr. W——. He wrote that he had got rid of his "lightning pains," that his herpes recurred much more seldom, and that his general health was better. He had, however, been recently troubled (May 31, 1887) by "a burning sensation which comes near the left angle of mouth and is followed by tingling of lips, especially of lower one, and of anterior part of tongue. These sensations used to pass away in about an hour, but the tingling is now nearly constant. Movement, articulation, taste, &c., are not affected."

I much regret that I cannot give the sequel to this case.

Recurring almost painless Herpes on the Buttock—No history of Syphilis—Patient chilly and catarrhal.

As another example of this recurring herpes on the buttocks, I may quote the case of a gentleman from Yorkshire, aged 37, who had been for three years liable to it. The patch of herpes always came exactly on the same place. It was on the back of the thigh, just beneath the middle of the fold of the nates. It usually occupied a space about as large as a child's palm. He thought that on an average his attacks had occurred once in three months, and, as is usual with recurring herpes, they were attended by very little pain. With one exception, the eruption had always disappeared quickly and healing had soon followed; but an attack which occurred in October, 1890, left sores which did not heal for some weeks. On the first occasion there was a good deal of smarting and pain, such as made him suspect he had been stung. During a stay of three months at Bournemouth, Mr. R—— had been quite free from his herpes. He attributed the attacks to catching cold, and said that he was a very chilly subject, liable to catarrh, and never well unless the weather was hot. He had never, either in youth or early life, suffered from herpes labialis. He had never had syphilis. He was a tall, thin man, very bilious, and liable to diarrhœa. In youth he had been cured

of lupus of the nose by Sir Erasmus Wilson. The cure was remarkably good, sound white scar remaining without any tendency to relapse.

Recurring Herpes on lower part of Abdomen—Remote Syphilis.

Mr. S—— tells me that in former years he was liable to herpes over the abdomen, on the root of the penis. It used to come very frequently. He had, I believe, had syphilis many years ago. He married six years ago, and since then has only had an attack of herpes once every one or two years. It almost ceased soon after his marriage. [January 9, 1891.]

(To be concluded.)

NOTES ON SYMPTOMS.

No. XXIX.—*The liability to Cramp after sleep.*

It is, I suppose, well known that the state of sleep predisposes to cramp in muscles. The exciting cause is probably always muscular action. Of all the muscles in the body the gastrocnemius is probably the one most prone to it. The usual time for its occurrence is just after waking in the morning. It may, however, in restless sleepers who move their limbs in bed, come on during sleep and put an end to it by the pain caused. Those liable to cramp in the calf must be very careful as to movements of their legs just after waking. When once the sleep state has passed off and the muscles are, so to speak, thoroughly awake, there is comparatively little risk of its coming on.

I was explaining the above to a patient who had suffered much from cramp, when he replied: "Yes, I have found that out for myself, and I am so determined to avoid bending my legs soon after waking, that I always take care that the bed clothes are not tucked in, so that I can slide out of bed feet first and so keep them straight."

No. XXX.—*Additional Notes on Horripilatio.*

"Creepy sensations," "A wave comes over me," "A wave runs down me,"—such are the expressions which our patients use to describe what is technically designated as Horripilatio. The phenomenon is so common, and under most circumstances of such slight import, that it is disregarded. Now and then, however, it may, either by the great frequency of its occurrence or the severity of the attacks,

rise to the dignity of a disease, and may in itself compel the attention of the patient and his adviser. Although allied in nature to what we know as a rigor, or shivering, horripilation is yet somewhat different. It concerns the skin, and in all probability its muscles, whilst in rigor there is arterial spasm. Spasmodic contraction of the muscular coats of the blood vessels is probably the essential cause of true shivering, whilst spasm of the arrectores pili is that of horripilation. The two are both nervous phenomena and often go together, but they may occur quite separately. At any rate horripilation may occur without any real shivering. It is perhaps less certain that shivering can occur without horripilation.

Some general remarks in description of horripilation will be found in Vol. VI. at page 3. In Vol. VIII. at page 311, I have referred to a case in which the symptoms had attained a high development. The patient spoke of his attacks as his "seizures." They were little more than momentary and from his description of his sensations it seemed probable that they were really of the nature of horripilation. It might be doubted, however, whether they should not have been considered as a form of *petit mal*, and this doubt suggests a further inquiry whether the phenomena of horripilation are in any degree allied to the epileptic state. The patient in the case to which I have just referred was a man of 50 who had had syphilis, and who had lived freely. His nervous system was undoubtedly damaged, and he had twice had attacks in which speech was temporarily lost, and had once been for a few minutes unconscious. His knee-jerks were excessive, but his pupils very sluggish. At the time that he was liable to the attacks of exaggerated horripilation, (or *petit mal?*) all the more serious symptoms were in abeyance. His attacks would, however, occur several times in a day. He described it as a sort of shiver, beginning at the head and running down to his legs, and attended by a creepy sensation. They were very quickly over, and were not attended by any loss of consciousness. His wife said that he always looked pale during them, and that his eyes, one or both, were drawn back into their sockets. I pre-

scribed quinine, mercury, and iodides, and under these remedies and a regimen of total abstinence from stimulants he got rid of the liability and improved in health. He returned after a time to a distant colony. I have heard that he has since had severe epileptic seizures.

By the side of this case I may place another which is very similar in some respects. Again I am puzzled what to name the attacks. Again the patient is a man who has had syphilis, and who has lived freely. He is at the present time liable to periostitis on the skull at various spots, and is obliged to take iodides for its relief. This patient complains of attacks which may occur at any time, and which are attended by creepy sensations and a feeling as if a wave were passing over him. I asked if the creeping ran down from his head to his feet. "No," he replied, "not when it is bad; it then always begins in my back and runs upwards to the head." He describes it as "a horrible sensation," but as always over in a few seconds and leaving no ill consequences. He always feels inclined to clutch hold of something, and although he never in the least degree loses consciousness, he feels as if he should do so, or, indeed, as if he might die. Under the use of iodide of potassium, in combination with nux vomica, the liability to these attacks has very much ceased.

It will not surprise me if some of my medical readers think that in the description which I have given there is nothing more than what is known as *petit mal*. If it be so, however, I feel sure that horripilation is an important element in that state. The wave-like creeping sensation in the skin was one of the feelings upon which both patients laid most stress. The entire absence of any disturbance of consciousness is also an important difference. The two cases given are examples of the symptoms in an exaggerated form. In minor grades, just what they mentioned is not unfrequent.

In the description of these cases, the phenomena being almost wholly subjective, we are dependent upon the intelligence and observing faculties of our patients. In each of the instances adduced, I had repeated opportunities for

listening to the statements made. I also requested the patients to notice their sensations as accurately as possible.

No. XXXI.—*Liability to pain in the Urethra, and also to Herpes on the Prepuce, and Proctalgia—Tabes suspected—Recovery under Arsenic and Tonics.*

In August of 1868 I saw a gentleman named G——, aged 38, who had in all probability suffered from syphilis eight years previously. He complained chiefly of recurring attacks of pain in the urethra. He had no stricture and no gleet. I thought that he might be liable to herpes in the urethra. He had, however, some other symptoms which suggested that possibly he was in an early stage of tabes. He was losing sexual appetite, and was liable to proctalgia after intercourse. He had also some backache, and his knee-jump was poor. Arsenic and nux vomica were prescribed. He had had definite attacks of herpes on the prepuce. From boyhood he had been the subject of the ordinary form of leucoderma over the whole trunk in patches.

In the following October he had, after a year's immunity, a severe attack of herpes on the prepuce. In all other respects he was better. After this he continued the arsenic for a year or more, and was free from symptoms.

In July of 1894, he came to me for another rather severe attack of herpes of the prepuce, with excoriation around the meatus. He was still liable to the attacks of pain and soreness in the urethra, but had been for a year quite free from external herpes. He was still, as he had always been, a healthy-looking man, and had no indications of syphilitic taint.

In February, 1898, ten years after my first consultation, he was brought to me again by his surgeon, Mr. Denton, of Brixton, on account of an outbreak of skin eruption of three months' duration. It had begun, he said, rather suddenly, by severe irritation after his morning bath, on one leg. The eruption was mixed on his legs, being in part pustular on his

legs, but on his back, over the sacrum, and on the sides of the abdomen it assumed the characters of lichen planus. There was, however, none on his wrists.

This visit afforded me an opportunity of inquiring as to his old symptoms as to herpes, tabes, &c. He said that he had been for some years almost wholly free from them, and in good health. He had taken a good deal of arsenic on and off, and believed that it usually prevented the recurrence of herpes. There was, however, no definite proof of this. He had been for a year, at least, quite free.

No. XXXII.—*Aggressive Pigment Patches on the Glans Penis and Prepuce.*

Repeated references have been made in ARCHIVES to the remarkable cases in which pigment-staining, of an aggressive form, is occasionally the prelude to malignant growth. In most of the cases which I have described, the disease was placed either on the eyelids or on the lips. I have, however, recorded other cases in which the same process occurred at the roots of nails, and in association with sarcomatous growths in the sole of the foot, and other parts. I have at present under observation a remarkable example of pigmentation of patches on the glans penis, and in the scar of a circumcision done thirty years ago. The patient is a man of 64, and the disease has been in progress three years. He was, in the first instance (two years ago), sent to me in the fear that the condition was malignant, but excepting increase of pigmentation, nothing further has been developed.

No. XXXIII.—*Herpetic Teethache and Deafness?*

Certain cases raise the interesting question as to whether there can be anything of the nature of herpetic inflammation of the pulps of the teeth. Also whether a nerve of special sense, such as the gustatory, can be attacked, and, if so, what are the consequences. We know already that the eyeball as a whole is often involved in herpes. In severe cases white atrophy of the optic disc may ensue. Great defect of sight,

unexplained by corneal opacity, is not very uncommon, and in at least one case I have had to excise an eyeball which was lost and painful after herpes. These cases prove, with many others, that herpetic affections of nutrition are by no means confined to skin and mucous membranes. There may easily be such a thing as herpetic loss of hearing.

No. XXXIV.—*Ptosis in a Boy—Recovery.*

We had one day about a year ago, a boy in whom ptosis had developed after an attack of headache and sickness, and in whom, as his father was the subject of lupus, a conjectural diagnosis of meningeal tuberculosis had been ventured. The case is described in the *Clinical Journal.* I advert to it now in order to record that the symptoms passed off, and that the boy is now at school again, and quite well.

No. XXXV.—*Pain in the Shin-bones—A Study of a Symptom.*

A gentleman has just been with me whose account was that he had been laid up for six weeks with pain in his shin-bones. He said that it had been most severe at night, and had kept him awake night after night until early morning, when he usually fell asleep. It had, however, never wholly left him either night or day. He described it as "just as if I had been severely kicked." He assured me that there had never been any swelling, nor, for the most part, any tenderness on pressure. He could always bear to have the bones tapped without any discomfort on the subcutaneous surface of the shin, but here and there on the edge there would be a spot upon which a tap would elicit sharp pain. I examined his legs, and found the shins quite clean. There was not the slightest evidence of periosteal thickening. A note which he brought me from his surgeon contained the following:—

"He had syphilis fifteen years ago, for which he was well treated. Ten years ago he was laid up with syphilitic rheumatism for seven weeks. For the last six weeks he has had pains in his tibiæ, chiefly at night, and of a boring character. I have regarded it as a syphilitic reminder, and have treated him with iodide of potassium in four-grain

doses three times a day. He is now improving, but we should be glad of your opinion."

It will be clear from the above statements that the diagnosis lay between an arthritic affection and syphilis. The pain had been in both shins, and without any swelling, and the patient assured me that it had begun in both almost together and almost suddenly. There had been no tenderness, only intolerable aching. Although it is true he had had syphilis, yet it was a long time ago, and he had for seven years or more been wholly free from reminders. So far against syphilis. In favour of gout were the following points: The patient's grandfather (paternal) had suffered from gout, and his own mother, in early life, had been through a severe attack of rheumatic fever. He himself from boyhood up had been liable to attacks of severe pain in his great toe joints, sometimes attended by redness and swelling. He had been a free beer-drinker all his life, and he had a pale but rather bloated face, suggestive of both beer and gout. For the symptoms described he had often had colchicum given. The attack which had been called syphilitic rheumatism ten years ago began, he said, very suddenly by most severe pain in one knee-joint, which was followed by inflammation of almost all his joints, and kept him in bed six weeks. There seemed no real reason for connecting it with his syphilis. It had been an ordinary attack of acute generalised rheumatic gout, with more of gout in it than rheumatism. Lastly, as to treatment, iodide of potassium had not relieved the pain in the shins in the definite way in which it usually does that of syphilitic periostitis. It is true, however, that some benefit had accrued, and that the doses had not been large. Again, however, it is further true that iodides will relieve the pains of arthritis as well as those of syphilis.

On the whole I was inclined to regard the attack of bone pain which he had just passed through as of a gouty rather than a syphilitic nature, and I prescribed quinine with colchicum and aconite, in addition to the iodides. The suspicion that it might prove the precursor of tabes did not escape me. If not better he must try mercury.

SELECTED CASES IN ILLUSTRATION OF INHERITED SYPHILIS.

(*Concluded from page 16.*)

No. XX. — *Details of a Syphilitic family, both parents having suffered.*

In the following case I had myself treated a husband and wife in the sixth year of their marriage for secondary syphilis. Both suffered severely, the wife especially so. She had a most acute attack of iritis. They continued in unrestrained cohabitation, and the following list furnished to me by their medical attendant shows the results. Prior to the syphilis three healthy children had been born. After it were as under :—

1st child, a boy, born whilst under treatment, lived six months. Contracted smallpox, which was followed by cancrum oris in cheek.

2nd child, a boy, born twenty months after the primary disease (premature seven months), lived five months; died (convulsions).

3rd child, a boy, born two years and seven months after (premature and stillborn).

4th child, a boy, born four years after (full time—stillborn).

5th child, a boy, born nearly six years after (full time and healthy) ; living now, in seventh year.

6th child, a boy, born about eight years after (full time) ; very strong and healthy.

7th child, a girl, about ten years after; strong and healthy now.

8th child, a girl, born twelve months ago; very strong and healthy.

In this instance, although both parents had suffered and the mother very severely, none of the children showed definite symptoms. We may, however, hold it as highly probable that those stillborn were tainted. By this calculation the disease may be supposed to have persisted in the mother with heritable potency for four years. After that she bore four strong and healthy children.

No. XXI.—*History of a Syphilitic family.* [*Notes taken June* 20, 1889.]

A Mr. L—— married eighteen months after syphilis. Six months after his marriage his wife complained of sore in the vagina, but nothing further was observed. She was confined within a year of her marriage, and her infant, a boy, had the usual train of syphilitic symptoms and recovered under the usual treatment. He was at that date aged 18, and to all appearance perfectly well. The next child, a boy, never showed any specific symptoms, nor did the third, a girl, although always delicate. The fourth, a boy, suffered severely, worse even than his eldest brother had done. He was brought to me for advice on June 20, 1889. He was eight years of age and suffered from a chronic form of interstitial keratitis. The eyes had been inflamed on and off for two years, in spite of much treatment, circumcision of the cornea, &c. He still had some superficial grey white deposits on both corneæ with some vascularity.

Three children younger than this boy had been born and were living. None of them had ever presented any symptoms. Both parents were apparently quite well.

Comments.—In this case probably the mother, who acquired her disease two years after the father, was the source of infection to their children. Hence its long persistence. The entire escape of the mother herself, as regards any obvious manifestations, is worthy of note, though not very unusual.

No. XXII.—*Primary Syphilis contracted during the late months of pregnancy—A mild attack in the infant—No constitutional symptoms in mother—The five following conceptions diseased—Mother apparently in good health.*

Mrs. T—— brought me an infant, aged three months, covered with a syphilitic papular rash, but well-grown and thriving. This was in December, 1866. My chief reason for relating the case is to illustrate the absence of relation between the severity of the symptoms in parents and offspring. Mrs. T—— herself appeared to be in robust health, and was a remarkably fine-looking woman. She had borne a large and healthy family. None of her infants before the present one had presented a single symptom. Her account made it probable that both she and her husband had suffered from primary syphilis just before her confinement. Her own symptoms had, however, been ill-marked. She had had a profuse discharge and much vaginal irritation, and after delivery a large bubo in one groin. The bubo did not break. She did not recollect any rash or sore throat, nor had she, when I saw her, a single symptom. Dr. Armstrong, of Gravesend, who had seen the infant, had told her the cause of its symptoms. I treated the child by mercury and it got quite well quickly.

In 1867 Mrs. T—— had a premature dead birth. She herself still remained in excellent health, and her husband, though delicate, was free from symptoms.

In December, 1868, Mrs. T—— brought another infant to me. It was two months old, and had a syphilitic rash on the neck, face, and buttocks. It improved rapidly under iodide of potassium and mercury. Mrs. T—— herself was florid and in vigorous health. She reported the child first treated to have remained quite well ever since and to be now "the picture of health."

I last saw Mrs. T——, for her fourth child, on February 21, 1870. The child, a girl, had been born healthy-looking; at the age of a month begun to snuffle, but did not till three months old show the rash. Her thighs, &c., were covered with eruption, and there was some also on her face. She

was much wasted. One child which I had not seen had died with severe symptoms.

It will be seen that in this instance both parents had suffered from primary disease. I do not know what treatment they had had. The mother continued to bear syphilitic children for at least four years. The case, therefore, gives support to the opinion that the poison may maintain itself in the mother much longer than it usually does in fathers.

No. XXIII.—*Important family history of inherited Syphilis with Keratitis.*

Miss K——, aged 16, was brought to me on December 19, 1873, for syphilitic keratitis of the left eye. It was quite characteristic, as were also her teeth. She was a good-looking girl, the physiognomy not being affected. The attack had begun a fortnight before. The father was living—a publican by trade. The mother had died of apoplexy, after a five hours' illness, nineteen years before which she had had "slow paralysis of the legs." The father had had a chancre, a rash, and sore throat a year before marriage, and had been some time under treatment. Since his marriage he had, he alleged, been perfectly well. He told me that he had always suspected a taint of syphilis in his children. There were seven children living; two had died in infancy, one of smallpox and the other of cholera, and a third of asthenia.

The following is a list of the children :—

1. Female. Living. "Headache sometimes."
2. Female. Died of variola, aged 4½.
3. Male. Living and healthy.
4. Male. Died of cholera in infancy.
5. Female. Has had "bad eyes."
6. Male. Died, aged 19, of "asthenia and bronchitis."
7. Male. Aged 20. "A fine strong fellow and wonderfully healthy."
8. Female. Aged 16. The patient, "delicate as a baby."
9. Male. Aged 13. Has had bad eyes.
10. Male. Living, aged 11.

Comments.—There is no proof that any were really syphilitic till No. 8. Between the seventh and eighth children there was an interval of four years, and I should feel little doubt, looking at the fact that No. 7 is strong and never suffered, that on the part of one or other parent a fresh introduction of syphilis had occurred.

No. XXIV.—*Inheritance of Syphilis erroneously suspected by parents—Microcephalus and partial blindness after severe infantile convulsions.*

Mr. and Mrs. B—— had been married seven years when they brought their infant child to me in July, 1893. The husband said that he had contracted syphilis about a year before marriage. His wife had always been well. The child, who looked healthy, had a narrow forehead with closed fontanelle, and was believed to be blind. She used to squint at times and turn her eyes up, and for two or three days shortly after birth was much convulsed. She was an eight months' child. The sight was certainly very defective. The discs were of a greyish colour, but not markedly atrophic. The child was the first born, and had never had either snuffles or eruption. Means had been taken to prevent conception during the early years of marriage.

Comments.—I explained to the parents that the conditions present were not those usually seen in syphilis, and that in fact the infant did not display a single symptom of that disease. On the other hand it was, I said, well recognised that such results might follow severe infantile convulsions. I assured them that they might continue normal cohabitation, and that they need not fear that other children would suffer. Seven years had now elapsed since the disease in the father, a period abundantly sufficient to give safety.

No. XXV.—*A healthy family after Vaccination Syphilis.*

Mr. W——, jun., was one of those whose cases are narrated in my first Report on Syphilis from Vaccination. He suffered rather severely, and his arm-chancre recurred several years

later. He married in 1878, seven years after his syphilis. In 1885 he brought his eldest child, who looked quite healthy. He then had three living and healthy children, and had lost none. He was himself in good health.

I mention this case because some authors hold that erratic or non-venereal chancres are productive of more severe syphilis than others.

No. XXVI.—*Dactylitis in an infant with periosteal nodes on skull and threatened abscess on bridge of nose—Syphilis or Struma.*

Alfred K——, aged one year and eight months, was brought to me on February 3, 1891. His father was living, but his mother was dead. Six weeks before, he was said to have had a blow on the bridge of the nose, which had caused the whole bridge to be now concealed by a soft swelling. For the last week there had been a discharge from the nose. There were large diffused periosteal swellings, symmetrically situated on the sides of the skull just above the temples, and rounded swellings of the fingers due to what is generally considered syphilitic dactylitis.

The patient was a big boy and looked well. There were no definite symptoms of syphilis and no clear history.

Comments.—Although I was not able to get any clear history of syphilis, yet the multiple periostitis was very suspicious. I would, however, by no means feel confident in that diagnosis, having seen precisely similar conditions in connection with struma.

ILLUSTRATIONS OF CANCER OF THE BREAST.

THE interesting paper which was recently read by Mr. Marmaduke Shield at the Medico-Chirurgical Society, and the important discussion which followed it, have drawn the attention of the profession to the encouraging fact that operations for cancer are in the present day far more hopeful than they were regarded by our forefathers. The paper referred to dealt with cancer of the breast only, but its conclusions are applicable to all forms of malignant disease which come within range of the knife. Nor is there anything unexpected in the fact which was chiefly dealt with, that many patients who have had cancerous breasts removed remain afterwards free from recurrence. It is only what those who believe in the local origin of these growths have all along asserted.

It is not my intention to, nor would it be suitable that I should, here attempt to go over the ground occupied by Mr. Shield's paper. I have, however, been induced to look into my case-books and to select for publication a few cases of special interest.

Large, soft growth of Scirrhus Cancer of six months' duration —Excision of breast and glands—Good health sixteen years afterwards.

I excised the breast and axillary glands of Mrs. B—— on July 23, 1880. Her history was that the tumour had first been noticed enlarged in January, and that for a time it seemed to subside, but had been rapidly increasing for two or three weeks before I saw her. The tumour proved to be a large, soft mass of scirrhus (microscope used). I did the operation at her own house in the country, and did not see

her afterwards. She came to me in November, 1880, with a perfectly sound scar.

I did not see her again for fourteen years. She came to me in the latter part of 1894, being then in perfect health.

(N.B.—This case and the following were referred to in my remarks at the Medico-Chirurgical Society, and have, I believe, been previously mentioned in print.)

Removal of a rapidly-growing and ulcerating Cancer in a young married woman—Good health six years later.

Mrs. J——, of A——. I excised her breast at Mrs. E——'s in February, 1891, on account of a large tumour with open, fungating ulcer. She had been quite unable to get rid of her milk. After two pregnancies, she had had profuse discharge of milk for six months, although not nursing; and in each pregnancy it had commenced six months before delivery. She had no menstruation after her confinements, whilst this flow of milk continued. At the time of my operation, although it was eight months since her last confinement, she still had milk running freely from her left breast.

I took away the breast, all the adjacent skin, great pectoral muscle, and the axillary glands, leaving a large wound to heal by granulation. The tumour had grown very quickly, and had been recognised only a few months. She did quite well after the operation, and, six years later, had no sign of return. The microscope had declared it a soft form of scirrhus.

Mrs. J—— was only 29 years of age. Her father was 50 when she was born.

Inheritance of tendency to Cancer—Both breasts affected in a mother and daughter.

Dr. G. T——, of W——, related to me an interesting example of inheritance of cancer which had occurred in his own family. His mother and one of his sisters had, he said, each had both breasts removed for scirrhus. In each the operations were done with a considerable interval. His

mother had survived the second operation several years, and his sister was still alive ten years after her second. In each of these cases the cancer had developed in senile periods of life. The daughter was the eldest child of the family, and was now nearly 80. A sister of the elder patient (and aunt of the younger) had also suffered from cancer.

No evidence from the microscope is forthcoming in any of these three case. The name of the operator in the younger patient was given me, and I corresponded with him. He told me that he had registered the cases in his notebook as "cystic sarcoma," because there was in each "a cyst or cavity in the deeper part." The tumours were, however, hard, and looked like scirrhus. He had taken them for scirrhus before the operation, but had felt encouraged, after finding the cyst, to hope that there would be no return. The case may have been only one of lobular induration, although it is scarcely likely that a well-experienced surgeon would have been twice mistaken.

Scirrhus mass in the skin resembling Keloid, and developed before any tumour in the breast was recognised.

About twenty-four years ago a lady from K—— came up to town on account of an indurated patch in the skin over the breast. The patch was scarcely larger than a shilling, and was at least a quarter of an inch in thickness. It was smooth and somewhat glossy. The involved portion of skin was quite movable. She consulted Mr. P—— as well as myself. One of the questions of diagnosis was between keloid and scirrhus. The age of the patient, 54; the fact that no scar had existed previously on the spot; and the short duration assigned to it, three or four months; as well as some minor peculiarities in its aspect, led us to think that it was scirrhus. Next came the question, was it primary scirrhus of the skin? This seemed *a priori* improbable, and I carefully examined the mammary gland. The lady was very stout and her breast large, but deep in its centre a certain amount of thickening was felt, of very suspicious character. We could not feel sufficient confidence in the

diagnosis of cancer of the mammary gland to advise the formidable operation of removing the whole, and she was accordingly allowed to return into the country to have the nodule in the skin excised by her own medical attendant. This was done at once, but within a month or two it became very evident that our suspicions as to the existence of primary disease in the breast itself was correct. She put herself for some months under the care of a quack, and it was not until about a year after our consultation that she determined to submit to removal of the breast itself. This operation was performed by an eminent provincial surgeon. The mass removed was very large, and the axillary glands had to be taken away as well. The patient sank within forty-eight hours of the operation.

Cancer of both breasts—Fracture of Clavicle from slight violence—Good union.

The following notes, taken in May, 1893, describe a case in which I declined any operation. Both breasts were affected and in an advanced stage of the disease. A point of much interest is that a fracture of a long bone had occurred from very slight violence, and yet probably independently of any malignant disease in it.

Scirrhus of both breasts in a woman, aged 52, with enlarged glands in both axillæ. In this case both breasts were of considerable size and adherent to the chest-wall and to the skin, the latter being infiltrated and puckered. The exact date of the commencement was uncertain, but it was probably present 18 months. A point of some interest in the case was that the woman had a recent fracture of one clavicle, which had united well, although with considerable thickening. It had been caused by a fall in getting out of bed in the dark. The poor woman, who was very anxious to keep her more serious trouble secret, boasted that she had succeeded in concealing from the surgeon who treated her fractured clavicle the fact that she had tumours in her breasts. I do not think that there was any reason to believe that the bone itself was affected with cancer, although one may suspect

that it was unduly brittle. I have in other cases known patients, who were the subjects of cancer, break bones, which yet united quite well.

Scirrhus of Breast—Excision—No local recurrence—Death five years later, after spontaneous fracture of the femur.

In May, 1881, I saw Mrs. B——, a married lady from the country, concerning whose case the following letter which I wrote at the time is the only memorandum I possess :—

"15, CAVENDISH SQUARE, W.
"*May* 28, 1881.

"MY DEAR SIR,—I should confidently believe the disease to be scirrhus, and should, on the whole, advise an operation. The case is not, however, a very favourable one, and I would not urge an operation if she is unwilling. If no operation is done I would cover the lump with lint wet in a strong lead and spirit lotion, and so endeavour to retard its growth.

"Believe me, yours truly,
"JON. HUTCHINSON."

Although I do not remember anything about the patient, and have sought in vain for any record of the case, yet from the tenor of my letter I have little doubt that the tumour was unusually large and the patient much out of health. I have always been a strong advocate for operations, and have never countenanced their omission if the conditions seemed hopeful. Some years ago I received the following as a post-script to a letter respecting another patient. At the same time my own letter, as given above, was enclosed :—

"P.S.—I sent Mrs. B—— to see you about six years ago, suffering from scirrhus of the left breast. You advised operation, but you did not advise me to press it if the patient was at all unwilling. She was quite willing and anxious to have it done. The glands in the axilla were affected. I removed the breast and glands affected. Dr. Edward Swales was present. I did it antiseptically, and there was no pus from beginning to end. She lived five years afterwards, and then it did not attack the breast; but she fractured her thigh by slipping downstairs, and there was secondary deposit in the thigh, and she died from exhaustion."

Facts such as the above, whilst in the main strongly

encouraging operative interference, would appear to prove that blood infection may occur at a stage when the local disease is yet restricted. The local cure was presumably complete, for five years elapsed without any local return. The growth in the femur may possibly have been wholly unconnected with that of the breast, and an evidence only of constitutional, possibly inherited, tendency to cancer. On the more probable supposition that it is from infection from the breast, the case illustrates the long latency which is possible even when germinal matter has found access to the blood. A fact which would favour the belief that the disease of the femur was really secondary to that of the breast, is that after scirrhus of the latter, spontaneous fracture of the femur is not very uncommon. A singular coincidence in illustration of this once occurred. Two ladies for whom I had removed the mamma on account of cancer in the same week and in the same home, both had spontaneous fracture of one femur about two years later, and within a few days of each other. Neither of them had had any local return (so far as I remember).

A lady whose breast I had removed on December 8, 1878, wrote to me respecting another ailment on May 29, 1893, and took occasion to remind me of the fact, and to report that she had had no return (Miss B—— C——). The weak point in the case is that I cannot offer any proof as to microscopic diagnosis.

Cancer in both Breasts, with a ten years interval.

I excised the left breast of Mrs. T—— in 1884. In 1889 I removed a gland from the axilla, and in 1894 the other breast. In the interval I had also operated on a younger sister for the same disease. Both sisters are now living, and free from any return. The elder is now fifty-four.

We may safely assume in such a case as this that the tissue-tendency to cancerous processes is strong. It is not probable that the disease in the second breast was in any connection with that in the one first affected.

Examples of long immunity after Excision of the Breasts.

My friend the late Dr. Smith, of Cheltenham, related to me several cases supplied by his long experience strongly in favour of excision of the breast for cancer.

A lady whose breast was removed in 1849 by Mr. Phillips, of the Westminster Hospital, and examined microscopically by Mr. Quekett and declared to be scirrhus, lived till 1869, and then died from "keloid of the skin of the chest." The so-called keloid began on the other breast, and spread over a large extent. In all probability it was cancer of skin.

Another lady whose breast was removed by the same surgeon in the same or the following year, was at the time of our conversation still alive and well (1870). In her case also I believe the diagnosis had been confirmed by Mr. Quekett's microscope.

Plugging of Veins following Excision of the Breast on two occasions—Gouty antecedents.

A lady aged 45, in excellent health, but with gouty antecedents, required the removal of the left breast for scirrhus. During her recovery, which was in all respects favourable, she had an attack of plugging of the veins of the left leg. Six years later (July, 1893) I had to remove her right breast, and on this occasion, a week after the operation, she being still in bed, a long tract of vein in front of the right elbow became plugged. She was doing perfectly well at the time, and no ill-consequences followed from the phlebitis on either occasion.

(*To be continued*)

INCREASE OF GENERAL PARALYSIS OF THE INSANE.

THE outlook as regards the alleged increase of general paralysis of the insane is not a cheerful one. It is asserted to occur precisely amongst those in whom it might have been least expected. Its victims are married men of the well-to-do classes. Amongst women it is, as it has always been, rare, and is becoming yet more so, and the labouring, or for Asylums the pauper class, shows no increase. The same is true in the main of the unmarried amongst the middle class who supply private establishments for the insane, but when we come to the married we have a very startling statement. I am taking these statements from a paper apparently compiled with great care by Dr. R. S. Stewart, of the Glamorgan County Asylum. It may be well before proceeding further to allow Dr. Stewart to speak for himself. After showing that the total increase of insanity in England and Wales is probably very slight, he proceeds to prove that the increase of general paralysis amongst widowers and married men is alarmingly great. The following are his figures on this point.

Contrasting general paralysis with other forms of mental disorder, the order of increase (per 10,000) of the average annual admissions of the five years 1882–92 over the five years 1878–82 in relation to the marriage state, is as follows:—

Admissions, excluding General Paralytics.		*General Paralytics.*	
Married Men	0·1	Married Women ...	0·005
Single Men	0·2	Single Women ...	0·010
Single Women	0·3	Widows	0·026
Married Women ...	0·4	Single Men	0·060
Widows	1·4	Widowers	0·261
Widowers	1·7	Married Men	0·804

The most striking feature of the foregoing figures is the position occupied by married men, for while the increase of the admissions (other than general paralytics) is least of all pronounced in their case, they most of all are responsible for the increase of general paralysis; in relation to these two groups of mental disorder they occupy the extremes. The extreme position occupied by married women and men in the increase of general paralysis is another very noteworthy point. The increase among single women is twice, and among widows five times what it is among married women; while as regards men the increase among the widowed is over four, and among the married five times what it is in the single.

The first thought which will occur to most in reference to these statistics is one which found expression in regard to a yet more important narrative: "Let us hope that it is not true." The fallacies of statistics are indeed so many that there is some ground for this hope. It seems at first sight equally difficult to assign any plausible reasons of increase of general paralysis amongst married in the present age as for its greater relative prevalence amongst them in contrast with single men. Married men are generally supposed to lead lives more conducive to health in all respects than those of bachelors. If the conditions of married life have during the last quarter of a century changed at all, they have probably changed for the better. Men drink less than they did, gamble less, and take more holidays. No South Sea bubbles have broke of late, and the days of the railway mania are now half a century past. We have lived through comparatively quiet and absolutely prosperous times. Thus it is not easy to see that social conditions involving excitement can have acted in causing an increase of this form of insanity. If we turn to the question of syphilis as a predisponent to it—and this is the aspect in which it chiefly interests me—we are met by the fact that more of the unmarried than the married have probably suffered. The reason in very many cases for a man remaining unmarried is that he has had syphilis. My own experience as to

general paralysis is naturally fragmentary and one-sided. I see not a few cases in which the thought occurs "that man is in danger of general paralysis." These are all cases in which syphilis has preceded the nervous phenomena, or they would not be brought to me. Almost all of these, under the prolonged use of specifics, get quite well. Concerning a minority I never know the sequel, and as to a very few I am made acquainted with the fact that the malady does develope. Of the latter class—although I may have known of more—only three are well impressed upon my memory, and in order to obtain some clinical basis for my remarks it may be well that I should relate some particulars as to these before proceeding further. They are good typical cases, and were all three the subjects of repeated consultations with others. Of these three, one was an honestly married man; a second married his mistress during the early stage of his symptoms, and ought, so far as sexual habits are concerned, to be counted as unmarried; the third had never married. All had had syphilis, and all are now dead.

CASE I.—*Tabes followed by General Paralysis of the Insane and death—Patient a man of free life who had suffered from Syphilis.*

In this instance the patient was a man of great business ability, who had made a fortune and who kept it. He had never had any sort of business anxiety, but he was accustomed to speculation. When he became ill his delusions were always in the direction of exaltation. He always boasted of his wealth and prospects, and was never depressed about anything. He had lived freely and was fond of champagne, but he was too keen a man of business to have ever been intemperate. He had probably indulged very freely with women, but he had, I believe, always been very vigorous, never until his illness experiencing any ill results. As regards his syphilis, he appeared to have got over it easily, and, excepting his nervous illness, no reminder or tertiary symptoms ever occurred. As in the case which is to follow, unless he had avowed his syphilitic history I should have found nothing to make me suspect it.

Mr. R——'s illness began with symptoms of tabes. He lost his knee-jerks, and optic atrophy followed. At this stage he was seen by Dr. Hughlings Jackson, and I give the diagnosis of tabes on his unquestionable authority.

My acquaintance with Mr. R—— began in 1894. He then told me that he had had syphilis twelve years before—but this he subsequently denied, and alleged, without the slightest grounds, that he inherited the disease from his father. This delusion became very firmly fixed in his mind.

During the whole of the time that Mr. R—— was under my care I gave mercury and iodides, and often with apparent improvement. He continued, however, to indulge in stimulants and sexual intercourse, and in these directions I think counteracted the drug treatment.

In February, 1896, I had the following diagnosis from Dr. Savage, and he was now placed in an asylum and I saw no more of him. I heard that he had died six months later.

DR. SAVAGE'S REPORT.

Feb. 18, 1896.—The patient is in the fat and demented state of general paralysis. He has great want of facial expression, greasy skin, bright capillary stigmata over malars, tremor of facial muscles and of tongue; when trying to speak there is a tendency to a kind of spasm, giving a sardonic look; swallows fairly but does not masticate properly. His hands are waxy and wanting in fine power of adjustment; gait very ataxic; K. J. absent; he has loss of control over rectum and bladder; he has only perception of light; pupils equal, dilated; discs not examined; hears well; seems to taste and smell well. His memory is very defective for recent events; he is fairly amiable, and has lost all his old antipathy to his father. He has a way of denying all things: thus, if asked where he is, says "nowhere"; if asked if has money, says "there is none"; that he "has no parents," "no relations," "no wife," "no house," etc. When asked further, said he created himself; that he had two shillings, which were enough to keep him for two weeks. He has had no fits; he is now hopelessly demented.

CASE II.—*General Paralysis of the Insane, beginning in the tenth year after Syphilis, and ending fatally in its fourth year.*

The subject of the following case was a man in whose family no insanity was known to have occurred. He had

suffered from syphilis, had been cured by specifics, and never showed any further symptoms. Two years, or perhaps less, after his syphilis, he married. His wife retained good health, and bore him four children, all quite healthy and all living at the present time. He had married above his own position and acquired property with his wife, which was a source of great satisfaction to him. This induced him to engage in speculations, which, although they involved no serious disaster, were not profitable and caused much disappointment. His first depression of spirits was distinctly in connection with them. He was a total abstainer as regards alcohol, and apparently a man of moderation in all things. No one would ever have suspected him of having had syphilis if he had not voluntarily revealed it to his surgeon when he became ill. Although he had been wholly free from symptoms for ten years, that is ever since the secondary stage, yet when his more serious nervous symptoms ensued he had a fixed idea that they were due to syphilis, and mentioned it over and over again to every medical man whom he consulted. From first to last there was an entire absence of indications of persisting taint, the case being an ordinary one of general paralysis.

Schedule of Case.

YEAR.	DETAILS.
1871	Syphilis complete. Mercurial treatment.
1872	Details of treatment, &c., not known.
1873	Married.
1874	
1875	No further symptoms of a syphilis. A family of four
1876	healthy children, all still living.
1877	
1878	
1879	Losses by speculations and some anxiety.
1880	His illness began by fits of depression.
1881	Went abroad and made foolish speculations.
1882	Liable to tongue symptoms, &c. (see memoranda below).
1883	Symptoms pronounced (see memoranda below).
1884	Died in an asylum.

From the date of his first depression of spirits to his death was five years, but during only the last three of these had

the symptoms been pronounced. Mercury was given twice during his worse attacks, and pushed to slight ptyalism. It was not, however, continued long. He was for a long time the subject of very profuse flow of saliva, possibly in connection with the mercury.

The case is the same as that briefly mentioned in Commentary LXIX. of my work on Syphilis.

Additional Memoranda.

On March 5, 1882, his wife wrote: "He has to-day had a curious sort of a fainting attack in church. He felt a sort of numbness in one side, and, on rising, found he could not stand. He lost consciousness for a few moments, and then after a rest was able to walk home, and now feels perfectly well again. His face looked, I thought, rather on one side, and he complained of the feeling being all down his left arm and leg. His speech was rather affected. During the last nine months he has had three slight attacks in his speech: his tongue seems to get cramped and for a few minutes he cannot speak plainly. Then he recovers entirely and is all right. This last seems to have been a similar attack, but affecting more than the tongue. He has been much better lately in general health, and he appeared quite well this morning when he went to church. I have been rejoicing to see him so well."

On December 20, 1882, one of his friends wrote: "He forgets the names of such places as London and York, and could not tell me how he had got here. He was unable to write to his wife this morning to say that he was coming home, and could not be made to understand the time at which he would arrive. A telegram which he received about business made him quite nervous and ill for the rest of the day, though it contained nothing of importance. Anything connected with money transactions seems to have a peculiar effect upon him. He talks almost incessantly, and seems impatient of any interruption. He often cannot or will not answer a simple question. He tells you the same story over and over again, and sometimes forgets who he is

speaking to, and talks to you about yourself in the third person."

On June 5, 1883, the report of his wife was: "During the last week he has been increasingly irritable, the least thing putting him out. Last evening he seemed to quite lose his balance, and he became almost violent. Two doses of morphia were needed to get him to sleep."

On July 8, 1883, the Medical Officer of an Asylum to which he had been sent, wrote, "In many ways he shows the typical symptoms of G. P. of I., but he is constantly alluding to an attack of syphilis which he says he had some years ago, and of which he describes the symptoms very accurately. He sleeps well and has a wonderful appetite. His mental condition is one of extreme exaltation, with hallucinations of sight and hearing. He was much excited one day and broke the windows."

CASE III.—*General Paralysis of the Insane in the sixth year of Syphilis—First symptom, Paralysis of Third Nerve—Death.*

YEAR.	AGE.	DETAILS.
1892	32	February: a sore. May: roseola. Sore throat and tongue.
1893	33	Rupia on leg whole year. Mercury and arsenic.
1894	34	Well. September: transient motor aphasia. Iodide and mercury.
1895	35	Well. Little or no treatment.
1896	36	January: brought to me, paralysis of left third and fourth nerves.
1897	37	He was for a short time in an asylum with G. P. of I.
1898	38	Death occurred nine months after leaving the asylum.

Additional Memoranda.

Mr. W—— was a man of no slight attainments. I saw him only once, and do not know details as to his progress beyond the fact that he became a G. P. His mother and two or three sisters had died of phthisis. He had cough from boyhood, but at the date of the consultation he looked well, and complained only of his digestion.

He had paralysis of all the muscles supplied by the third and fourth nerves, and possibly some weakness of the external rectus also. His attack of ophthalmoplegia occurred suddenly. He had been out that morning on horseback. Drooping of lid was the first symptom. No headache had preceded it. He had been very busy in an arduous avocation.

It will be seen that the treatment in the first instance was not commenced until the secondary stage was well developed. The treatment throughout was mixed and intermittent. In the third year the nervous system was threatened.

ON HYDROCYSTOMA.

It would appear that the condition known as Hydrocystoma, and which is said to be fairly common in the United States, is rare in England. When I published in the *British Journal of Dermatology*, in May, 1895, the case of the patient of whom I now give a portrait, I stated that I had seen a few much less well-marked cases, but none others which in the least approached it in definition. Now, four years later, I have to repeat the same statement. No other well-marked case has come under my notice in private practice, nor have any of those who assist at my Museum Demonstrations produced any.

Dr. Robinson, of New York, who was the first to describe the phenomena of Hydrocystoma as constituting a distinct malady, stated when he read his paper (1884) that he had four examples of it under observation, and he has subsequently said that he has seen thirty or forty. It is said to occur chiefly in washerwomen, whose faces are much exposed to hot steam. It may be that there is something peculiar in the kind of influence to which women of this calling in New York are exposed which does not hold in this country.

It will be seen, in the portrait, that the patient's face shows a great number of little watery vesicles which might at first

sight be mistaken for those of a mild herpes. Although, however, they are in this instance far more abundant on the right than on the left cheek, they occur on both. Nor do they pass up the forehead as herpes would have done. In the patient there is no difficulty in excluding herpes, for the little vesicles are persistent and not transitory. The subject of the case was a florid woman, aged 64, whose chief employment was in charge of a church as sextoness, and who did no more washing than for her own domestic purposes. She had on the whole enjoyed good health, but had been subject through life to very severe headaches. Her case gives support to the theory that the nervous system takes a considerable share in the production of the condition. This suggestion had already been made by Dr. Hallopeau of Paris, and Dr. Allan Jamieson of Edinburgh, both of whom have published cases very like mine.

My patient had been liable to unilateral sweating of the face and also to neuralgic pain of very severe character, chiefly in the right side of the tongue. The vesicles or little cysts had been present more or less for ten years. They were tense, and varied in size from pins' heads to peas. Their contents had an acid reaction. There could be little doubt that they were sweat-cysts. Mr. Sequeira, to whom I was indebted for the opportunity of examining the patient, told me that he had often verified her statement that she was liable to sweat on this side of the face. It was clear that her neuralgic pain, her headaches, and the sweating had all been most marked in the same side of the head as that in which chiefly the cysts had developed. They had not, however, been wholly confined to it, nor were the cysts on the face wholly one-sided.

We may regard Hydrocystoma as an affection of the sweat glands—"retention-cysts"—to which those who perspire freely on the face are liable. The cause of the increased perspiration may probably be neurotic in some cases and from external heat in others. In the neurotic cases, of which the present is an example, we must expect deviations from bilateral symmetry, whilst in others the two sides of the face will probably be equally affected.

PLATE CXLIV.

HYDROCYSTOMA OF THE FACE.

The particulars of this case are given on page 159.

West, Newman chrom

TERATOLOGY.

(*Continued from Vol. VIII., p. 361.*)

No. XIX.—*Congenital defects in lower extremities.*

I once saw in the Ipswich Hospital, under the care of Mr. Hetherington, an interesting example of defective development of the lower extremities. The infant was a female child about six months old, one of a family of five, the other four being quite free from defect. The most conspicuous feature was a form of talipes varus, the feet being much bent and strongly turned inwards. For the relief of this several tenotomy operations had already been performed. There were, however, other and more exceptional defects. Thus the knees were turned inwards until they faced each other. It was even difficult to recognise the knee by sight. On examination of the knee with the finger I could identify the condyles of the femur, but could not find a patella or any ligamentum patellæ. The tibia was very loose on the femur. There was a fleshy substance in front of the femur which might be a quadriceps muscle; but it never, so far as I could tell, took on any action. The lower limbs were altogether short, this being perhaps due to the fact that the great trochanter was higher up than usual. As far as I could tell, neither of the femurs had any neck or head, and very probably the acetabulum was absent. As the child lay on its back it was constantly lifting the extremities up into the air, evidently by means of its psoas and iliacus. This movement it accomplished very vigorously, but I never noticed that it moved its knees or ankles. The conditions appeared to be quite symmetrical.

No. XX.—*Congenital defects in all the limbs.*

A girl aged sixteen months, under Mr. Tay's care in the London Hospital, had congenital defects in the development of all its limbs. They were much more marked on the left side than the right.

Left hand: the middle and ring fingers were webbed together and dwarfed to one-fourth their proper size.

Right hand: the middle and ring fingers almost of full length, but wanting their nails and pulps. The last phalanx of thumb wanting.

Left leg showing a little below the knee a deep furrow as if it had been compressed by a band; below this furrow the limb was of normal size, but looked more dusky and congested than the other; the foot was twisted inwards, and all the toes were very short and small. It appeared that the bones of the digits were either wholly absent, or almost so.

The right lower limb was quite without defect, excepting that the ends of the three middle toes were absent.

The child had no other defects.

No. XXI.—*Depressions in the Skull behind the Ears.*

William W——, æt. 37, came to see me November 10, 1888, with Dr. Tapson, for facial paralysis with numbness on the left side. His history was that he had been very delicate as a boy, and had suffered much from eczema, but was now well of that. Four years ago he had partial paralysis of the facial muscles, with numbness of the face. There was much general weakness, and his pulse was very feeble. Recently he had had pain and swelling over the antrum. He had previously been treated for syphilis. There was a peculiar depression, quite symmetrical, behind the ears; it was deep and shelving in the mastoid and occipital bones at the base of the mastoid process. No deafness or defect of sight.

No. XXII.—*Congenital defects—Multiple.*

I saw Master C——, aged 4, on January 20, 1894, in consultation with Dr. Molyneux. He was a seven months'

child, and at birth weighed 1¾ lbs. The anus was imperforate, and two days after birth an operation was performed, and at the age of eight months this opening had to be enlarged. In infancy he was subject to obstinate constipation, and when one year old enemata were used constantly. The scrotum was divided by a deep raphé. Hypospadias was present. The end of the sacrum projected under the skin, and there were no signs of a coccyx. The left testis was undescended, the right one being of normal size. There was a doubtful tendency to spina bifida, and the child could not walk well. The forehead was very suspicious of syphilis. The mother had had three children in twenty-eight months. Two children born since our patient were dead; one having been born at six, the other at seven months. One of these infants was believed to have had some malformation in the throat.

No. XXIII.—*Congenital absence of one finger, with slight general excess in size of all the others.*

In May, 1867, I had under observation a married woman in whom the right forefinger and its metacarpal bone were absent. There was no trace of appendage, nor even of scar. The girth of the knuckles on this side was an inch less than in the sound hand. All the digits were, however, individually larger than their fellows. This increase concerned their bulk only, for they were not longer. Thus the middle finger of the left hand had a girth of two inches and a half round its middle joint, that of the right being only two and a quarter. The difference in the size of the nails on the two hands was very conspicuous. The wrist of the right was a quarter of an inch greater in girth than that of the left. Thus it would seem that the hand which had grown only three fingers had used the nutritive force, or blood supply, to increase the size of all its other parts, and that with equal distribution. The woman was right-handed in spite of the defect. She had six children, none of whom had inherited any defect. She had the normal number of toes on both feet.

No. XXIV.—*A Spina bifida in the cervical region.*

I saw at Shottermill, many years ago, a child nearly two years old in whom a spina bifida was present between the shoulders. The tumour was rounded, and the skin over it very thin. It was as big as a fist. It evidently sprang by a large neck from the lower cervical region, and certainly did not pass up to the occiput. There was no positive talipes, but the lower extremities were flabby and cold, and the child made but little attempt to use them. The child was well grown, but had a large hydrocephalic head.

I heard some time afterwards that the tumour had given way and was draining a serous fluid, and still later that the child and its mother were both dead in consequence of accident. I record the case because spina-bifida tumours in the cervical region are very rare.

No. XXV.—*Optic Atrophy and white discs in association with Occipital Encephalocele.*

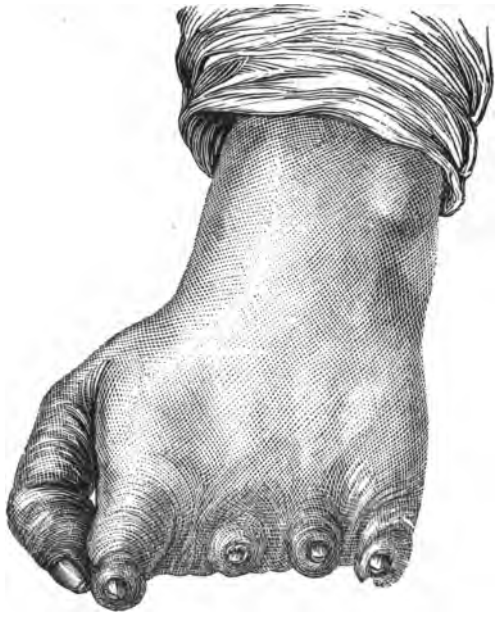
An infant under observation in October, 1866, had an occipital encephalocele as large as a hen's egg. The swelling became tense when the child cried. It was well covered with scalp hair, and bony plates could be felt in its walls. The infant was blind, and had white discs. It died at the age of seven months.

No. XXVI.—*Conditions supposed to be characteristic of Intra-uterine Constriction by Bands occurring in four members of the same family.*

Photographs representing the condition of the hands in a brother and sister, whose cases were briefly alluded to in my last ARCHIVES, p. 360, have been placed on the screen in the Museum and may be examined by any one who takes interest in the subject. It seems scarcely worth while to reproduce them as woodcuts, since the conditions are almost exactly those shown in the illustration from another case which I now, for the reader's convenience, again insert.

The point is that a brother and two sisters have been born with their hands deformed on exactly the same pattern, and that it seems impossible to explain such an occurrence by supposing the deformities to be due to constriction by amniotic bands. There is the further fact—possibly of great importance—to be mentioned, viz., that a great-uncle presented the same malformation.

Now the conditions present are exactly and precisely those usually attributed to the mechanical effect of constricting



bands; yet, as just remarked, it seems absurd to suppose that such bands should chance to have been formed on the hands of three different fœtuses, affecting in all the same hand and producing exactly parallel results. These facts of family occurrence and inherited defect look much more like some arrest of development. Yet if we admit arrest of development as a cause in this case, surely it must be allowed in others which are just like them. It seems highly improbable that precisely the same result should be in con-

nection now with one and now with another cause, such causes being extremely different. I can, I may confess, see but one supposition by which it is possible to admit or reconcile the two hypotheses. It is this, that possibly a defect, originating in a mechanical cause (constriction by bands) in the first instance, may be transmitted hereditarily. This supposition, of course, contradicts the general creed which denies that acquired defects are transmissible. I have, however, on several occasions mentioned facts which seem to invalidate that creed. If it can be got rid of, and if we may believe that the results of injury and of disease may, in some instances, have the effect of stamping peculiarity of structure on future generations, a great step will have been taken towards our comprehension of the phenomena of family diseases as well as of the general possibilities in reference to structural inheritance. In the present instance it is to be remembered that it is a great-uncle and not a grandfather who is supposed to have shown the malformation. On this point, however, my informant's knowledge may be inexact, or it may be that the great-uncle himself inherited from a predecessor.

I have been in correspondence with Dr. J. W. Ballantyne, of Edinburgh, a very high authority in all that relates to Teratology, and the following extract from his letter will, I am sure, be valued by my readers.

"In reference to the influence of pressure—amniotic, funic or otherwise—in the production of the so-called intra-uterine amputations; that they are sometimes due to constricting bands is, in view of the evidence of Simpson, Montgomery, Reuss and others, undeniable. I believe, however, that they may also be due to a diseased condition of the skin itself, as Jeannel holds, while it is just possible that some are really want of development from inherent absence of formation as occurs undoubtedly in the more advanced hemimelic and amelic types. If they be due to these two latter causes, it is easier to understand how they may be hereditary, but to my mind it is incomprehensible to think of an amniotic band, or the umbilical cord, producing similar conditions, and necessitating exactly similar arrangements in successive

pregnancies. Nevertheless, although incomprehensible, it may be true."

No. XXVII.—*Absence of Limbs.*

In the College of Surgeons Museum there is a specimen of a child without limbs. It is a large baby and probably lived some time after birth, a male. The skin over the shoulders is smooth, there being no trace of arms. The muscles of the left hip have been dissected (338). It is otherwise well developed. (I have two portraits of the like.)

Specimen 278 is also a skeleton without limbs. There is, further, the skeleton of a one-legged seagull.

No. XXVIII.—*Occipital Encephalocele associated with cleft palate, convulsions, and blindness—Death in the third year.*

On June 5, 1868, an infant aged one month was sent to me by my friend Dr. Dove, of Pinner, on account of a large occipital encephalocele. The infant had been born at full time and was its mother's first. It was rather small. Both fontanelles and the whole length of the sagittal suture were open. The head was well formed with the exception of the occiput, which looked very small, as if sliced off. The tumour was of irregularly oval shape, its long axis being horizontal and its chief projection to the right. It was as large as an adult fist, and fully half the size of the rest of the infant's head. At right projecting end the skin and membranes were distended so as to be quite transparent. On the upper part the tumour was covered with scalp hair. This filled up the nuchal cavity and hung upon the back; it pushed the head forwards so that the child's ears touched its shoulders, and its chin its chest. The spine seemed to be rounded and to project backwards, but probably all these deformities were merely the result of the displacement by the tumour.

Parts of the skin of the tumour were in the condition of port-wine nævus. The palate was cleft nearly up to the

alveolus, the cleft being double and leaving the vomer in the middle. The feet were not distorted. Convulsions had occurred several times, attended by blackness of face. Owing to the cleft palate the infant could not suck. The infant did not use its arms well, but still it could grasp, and perhaps there was but little deficiency.

Dr. Dove was subsequently kind enough to inform me that the child had died at the age of three years. It had been blind, or almost so, for some time before its death, and had also repeatedly suffered from convulsions.

No. XXIX.—*Spina bifida in two brothers.*

An instance of spina bifida occurring in two children of the same family was brought under my notice by Dr. Byles, of Victoria Park, in 1870. The conditions were very similar in the two. Death resulted, I believe, in both. Both were boys. There were about eighteen months between them.

No. XXX.—*Case of Hypospadias with apparent absence of Testicles, and some curious features of resemblance to the female sex.*

July 20, 1883. The subject of this case was a boy aged 16. He was short for his age, with wide pelvis and somewhat female gait. His voice was an ordinary boyish one. Some fine hair on the upper lip and chin was commencing to grow. The pubic hair was rather plentiful and long, and there was also some on the scrotum as far back as the anus. The penis was small. There was a large meatus at its base and under-part, the lower lip of which was a thin fold of mucous membrane. The penis was grooved, and in the groove were three openings which seemed to pass only for a few lines into the wall of the groove, and were probably glandular follicles. A gum-elastic catheter passed fairly easily for several inches, but no urine came, and it could be felt by the fingers to be close to the rectum; at the same time no prostate could be felt. A silver catheter with some difficulty was made to enter another canal leaving the one

mentioned at some distance from the meatus, and this led more upwards and into the bladder. The lower canal could not have been a false passage, as he had not been catheterised before. The instrument passed readily, and no blood followed its withdrawal. The scrotum had a marked groove leading back from the meatus and the perineum also, the bottom of which had the appearance of a scar.

The testicles could not be found either in scrotum or abdominal wall. There was no impulse at the inner ring when he coughed.

No. XXXI.—*Intra-uterine repair in Coloboma.*

In many cases of coloboma of the iris (congenital) we have evidence of a sort of intra-uterine repair of a defect. In one eye there may be a large open coloboma, in the other a wedge-shaped portion of fibrous-looking tissue in the corresponding part which is destitute of colour of the iris. In the case of the Rev. M. B. A.—— this wedge was grey and pigmented, and looked exactly like scar tissue. The coloboma was complete in the left and this scar existed in the right. A similar evidence of repair is sometimes seen in the upper lip, a child being born with a scar in place of a cleft, looking exactly as if a harelip had been closed by operation.

No. XXXII.—*Congenital defect in development of the femur.*

There is in the University College Museum the skeleton of a man in whom the femur on both sides is almost wholly absent. The rest of the bones are almost normal; those of the trunk and upper limbs are remarkably well formed. The front part of the pelvis is very light; the leg bones, especially those of the left leg, are, I think, almost of natural length and size. Those of the right leg appear to be smaller and somewhat bent, and the right foot is small and with a very high instep. The femur on each side is represented, above by two fragments of bone as big as half-walnuts, possibly the two epiphyses, and below by a fragment which clearly

represents the lower epiphyses. The whole of the diaphysis is wanting, and the leg appears to have been attached to the pelvis, just below the anterior iliac spine. I am describing the specimen on a cursory examination, and without having had reference to the catalogue. It has, I believe, been figured and described by Mr. Liston.

No. XXXIII.—*Hydrocele of the Neck.*

[A note written Nov. 18, 1878.] An infant now attending at the London Hospital has a large tumour in the right side of the neck which bulges forwards in front and under the chin. It consists of large cysts, most of which have a bluish tint. They adhere closely to the skin. It is not quite in the usual position, coming much more in front and less in the side. On the left side, just in front of sterno-cleido mastoid is a very soft swelling, only detected by the finger (not visible). I did not notice it on the first occasion. It is, I think, quite distinct from the other, but they meet in the middle. The infant is four months old. I advise to defer treatment.

No. XXXIV.—*Dwarfdom and defective development in many regions.*

In May, 1883, I had under observation at the London Hospital a very peculiar case of multiple and disconnected defects in development. The young woman, although 23, was, I should think, not more than 4 ft. 6 in. in height, and looked like 16. Her frontal eminences were prominent, and the forehead somewhat squared. The upper half of her sternum projected strongly, but at its middle there was a deep depression. There was a very curious depression of the skull bones on the left side a little above the occipital protuberance, much as if it had been indented by a severe fracture, and at both elbows the head of the radius appeared to be much larger than natural, and the external condyle much smaller: thus the upper and outer two-thirds of the head were quite free from the condyle. In the upper jaw

she had but two teeth, a bicuspid and a molar on the left side. In the lower jaw she had no incisors or canines, but six or seven bicuspids and molars irregularly placed. The teeth that were present were of large size; the gums in the incisor region were much shrunk. She had epicanthus, and the eyes looked small, the pupils not being exactly in the middle, but rather towards the nasal side: her sight was defective, and she had a high degree of hypermetropia. Her forehead and face were suggestive of inherited syphilis; but I could not find any evidence of periostitis in the long bones, and she had never had keratitis. She was the eldest of six or seven, and reported her brothers and sisters healthy. She had had fits in infancy.

No. XXXV.—*Note on cases of Congenital Absence of part of the Pectoral Muscle.*

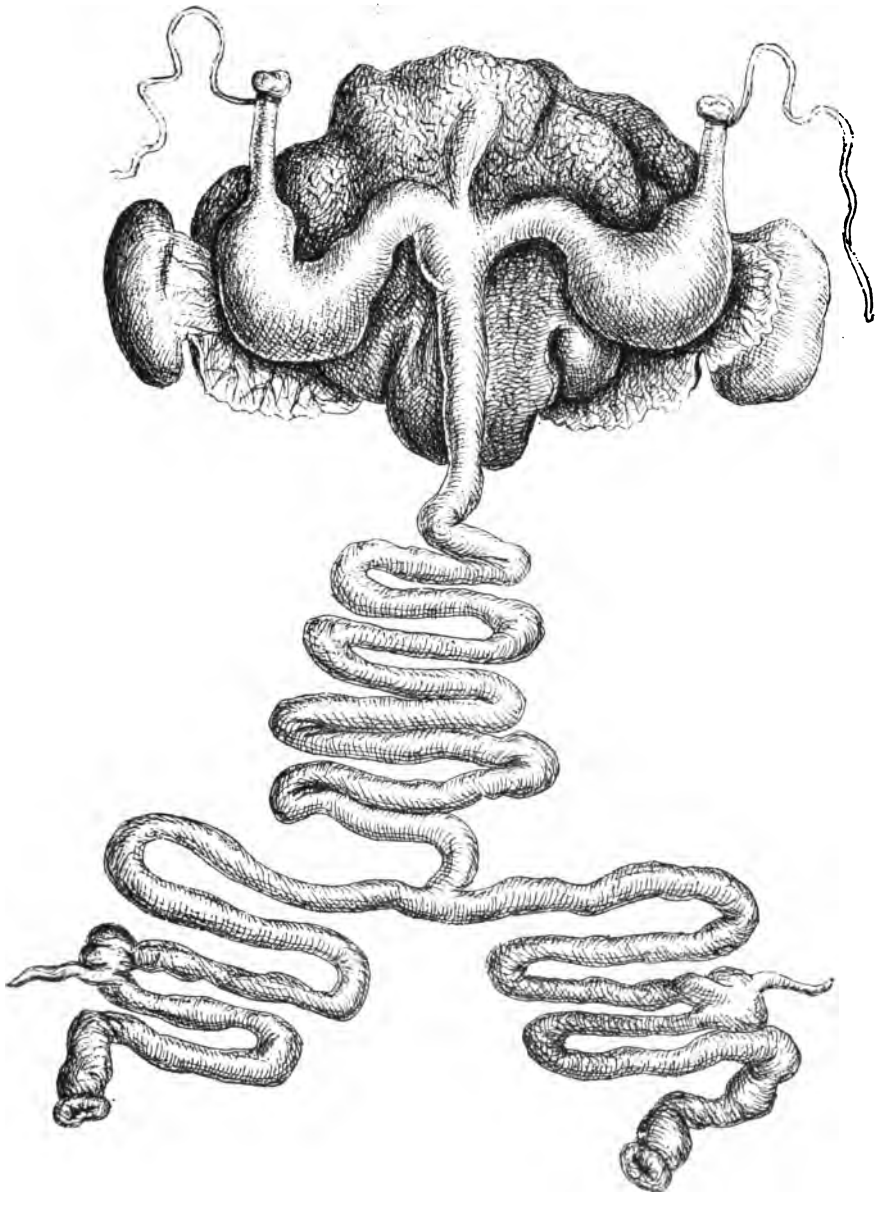
In the cases of congenital deficiency of the pectoral muscles to which I have twice referred (Vol. V., page 342, and Vol. VIII., page 356), the fact is repeatedly noted that the sterno-costal portion may be absent whilst the clavicular part is perfect. The essential distinctness of these two halves of the muscle is confirmed by what is sometimes observed in the results of disease. Thus Gowers has noted that in Duchenne's paralysis the sterno-costal portion is often wasted when the other escapes.

Two cases of this congenital defect are recorded in Virchow's Archives, vol. cxxi., p. 598, with a lithograph. I am indebted to Mr. H. C. Durham for this reference, which I am glad to add to those already given.

No. XXXVI.—*Double Monsters—Posterior Dichotomy.*

In my last issue mention was made of two specimens of the "Double Monster" which had recently been obtained and were in process of dissection. A graphic illustration

(copied) of the condition in a living hare was also given. This woodcut showed an animal with one head, but three ears. Its shoulders were so joined that two of its fore-legs came to the ground, whilst two others were on its back. Its hind-quarters were quite separate, so that it ran with four hind-legs all touching the ground. These conditions are almost exactly reproduced in the two specimens which I have recently dissected. One of these was a pig, the other a kitten. I mention the subject again here in order to reproduce the accompanying illustration which shows the manner in which the bowel is united into a single trunk in the ileum. The woodcut is copied from one given at page 288 of the Ephemeridum Medico-physicorum for 1686. It will be seen that the bowel, which was of course double from the anus upwards, in the dichotomised lower quarters of the animal becomes single by union of the two at the certain position in the middle of its course. In place of speaking of union of the two bowels at this point it might perhaps be more correct, though less convenient, to speak of division commencing here. The result is, however, the same. This union of the duplicated bowel at a certain point appears to supply a strong argument in support of the doctrine of dichotomy as opposed to union of two embryos. Were these double monsters produced by the latter process it is very difficult to understand how the organs should, in the upper part of the trunk, become single in such a well-ordered arrangement; whereas it is just what would be expected if division of the embryo had taken place from below. On the dichotomy hypothesis it would appear to be usual for there to be some simultaneous tendency to division from above as well as from below;—anterior as well as posterior dichotomy. In the specimens from which the woodcut was taken this was marked, there being two heads, and the upper extremities as well as the lower being duplicated. It will be seen that there are two stomachs and two spleens. Only a very short central region are the viscera single. Thus it will be observed that the liver is single and the gall bladder single. So also is part of the duodenum and the whole of the jejunum. It is from the human subject,



EXPLANATION OF WOODCUT.—The viscera from a double monster (human), in which the bodies were united only at the thorax and upper part of abdomen. There are two stomachs and two spleens, a single malformed liver and a single gall bladder. The first part of the small intestine is single, but dichotomy occurs in the ilium, and below the bowel is duplicate. (Seen from behind.)

the twinned monster being united only along the chest and abdomen and possessing a single umbilicus.

In neither of the two specimens which I have recently had under examination was there a double head, but in both there were conditions which suggested a tendency to division from above. In one there was cleft palate and non-union of the symphysis of the lower jaw. In the other there were four ears and a cleft palate.

DISEASES OF THE EYE.

No. XXIV.—*Recurring and persisting Hyalitis in one Eye only—Great benefit from residence abroad—Gout probable.*

In the case which is to follow we have, I think, a good example of the insidious form of inflammation of the eye-ball with opacities in the vitreous which I described many years ago as occurring occasionally in connection with gout tendencies. We have also an instructive instance of the benefit to be obtained in these cases from a change of climate.

Mrs. P——, aged 32 (?) was sent to me by a distinguished ophthalmic surgeon. A letter which she brought with her described her ailment as "a very curious retino-hyalitis of the right eye, which makes the fundus quite obscure," and gave me the following additional particulars :—

"The fundus has been more obscured than it is at present, and to-day for the first time I thought I got a glimpse of the O.N. The vision has usually been $\frac{6}{18}$, and is to-day $\frac{6}{12}$. The other eye has myopic astigmatism, but I have not yet ordered glasses. She developed symptoms of glaucoma, and I used eserine. It has improved since. Her husband had syphilis many years ago. Inquire of him as to their marital habits, and let me know if you think any part of the eye-mischief traceable to either cause. Mrs. P—— had blue pill at first, with a blister, but latterly bark and iodide of potassium, under which she thinks she has had much benefit. It is a very obscure case."

I found the eye in the condition described in my friend's letter, the vitreous full of fine films which obscured the fundus. The ciliary region was somewhat congested and the eye very irritable. It was necessary to wear a shade constantly, and

she never attempted to read. She was a florid woman, rather thin, looking well, and of nervous temperament. I could not find any indications of syphilis. It appeared that she was her husband's second wife, and that his syphilis was prior to his first marriage and more than seventeen years ago. He had a healthy child by his first wife. The eye affection had been coming on for about a year, but had varied much at different times. Mrs. P—— had herself had some attacks of pain in her toe-joints, but I could not learn that definite gout had ever been recognised in her relatives. Neither she nor her husband were in the least out of tone, and I did not think it worth while to prosecute inquiries in the direction which my friend very plausibly suggested. My diagnosis was inherited gout, in spite of the absence of history, and I advised most strongly an immediate change of climate.

My advice was promptly acted upon, and Mrs. P—— spent the ensuing five months abroad in Egypt. She returned to me at the end of that time with the statement that her eye was no longer in the least irritable and that she was able to read with it. I found the vitreous much less hazy, the fundus easily seen, and the vision $\frac{20}{40}$. It appeared that the irritability had ceased six weeks after she left England, and she had then been able to throw aside her shade. It had never returned, and she had been able to do a certain amount of reading. She thought that she had again been threatened with gout in her toe, but she had not had any definite attack.

Whilst abroad she had taken quinine, small doses of aconite and iodide of potassium, and had been carefully dieted (see page 184 for details).

My next case must be related in two letters from a surgical friend. I saw the patient only once and very hurriedly. He was a young man of 20, in somewhat feeble health, and practically blind. His father came with him, and there was a clear history of family gout. I could not find any symptoms to support the suggestion of syphilis, nor did any such develope subsequently. The case seemed to me to be an

unusually severe one of the relapsing ophthalmitis of inherited gout. In the strongest language that I could use I urged an immediate emigration to a southern climate as the only chance of saving any sight.

The first letter gives the history of the case and describes the patient's state when he was brought to me. The second, written six months later, gives the sequel.

"*April* 8, 1896.

"The first attack occurred seventeen months ago, taking, I gather, the form of a severe iritis. He was under several men, but the iritis constantly recurred. He came to me in May, 1895, with sight very much impaired, suffering from an acute attack of iritis, which subsided under leeching, belladonna fomentations, and pills of mercury and opium. The media remained opaque for many days, but were gradually clearing, when the other eye suffered in a precisely similar way, and this has been the history for months, alternate eyes suffering. Gradually the other tissues of the eye have became involved, and each time the media show greater delay in clearing up.

"Latterly he has had several (three or four times) attacks of pain, inflammation and high tension of the eyeball, which have been only relieved by tapping the anterior chamber.

"I have tried to build up his system by diet, steady exercise, and all that might conduce to good health; have treated him for rheumatic gout and with iodide of potassium.

"I should say that when he came to me in May, 1895, he had a round ulcer on the scrotum with hard raised edges, which soon yielded to lotio nigra, and a hard, swollen condition of the left leg. No edema or apparent obstruction of the veins.

"He denies having had syphilis."

"*September* 13, 1896.

"About ten days after seeing you, Mr. W—— and his father went to Woodhill Spa; his eye was then clearing. The next day he felt great pain in the right eye and commenced vomiting; they took train home. The vomiting persisted on the journey home as well as the pain. They put leeches on the temple, without any effect on the pain. In the night they sent for me. He was suffering from acute glaucoma. I performed an iridectomy, which relieved the pain at once. About a week afterwards the pain recurred violently, and as the sight was completely gone, after consultation I removed the eyeball. The left eye seemed to improve for a time greatly, and he began to distinguish objects with it, when he had another recurrence of the iritis, and he can now hardly distinguish light from dark. Unfortunately there were pecuniary reasons which prevented them adopting your advice as to residence in a tropical climate."

The whole history and progress of the case fits exactly

with what occurred in the girl Mabey, the first example of this malady which attracted my notice. In her, although the attacks were not so severe, they were recurrent after just the same fashion and were attended by glaucomatous tension, which was relieved repeatedly by paracentesis and iridectomies. In her also one eye was lost and excised. The other was saved only by iridectomies, which in the end had taken away almost the whole iris. Her father had had gout. She herself subsequently died of phthisis. In reference to the suspicion of syphilis, it will be seen that the sore on the scrotum occurred long after the first attack of irido-hyalitis.

No. XXV.—*Remote results of a blow on the eyeball—Complete detachment of the retina and secondary cataract.*

Mr. C——, a Lincolnshire farmer, aged 50, was sent to me by Dr. Stiles, of Spalding. His left eye had long been quite blind, and had recently become painful. It was congested, rather hard and showed a swollen, cataractous lens, which bulged into a widely-dilated pupil and almost touched the cornea. I had no hesitation in advising its excision. After the operation we found complete, umbrella-detachment of the retina and entire absorption of the vitreous.

Mr. C—— reminded me that he had consulted me some years before, and on looking up my notes I found, under date May 13, 1885, the following interesting facts:—Ten months had then elapsed since Mr. C—— had received a severe blow on the eye from the handle of a winch. He had after it a bad black eye, but the sight was certainly not destroyed at the time. He was confident that two months later he had been able to shoot from the left shoulder. By degrees, however, the sight had failed, and when, on the date given, he came to me he could not count fingers. The ophthalmoscope showed subretinal effusion in several different places. There was no great elevation of the retina, but it showed long white streaks and thin folds. There were

also some films in the vitreous. There were some pigment patches at one or two places in the retina, which probably represented the remains of hæmorrhages, and the retina near the disc was hazy. Five months later Mr. C—— could only just discern light with the injured eye and the subretinal effusions had increased; and three years later the lens had become so opaque that it was impossible to inspect the fundus. After this I did not see Mr. C—— until the occasion on which, in December, 1896, I excised the eyeball. There had been no material irritability of the remaining eye, and throughout it had enjoyed perfect vision.

The case is of interest in reference to the prognosis after blows on the eyeball. Although the eye was not disorganised nor, indeed, apparently much injured at the time, yet we find a tendency to subretinal effusion following in the course of six months, which, gradually increasing, led to complete detachment of the retina and absorption of the vitreous. Through this process the eye retained its normal tension. In connection, no doubt, with the removal of the vitreous, the lens became opaque, and finally, at the end of eleven years, a state of increased tension with congestion and severe pain made removal necessary.

No. XXVI.—*Ophthalmitis of those hereditarily gouty.*

Miss T——. Left eye was formerly the worse, but is now the better. She can read with it for hours together, and does read a good deal.

The right eye has been worse since an illness at Christmas, 1880. In February, 1881, she had an attack of inflammation in the right eye, with great pain, and at present she cannot read anything with it except the largest print. Sometimes there is a little aching in it after reading, but no recent relapses of inflammation. Still she thinks eye worse during last few months. I found a large beeswing opacity in the vitreous, which caused the failure of

sight. The disc could be seen easily, but was veiled. She was not liable to any form of arthritis, but five years ago she had an affection of the hip, from which she had quite recovered. There was gout in the family.

No. XXVII.—*The Mabey Group—Relapsing Cyclitis with feeble circulation and Gout.*

Miss F——, aged 39, has got stout, but is not strong. Iridectomy a year ago. Got through the early winter pretty well. Caught neuralgia in the left jaw in April. Whilst suffering from its effects the eye relapsed. Has been freely blistered, and has taken belladonna till the pupils were large and the throat dry. There is a large downward coloboma, with much discoloration of the ciliary region, and some pits due to sub-conjunctival scars. Every spring she is accustomed to get eczema on her hands. This last spring she "stopped it by a soda solution," and as soon as it was well her eye inflamed. "See-saw Ailments."

No. XXVIII.—*Inherited Syphilis—Consanguineous marriage—Relapsing Ophthalmitis between the ages of ten and eighteen—Keratitis—Cyclitis—Iritis—Choroidal changes and glaucomatous tension in one eye.*

No. XXIX.—*Vitreous opacities in both eyes—Patient a young woman in poor health and liable to severe headaches.*

No. XXX.—*Detachment of the Retina from Sea-sickness in a healthy young man.*

A young gentleman in good health, at sea in rough weather, had prolonged retching with the head bent forwards. A few days afterwards he found that there was a waved line across the letters which he was reading, and that when he closed the left eye he could see nothing above this line. In the

course of a week or two the affected eye had so far failed that he could see nothing distinctly with it. An ophthalmic surgeon recognised detachment of the retina, and ordered him to bed. He was kept six weeks in the recumbent posture and under the influence of pilocarpine, but with no benefit. He came under my care for another matter two years after this occurrence. His eye was almost blind, but had given him no further trouble. His health was good, and he could see perfectly with the other. As an example of detachment of the retina from a definite cause, and apparently in a man of sound tissues, the case seems worth mention.

No. XXXI.—*Case illustrating the symptoms of Hæmorrhage into the Vitreous.*

A very voluble but at the same time keenly observant woman has just been describing to me her husband's illness. He is, she says, paralysed in one side of his body and blind in one eye. The eye is affected on the same side as the limbs, the left. "He lost his eye, you know, some days before his paralysis. He went into his workshop one morning, and suddenly exclaimed to the men, 'Look, look! there is blood running down the window!' and then almost directly after, 'I am blind in my left eye!' After this he came to me, and I tried to laugh at him. He said he felt quite well and would have his breakfast, but in trying to go into the next room he knocked against the door-post, and I saw that he was really blind on that side. The paralysis came on during sleep about two weeks later, and the limbs affected have been disabled ever since." This was two years ago, and the man still retains good health, but cannot walk or use his left hand. "The curious point is," adds his wife, "that he is not always blind. Sometimes he will shut his right eye and say, "I can see you with my blind eye. You are there! Now you are gone! Are you gone?' It is as if a curtain came over his sight." The patient is a man aged 64. Respecting his paralysed hand, his wife gives the interesting fact—"The fingers are always contracted into his palm and cannot be straightened. But this is only when he is up and

about. When asleep they are quite straight, and for some little time after he wakes you can move them about quite easily. They are as loose as those of the other hand. Gradually, however, when he gets about they stiffen and contract, and it is impossible to straighten them."

The diagnosis of intraocular hæmorrhage preceding by a fortnight hæmorrhage into the right corpus striatum is here clearly indicated. No doubt a large membranous opacity in the vitreous has remained after the partial absorption of the blood-clot, and it is by alterations in the position of this veil that he is enabled at times to see with an organ from which more usually light is shut out.

No. XXXII. — *Retinitis pigmentosa in three brothers—No consanguineous marriage.*

In January, 1887, Dr. Osborn, of Dover, consulted me by letter in the case of a gentleman, aged 62, who had lost his right eye and in whom the left was failing. In November of the same year the patient came up to town for my examination. There was most extensive pigmentation of the retinæ with pale, waxy discs. There was no history of special cause. The chief interest of the case lies in the fact that two of his brothers, both older than himself, were also blind. In all the disease had been of a slowly aggressive kind. In all the disease had begun in early life. The family consisted of seven. Two sisters had wholly escaped, whilst of five brothers three had suffered. In this instance there had been no consanguineous marriage. It was believed that a paternal uncle who was in the army had very defective sight, and that he lost his life owing to his mistaking the enemy for his own corps and riding into their ranks.

Mr. S—— was in fair health, and said that he had never known a headache in his life. His pupils were small and sluggish. He was frequently troubled with a glare of light before his eyes, and at other times by the appearance as of a white ceiling over him. He had but bare perception of light and shadow when I saw him, and could not count

fingers. It was a year since he had read, and then by the aid of a hand-glass.

About ten years before I saw him, Mr. S—— had, with an interval of a year, gone through two amputations. The first was through the thigh for diseased bone, and the second at the hip joint. On the second occasion there was almost fatal secondary hæmorrhage. He himself believed that the loss of blood on each occasion had very much prejudiced his already failing eyes. After each operation he had been for a time "in a mist," and after the second this was very marked and he never regained his former sight. It is quite probable that severe losses of blood might be felt by structures already degenerate and with contracted arteries, and not unlikely that such influence might be in some degree permanent.

THERAPEUTICS AND DIET.

Rheumatic Gout of the Knees and Diverticulum into the Popliteal space—Record of Treatment.

An intelligent patient from the country, making a second visit, two years after his first, very prudently brought with him a memorandum which he had himself written of what I had told him. It was so clear and explicit that I venture to transcribe it here:

"Mr. H. said that my trouble was caused by rheumatic gout which had led to a *Diverticulum*, that is a bursar communicating with the knee-joint. On no account am I to have the bursar cut out or interfered with. It is caused by rheumatic gout, and will cease when the gout is less active. I am to use a salt-pack and take the medicine prescribed as long as the knees are troublesome. I am to take any exercise I like so long as it does not hurt the knee. To drink only whisky and to take plenty of weak tea. No Burgundy. Eat plenty of fresh green vegetables, but no fruit which requires sugar, *e.g.* gooseberries or rhubarb."

Under these measures, aided perhaps by drugs, the effusion into the knees had disappeared and the bulging diverticulum had receded.

Arsenic causing Ascites.

I have recorded in detail two cases in which an inflammatory form of ascites, requiring repeated tappings, occurred during a long course of arsenic. One of these will be found in Vol. VI. at page 389, the other at page 23 of the current volume. The cases were much alike and both patients recovered and regained good health.

Effects of Large Doses of Arsenic.

On August 21st I ordered for an adult man six minims of Pearson's solution of arsenic, with three of Fowler's, and four grains of iodide of potassium. These quantities were to be taken three times a day. For about a fortnight he took, in error, double doses. It made his legs heavy, and caused a dragging feeling, especially in the calves. After walking a little way his legs ached so that he could go no further. He had no pricking of eyes, no herpes, nor any sickness, but he lost his appetite. On discovering his mistake he reduced the dose and went on with that ordered; but finding his appetite still bad he left it off entirely. On doing so he at once felt better, and three weeks later his legs were all right again. The psoriasis for which the arsenic had been ordered had been much better during its use, but showed a tendency to relapse a month after its discontinuance.

Absence of odour in the Urine from eating Asparagus.

The disagreeable odour which is communicated to the urine by asparagus is well known. In the case of a gentleman of intemperate habits, who was the subject of albuminuria, the curious observation was made by his attendant that when the albumen was absent asparagus might be taken to any amount without causing any smell. When the albumen was present, then the urine received its odour as usual. The urine had a specific gravity of 1010. The absence of odour was observed during several days. The patient was at the time the subject of acute pemphigus, and the return of odour and of the albumen was coincident with marked improvement of his eruption under the use of arsenic.

Physiological effects of Excessive Medicinal Doses of Aconite.

In December, 1890, I gave to a lady who had diverticula from her knee-joints my favourite prescription for all active forms of rheumatic gout. It contains ten minims of tincture

of aconite to the dose, three times a day. She took it for several weeks with great benefit and not the least inconvenience. It was dispensed in London. On a subsequent occasion she had the prescription made up in Pau, and again had no ill symptoms.

In the end of 1896, the same prescription was made up in an English county town. Two doses of it made the patient so numb and cold that she had to walk about the room to keep warm. On that occasion she did not venture to take any more, but six months later she ventured to try half-doses from the same bottle. These had precisely the same effect, though in less degree.

A year later Miss W—— called on me again and narrated the above experience, bringing with her the prescription, and declaring that although it had once cured her, she dare not take it again. I asked her to tell me exactly what had happened, and what precisely her symptoms had been. She said that on the first occasion she took a dose at bedtime, and slept through the night without experiencing anything special. In the morning she took another dose, and very shortly afterwards began to feel cold down her back and a sense of constriction in the throat, just as if a bad cold were beginning. The sense of coldness spread from the back to the limbs, and the latter felt as if they would go to sleep. Nothing relieved her but incessant walking. On the second occasion two half-doses produced similar effects, the back and the throat being again affected. No tongue symptoms were experienced.

There can be little doubt that in this instance the dose of aconite as dispensed by the provincial chemist was from some error much stronger than it ought to have been. The patient had taken the same prescription from two other chemists for considerable periods with impunity. The patient was very careful as to her doses, always using a graduated measure, and there had been no error in this. Probably the quantities had been miscalculated by the dispenser. The symptoms produced were distinctly those of aconite poisoning, and it is of interest to note their character. I am in the habit of using tincture of aconite

in ten-minim doses, three times a day, for strong adults without the slightest fear. For the pains of neuralgia, of rheumatic gout, and of cancer, it is invaluable, as also for the control of all forms of arthritic inflammation. I always enjoin great care in measuring the dose, and with that precaution have never known any serious ill consequences. The case now narrated is almost the only one in which I have ever known any physiological effects to be observed. In one sense it is a matter of satisfaction that such effects should now and then be witnessed; they prove that the remedy is really powerful. The production of coldness and numbness is precisely what we want in the affections just named.

Mercury in the treatment of Osteitis of the Tibiæ from Inherited Syphilis.

The mother of a lad who was under my care for keratitis told me, when I examined his shins to ascertain whether he had any nodes, that he had formerly and for long suffered from "periostitis." She knew what she was talking about, and added, when I asked whether iodide of potassium had been prescribed, "Yes, and it did no good. He took it for two years, and it made him so weak that I thought he would die. He suffered very much from pain in his legs, and got no better until I took him to another doctor, who gave him mercury, and in a few weeks he was well."

I cross-questioned my informant a good deal without in any way shaking her testimony. She insisted that large doses of mercury were given, and that the pains in the bones and the lumps in them soon disappeared, and that they had never returned. The boy's shins confirmed her statement, for only very slight unevenness here and there remained. He was now seventeen, and it was eight years since the periostitis was cured, and there had been no tendency to relapse. Thus I think we must accept it as a fact that mercury did really cure a chronic osteitis which iodide of potassium had failed to relieve. The fact is by no means a novel one. Although as a rule iodide of potassium is a specific for syphilitic periostitis, and equally as a rule

mercury rather tends to increase the pain and the risk of suppuration, yet we have long known that there are cases in which the reverse is true. The practical rule seems to be this: that when iodide fails, we should try mercury instead.

"*Fish is Leprosy.*"

Mr. W. Clark, who has long lived as a missionary in Madagascar, has given me the following Malagasy proverb:—

NY TRONDRO NO BOKA = *Fish is leprosy.*

Mr. Clark tells me, as I have been told before, that the consumption of a small fresh-water fish like a gold fish is very large in the interior of Madagascar. The proverb bears testimony to the native creed as to the association between fish-eating and leprosy.

Effects of certain Drugs in Combination.

The prescription referred to in the following letter contained ten minims of tincture of aconite with two grains of quinine in solution, together with a third of grain extract of Indian hemp in pill. The pill and mixture were to be taken together three times a day.

"SIR,—The enclosed prescription will remind you of a consultation some three weeks ago. As soon as I began to take the physic and pill I experienced a burning and stinging feeling in the hands and feet. This extended to the rest of my body, and red splotches appeared all over my body, accompanied by a most intolerable itching which effectually banished all sleep. The rheumatism, however, disappeared except from my left shoulder, where it still remains. After a fortnight of the physic (the itching continuing all the time) I was obliged to give up taking it. The spots and itching then disappeared, but the rheumatism is developing again in my arms, but I am positively afraid to resume the physic. I write, therefore, to ask whether there is anything in the prescription that may be eliminated to avoid the itching which it sets up."

The symptom of itching which was here complained of may have been due to the Indian hemp, but I should incline rather to suspect the quinine.

MISCELLANEOUS.

No. CCCI.—*Fatty Tumour on the side of one finger.*

The tumour in the case referred to in the following letter was about as big as a small marble flattened out.

"DEAR MR. HUTCHINSON,—Perhaps you may remember a lady calling some time ago to show you her finger, when you were good enough to say you should be interested to know exactly what the growth turned out to be. I had it taken out a week or two since, and it proved to be a fatty tumour. The finger is quite healed now, I am happy to say."

No. CCCII.—*An Eruption after Vaccination.*

An infant three or four months old was brought to one of our Demonstrations a month after vaccination. It was in good health. The vaccination sores were not yet healed. The history given was that the child had had a general eruption of red spots over the body, face, and limbs, but this had disappeared, leaving only slight stains. There was said to have been some peeling in the feet, &c. The eruption was first noticed between ten days and a fortnight after the vaccination, and came out suddenly. The child had not been seriously ill. The eruption had disappeared without any special local treatment. It had been attended in parts by some little watery blisters.

QUESTIONS.

1. What may be inferred from the fact of spontaneous disappearance?
2. What was the nature of the eruption?

No. CCCIII.—*Scarlet Fever after Measles.*

A child of eight during an epidemic of measles passed through an attack of moderate severity. She had apparently got quite well, and was allowed to be out of doors, when one evening she complained of sore throat and felt unwell. Next morning a scarlet punctate rash appeared. The throat was much inflamed, and the tongue was red. The eruption developed during the next few days, and three medical men who saw it declared that it was scarlet fever. The temperatures for several days ranged from 101° to 103°. The tongue was said to be characteristic as well as the eruption, but it was a lobster tongue, not strawberry. Several other children who had not had scarlet fever were in the house, but no other cases occurred. There was no known source of infection, and the disease was not in the neighbourhood. Of course as soon as the diagnosis was made, all precautions as regards isolation, &c., were taken. The disease ran the usual course of scarlet fever, but was not followed by albuminuria or œdema. Moderate but definite peeling took place, and during convalescence erythema nodosum developed in the legs. The so-called scarlet fever occurred about three weeks from the date of onset of the measles. The child had never been further than the garden of the quite isolated house in which she lived.

QUESTIONS.

1. Is it probable that the second illness really was scarlet fever?
2. If so, what was its relation to the measles?
3. What suggestions can be made as to the source of infection?

No. CCCIV.—*Urticaria recurrent almost daily in connection with trivial exciting causes.*

Miss P——, a fair, florid woman, aged 43, consulted me in July, 1883, on account of a liability to attacks of urticaria. Menstruation was still regular, but she was very

liable to flush. The first attack had occurred eighteen months previously, and came on whilst at church during the evening. Since then she had rarely been free for a day. The eruption was better out of doors, but came on again at night. Almost always it appeared after meals, without much regard to the kind of food. Changes in diet had proved of no benefit. French plums were most certain to bring out the eruption. Sleep fairly good. Bowels open. Tongue clean and not abnormal in any way. For nine years a total abstainer. Miss P—— had had a similar attack of urticaria some years before.

No. CCCV.—*Congenital and symmetrical prolongation of the Olecranon.*

A man has both olecranons prolonged into a blunt spur which is directed inwards. It is developed from the inner side of the bone. He thinks it has grown lately, but I feel sure that it must have been congenital. It is quite symmetrical. I told him that it must be an assistance in getting through a crowd, and he seemed quite aware of his advantage.

No. CCCVI.—*Lupus of the Pharynx.*

Lupus of the pharynx is not a common malady, and when it does occur is almost always secondary to lupus of the nose. I have seen only two or three cases in which the disease had begun in the throat itself. One of these has quite recently come under notice. A delicate-looking little boy æt. 9 was brought to me by Dr. ——, with the history that he had already had much treatment for his throat, and that recently lupus had shown itself at one nostril. The diagnosis had throughout been that of lupus of the pharynx, &c., and scraping and cauterisation had been repeatedly practised with great benefit. The throat was now practically well, the uvula and the free border of soft palate having been destroyed. A small patch of ulceration on one tonsil was all that remained which could be called lupus. At the orifice

of the right nostril, however, there were quite characteristic conditions of lupus vulgaris. Here the disease had not as yet involved much skin, but it clearly spread within the nostril. I have no doubt that it had advanced from within by direct contagion. The results of treatment in the throat were most satisfactory.

No. CCCVII.—*Severe Convulsions—Hydrocephalus—Loss of both Eyes with Iritis, Corneal Ulcers, and probably Optic Neuritis.*

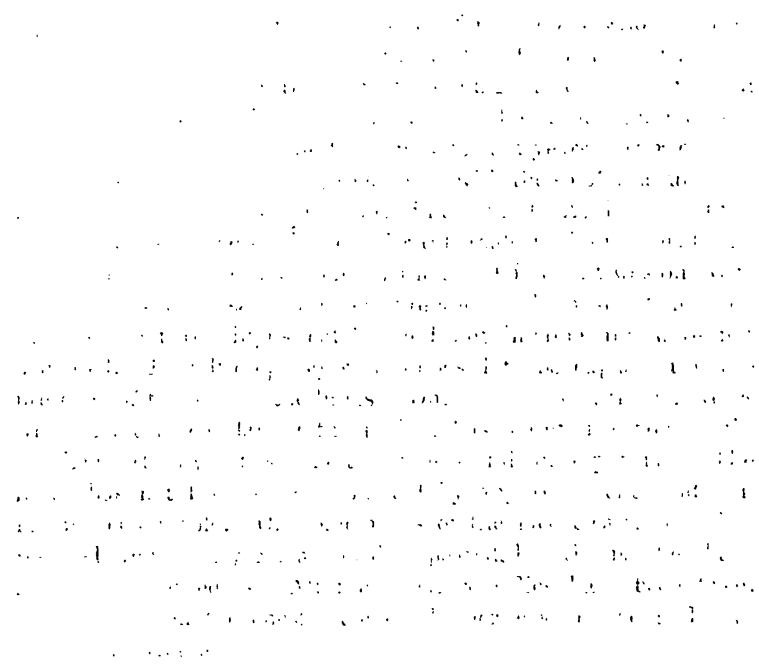
The following are the notes of a case which was sent to me by Dr. B—— in February, 1878. I saw the child only once, and do not know anything as to his subsequent progress. He had been, I believe, an out-patient at Great Ormond Street. I give his name, as it is possible that some of my readers may identify the case and be able to complete it. It was thought that one eye was clearing a little. The case is of interest in reference to certain examples of destructive ophthalmitis which occur in children after the exanthemata and severe illnesses.

William Barton, now two years and two months old (February 2, 1878). His mother's first. During his first year he ailed nothing, but when he began "to cut his double teeth" he had fits. He had five attacks of considerable severity within six months. The last was seven weeks ago. His head began to enlarge after the first fit. He "seemed to lose his sight with the fits," and his eyes inflamed. He is now believed to be blind, and has considerable leucomata in each cornea, but the pupil of right is not covered. His mother thinks that he cannot see light. In each there has been perforation of cornea, and anterior sanechiæ have formed. He has a very large head, the displacement of bones being in the posterior two-thirds. The forehead is not enlarged. He is very thin. No evidence of rickets. Premature growth of hair. He is growing a distinct moustache, and his forehead is covered with downy hair. Dentition rather backward. The lower incisors have fallen out. I did not succeed in inspecting his eyes with the ophthalmoscope on account of his fretfulness. He has probably had inanition ulcers of corneæ in consequence of his severe illness, but his blindness is probably due to optic neuritis.

PLATE CXLII.

LUPUS ERYTHEMATOSUS.

This portrait is that of a woman of middle age who had been several times, in the course of her life, suspected of phthisis. The diagnosis of tubercle in the apex of one lung was confidently given by a well-skilled physician at the time that her lupus commenced. She has been the subject of lupus now for ten years. Her case is a typical one of the erythematous form, with the somewhat unusual feature that patches have developed in the chest. At the time of the introduction of Koch's injections for tuberculosis she was made the subject of systematic treatment by them. The result was on every occasion a great rise in temperature and much constitutional disturbance, but the lupus patches did not inflame and were not benefited. This discrepancy was supposed to be explained by the presence of tubercle in the lungs. During, however, the six years which have since elapsed the patient has maintained fair health, and has certainly not become the subject of definite phthisis. The lupus has not been much benefited by any treatment, and still maintains its hold. On some parts of the face cicatrisation has resulted, and the erythema has disappeared, but the patches have spread at their edges. All the usual remedies have been tried. The patches on the chest have much increased in size, and have been very irritable.



West, Newman chror

ARCHIVES OF SURGERY.

JULY, 1898.

TWO CASES OF YAWS IN ENGLISHMEN.

THE papers * on Yaws which have recently appeared; the two Government Blue Books; and the Selected Essays republished by the New Sydenham Society, may be considered to have brought the facts very fully and fairly before the British profession. They may be held to have made it certain beyond cavil that either yaws is syphilis modified by climate and race, or that it is a distinct malady of a precisely parallel type. Observation and experiment have concurred in showing that these two diseases always originate in a primary local sore, that they observe the same periods in their stages of evolution, are both of them attended in their secondary stage by an abundant and general eruption on the skin, and that both may have remote sequelæ. In each instance immunity is conferred for a very considerable period. The chief points in which they are alleged to differ are, that in yaws the primary sore is rarely on the genitals, whilst in syphilis it is usually so placed; that in syphilis sores on the tonsils are common in the secondary stage, whilst in yaws the mucous membranes are not affected; and lastly, that the secondary eruption, which in syphilis may present many varieties of type, is in yaws always the same, and always frambœsial.

* See ARCHIVES, Vols. VII. and VIII., also *The Lancet* and *British Medical Journal.*

Those of us who have never visited districts where yaws is indigenous have been at some disadvantage, in that we could not critically examine these assertions. In the case of diseases so much alike in their main features it has always seemed to some of us a possible source of fallacy that, unconsciously by the observer, the examples of "yaws" were selected. We have proved that even in temperate climates the eruption of syphilis is sometimes frambœsial, and it is of course well known that the primary sore may be on any part of the body. It has therefore seemed to us that in a country where both maladies (if they be two) are prevalent all the cases beginning from genital sores may be counted as "syphilis," and so also all those which exhibited mixed eruption and sore throats. By a few exclusions of this kind the type of supposed yaws might be kept pure. It might easily be asserted that yaws never had a sore throat, and always had a frambœsial form of eruption, by the simple expedient of calling all exceptions to these statements syphilis. I do not for a moment hint that any one did this consciously, but I think it highly probable that it has really been done.

Amongst the weak points in the argument of those who contend that yaws is a disease wholly distinct from syphilis, has hitherto been their inability to produce an imported case for the inspection of English surgeons. As the disease is one which has stages as prolonged as those of syphilis, and as it is asserted that it is no respecter of race, we might have expected that, by chance, a case would now and then find its way to England. If I were to assert that no case of yaws, or what has been called so, has ever been recognised in England, it would be going beyond the truth. A few cases have been so named, but they have, I believe, all been in negro patients, and all in the late or tertiary stage. Now in this stage the diagnosis from syphilis is impossible, and rests rather with the self-confidence of the observer than with any demonstrable manifestations in the patient. The cases which we have wanted were not cases of this kind, but examples of the general eruption in the secondary stage. Of this I believe that, until the last three months, no case has been seen. I have often commented on this fact, and

when conversing with those who have lived abroad, and who believe in the specificity of yaws, have challenged the production of a patient. It is also remarkable that, although it is asserted that in the yaws-districts Europeans are not exempt, yet no one, writing on the malady, has given a good circumstantial narrative of such a case. One such was published long ago by Dr. Joseph Adams, but on examination of his statements no one can, I think, doubt that his patient really suffered from syphilis. I have recapitulated this case at p. 79, ARCHIVES, Vol. VII. Nor can I doubt that most of those who have studied the cases as detailed in the reprint of Professor Breda's essay in the New Sydenham Society's volume, have come to the conclusion that the supposed yaws was really syphilis. This conclusion is also supported by the plates there given, illustrating, amongst other points, ulcerations in the mouth and throat.

Such being the state of the facts, it has been with keen interest that I have during the last three months been enabled to examine two English patients who had contracted yaws abroad, and still displayed its phenomena in the secondary or eruptive stage. Both patients have come under my observation in private practice.

I will briefly record the chief facts as regards these two most important cases so far as they have at present gone. Both will probably be the subjects of more detailed statements at some future time.

CASE I.

In this instance the patient is a surgeon who pricked his finger with an injection-needle which he had just used upon a yaws patient. Nothing followed for nearly two months, when a little tubercle showed itself at the site of the puncture. Almost immediately another appeared by its side. They were treated very liberally and repeatedly with sulphate of copper, and never became painful and never showed any fungus growth. The latter was, the patient believes, prevented by the repeated cauterisations. There was never any enlargement of the glands in the armpit. The puncture was on

July 17, and it was not till the beginning of September that the primary sores were recognised. Three months later tubercles began to appear on the ankles, and these were followed by a general eruption on the body. At this stage the patient says that many of the sores were characteristically frambœsial, and he made no doubt as to the diagnosis of the disease. The primary sore had now soundly healed. From this date mercury and iodide of potassium were used, but the former only in very small doses (m. xv of Liq. Hyd.).

It was on April 19, 1898, nine months after the inoculation, that I first saw Mr. B——. At that date he had a general eruption of mixed character over his limbs and body. In the palms were peeling areas like the psoriasis palmaris so frequently seen in syphilis. On the wrists were well-margined patches of congestion with spreading edges slightly crusted, and on the limbs, &c., were many blotches and indefinite papules. There were also many stains and slightly marked scars where I was told frambœsial masses had formerly been. Nowhere, with a single exception, was any frambœsial growth still present. The exception was a single strawberry-like growth on the side of one ankle. This growth, the size of a shilling and raised much like the half of a strawberry, was very peculiar and quite characteristic. I inspected the throat and found nothing. The scars of the primary sores were hardly visible, and there was no trace of enlarged glands in the axillæ.

I advised Mr. B—— to take the grey powder pill (gr. i) four times a day, and with it five grains of iodide of potassium. Six weeks later Mr. B—— called on me again. His eruption had almost wholly disappeared. The palmar patches were represented only by stains, and the strawberry had withered and left only a florid scar. On the inside of one thigh a patch still slightly thickened and papillary remained, but it also was in course of disappearance. On the right tonsil were two small filmy patches. These were either new or had not been observed on the previous occasion. Mr. B—— told me that the mercury had purged him, and that he had not continued it more than half the time since his last visit. He had, however, continued the iodide, and been very diligent

in the local use of an ointment containing the white precipitate. On the supposition that the filmy sores on the tonsil were not part of the disease, but were caused by the mercury, they are important as evidence of the constitutional influence of the latter. Mr. B—— told me that at the time that he left it off the frambœsial sore on the ankle was still persisting, and that the chief improvement had occurred since. He was disposed to think that the iodide rather than the mercury had worked the cure. There is, however, nothing unusual in seeing improvement continue rapidly after mercury is left off, if the iodide be continued and local applications persevered with. At any rate, as regards the gross result, I may record the belief that I never saw a syphilitic eruption yield more rapidly and satisfactorily under specifics than this had done.

Case II.

My second case is that of a gentleman aged 28, who had long lived in South Africa (Benin). He had seen much of yaws, and had lived in company with those who had it. In January of 1897 a sore formed on the front of one forearm. He was not aware that he had been inoculated. The sore, according to his description, fungated. It lasted two months, in spite of repeated applications of caustic. In March some spots appeared about the ankles. They were called eczema, but were quickly followed by a general eruption over the whole surface. This rash was not attended by sores, and was probably in the main erythematous. The doctors who saw it spoke of syphilis, but one of the most experienced gave it as his opinion that it was not syphilis. No definite diagnosis was given. This was in May and June. In July the spots began to enlarge, and some of them fungated. This eruption persisted in spite of some treatment, and in December of the same year Dr. F——, who had seen yaws repeatedly and who was quite familiar with the malady, declared that this case was unquestionably yaws.

In April of 1898 Mr. W—— returned to England, still

suffering from the eruption. He placed himself under the care of Dr. Adam, of Liverpool, a surgeon who had practised abroad and was familiar with yaws. In May he came up to London and called upon me.

On May 11th, I found Mr. W—— covered from head to foot by a polymorphous eruption, which was especially severe on the lower extremities. Excepting that it was much more severe and abundant, the eruption was exactly like that in Dr. B——, and could not be distinguished from many seen in the secondary state of syphilis when inefficiently treated. Mr. W—— readily consented to my suggestion that he should attend at one of my Demonstrations, and his condition was there subjected to the observation of many competent observers. A photograph of his legs was also taken. At this stage no part of the eruption was definitely frambœsial. It was exceedingly mixed in character. There were lichen papules, pustules, erythematous areas, and patches with abrupt margins and with more or less of crust which resembled ill-marked forms of rupia or of lupus. Everywhere the spots were dusky and discoloured. It must be remembered that at this date the case had received much treatment, chiefly by the iodides, and that the eruption was probably in part controlled by it. There was no sore throat, and had not been any from the first.

I prescribed mercury, as I had done in the previous case, but do not as yet know the result. I also wrote to Dr. Adam, who had been consulted before I had, to know his opinion. He replied that he had considered the case as an undoubted instance of yaws.

As these two cases are still under observation, I will forbear to comment in detail upon them. We shall probably in the course of another year be in a position to speak more positively as to their nature. I may, however, venture now to point out that they quite discredit the statement that the eruption of yaws is not polymorphous, but always keeps to the frambœsial type. The two cases were alike, and in both the eruption was mixed and closely resembled what we see in syphilis. At the same time it is to be admitted

PLATES CXLVI. & CXLVII.

THE ERUPTION OF YAWS (AN EARLY FORM).

These two Plates, which have been executed from photographs, are intended to illustrate an early form of eruption in Yaws. They show the front and back aspect of the same patient, apparently a lad or young adult. The eruption consists of small patches, for the most part isolated, which occur freely over the trunk, limbs, face, and even the scalp. They are arranged with fair symmetry, and are tolerably uniform in appearance, with the exception that there is one in the left groin much larger than the rest.

It would be unsafe to use these portraits as demonstrating anything more than the location, size of patches, and generalised character of the eruption in the secondary stage of Yaws. The portraits do not show enough detail as to the condition of the crusts to make any description trustworthy. It may be stated, however, that in this stage the eruption of Yaws is described by authors as presenting different characters in different cases, being sometimes papular, sometimes scaly, and in others attended by greater or less tendency to the growth of raspberry-like granulations. As a rule, however, the latter are not seen till a later stage of the malady. The eruption here shown is stated to occur usually at about two or three months after the date of contagion.

N.B.—These two portraits, as well as the following one, have been published before. I re-introduce them for the reader's convenience, in order to keep in mind how closely the secondary eruption of Yaws, even on a dark skin, resembles that of secondary syphilis. The next Plate, CLX., shows how closely secondary syphilis in an Englishman may resemble Yaws.

West, Newman chromo.

PLATE CLX.

FRAMBŒSIA IN AN ENGLISHMAN.

This Plate, copied from a photograph, represents a well-characterised example of Frambœsia or Yaws Eruption in an Englishman. In this instance there was not the slightest doubt that the eruption, which was everywhere of frambœsial type, was syphilitic. The patient had had a chancre, and he was quickly cured by mercury. His eruption disappeared without leaving any conspicuous scars.

that in neither has there been any characteristic sore throat. The absence of enlargement of the axillary glands in both is probably no more than an accident, for no observer of yaws has failed to remark that as a rule there is a bubo. This was present in all cases in the series of experiments by Dr. Charlouis (see New Sydenham Volume, p. 341). One of my cases has yielded to mercury and iodides, just as syphilis might have been expected to yield. Here, then, I leave these important cases for the present, not, however, without venturing to hint the belief that, thanks to the attention which has been attracted to the subject, and the ready communication which now exists between the yaws-districts and England, the question is likely before long to be finally set at rest.

POSTSCRIPT.

Since the above statements were in type, and only just before going to press, I have seen for a second time the patient who is the subject of Case II. He has taken mercury for about five weeks and is almost well. His eruption has everywhere faded and for the most part only stains remain. As in Case I., the symptoms have disappeared as rapidly as is ever witnessed in cases of syphilis. Some peeling patches in the middle of his palms still persist. I had omitted in my notes to say that he had suffered from pain and tenderness over the upper part of the tibia. Of this also he has been quite cured by the mercurial course. It was precisely in the position in which syphilitic patients in the secondary stage often have a slight and temporary periostitis.

I feel justified by what has occurred in this case, coinciding as it does so exactly with what was observed in Case I., in saying that I feel no doubt that yaws and syphilis are one and the same disease. These two cases were unquestionably yaws in Africa, and in England they have most certainly proved to be syphilis. The supposed differences between the two maladies are simply due to race and climate.

ON XANTHOMA AS A SYMPTOM.

To the zoologist some of the most interesting animals are those which appear to afford connecting links beween species, or which indicate alliances between different genera. It is the same in clinical pathology, although here the lines of distinction between differing species are much less definite than in the zoological field. In other words, the factors of causation are more easy of combination, and hybrids and mongrel forms are more easily produced.

We recognise in the Xanthoma or Xanthelasma group four different types: 1. The common xanthoma which occurs on the eyelids, and is often indicative of liability to sick headaches from liver disturbance, but not of organic disease of the organ. 2. A general eruption of sudden outbreak and capable of spontaneous disappearance, which occurs to the diabetic, and also sometimes to those who are severely bilious but in whom the urine does not contain sugar. 3. A form which is consequent on persisting jaundice and indicative of organic liver-disease and great disturbance of health. In this form plates and lines of xanthoma form in various parts and notably in the flexures of the finger-joints. 4. A congenital and family form in which, without any disturbance of health, children present xanthoma spots and patches on various parts, more especially on those prone to be affected in psoriasis. Thus, then, we count X. palpebrarum, X. diabeticorum, X. ictericorum, and X. congenitalis. The bond of connection which allies them all is the circulation of bile-acids in the blood as a primary cause, and this receives its modifications from other conditions, such as inheritance, the proneness to psoriasis, and the degree of persistence of the liver-disturbance. We meet every now and then with mixed cases, and one such, of very remarkable interest, I have now the pleasure to narrate.

CASE I.—*Xanthoma of Eyelids in exceptional positions—Deep pigmentation of Eyelids, &c.—Jaundice—Lobules of Ears affected.*

Miss B——, a fair complexioned, thin, and somewhat fragile-looking young lady, was sent to me last April by Mr. K—— C——, of H——. She was twenty-three years of age. Her eyelids were deeply pigmented, not in patches but in a diffuse manner, the upper ones being especially so. Large ill-defined patches of xanthoma were present on both lids, but they occurred not, as usual, above and below the inner canthus, but on the middle of the lid. They were not in the least raised, but looked rather as if the skin had been scorched. On the deeply pigmented skin they were not very conspicuous, but sufficiently so to have caused the patient great distress. On the tip of the lobe of each ear was a patch as large as the end of the little finger, which at first sight I took for lupus, but on careful inspection it was evident that here also was the dull-yellow growth of xanthoma. The patches on the ears, like those on the eyelids, were accurately symmetrical. No other spots of xanthoma were to be found on other parts of the surface either on trunk or limbs. Miss B——, however, alleged that she had suffered much from eczema, and the eruption to which she gave this name consisted of little dry nummular patches on the face, arms, &c.

The history of the antecedents was as follows. Xanthoma was not known in the family, but there was gout and liability to severe bilious attacks. Miss B—— herself had suffered much from headaches, often so severe as to make her go to bed, and always attended by dark pigmentation around the eyes. Her xanthoma on the eyelids had first been noticed about ten years ago, at the age of twelve, and the patches on the lobules of the ears had followed soon after. Two or three years after this she experienced an attack of deep jaundice which lasted a considerable time. This had, however, passed completely away, and had left the skin not in the slightest degree tinged. With these exceptions the general health, although not strong, had been fairly good.

She had suffered from habitual chilliness, but not specially from cold extremities. Her chief reason for seeking my advice was the desire to get rid of the disfigurements. As regards treatment, I advised that the ends of the lobules of the ears should be cut away, but that the patches on the eyelids should be left to themselves, as they were too large and too ill-defined to admit of excision. A mixture containing nux vomica, taraxacum, and small doses of mercury was prescribed.

Amongst the noteworthy features in the case we may remark: (1) the early age of the development of xanthoma palpebrarum; (2) the unusual position of the patches; (3) the extreme pigmentation of the eyelids; (4) the occurrence of xanthoma on the lobules of the ears and the simulation of lupus vulgaris in these positions; (5) the occurrence of a prolonged attack of jaundice in a patient already the subject of xanthoma of the eyelids.

Case of severe Nervous Disturbance in association with Xanthoma of the Eyelids and Bilious Headaches—Hemiopia and Petit-mal.

A case which is instructive in reference to the nervous disturbances which occur in connection with the liver disorder which is denoted by xanthelasma palpebrarum, has recently been under my observation. Its subject, Mrs. R. R——, is now forty-three years of age. She has been married twelve years, but has borne no children. Her xanthoma consists of very thin yellow patches placed in the usual positions above and below the inner canthi. They have been demonstrated to my class at Park Crescent on two occasions. The patches are symmetrical and extensive, but, as usual, larger on the left than the right side. She has also slight acne rosacea with tendency to eczema on cheeks. The xanthoma patches had been present some years at the date of my first consultation by Mrs. R—— in 1896. The exact date of commencement could not be assigned. At that date Mrs. R—— was described in my notes as of "a bright, clear, florid complexion."

It seems probable that the liver disorder is on the increase rather than otherwise, and in spite of treatment. At present Mrs. R——'s complexion could not be described as clear or bright. Her nervous disturbances have also increased. She asserts that her liability to sick headaches began only about the time that she first noticed the yellow patches on her eyelids. At any rate she was never considered bilious in girlhood. After the age of twenty, however, she became liable to a bad sick headache about once a year. One of her grandmothers had been liable to similar ones. These had increased on her until, when she came to me in 1896, she frequently had them once a fortnight. She was also at this time liable to what she described as "awful sensations" in her head. A sort of wave, lasting not longer than half a minute, would pass over her brain, making her feel as if she must lose consciousness or might even die. She was liable also to waves of icy coldness in her limbs. For eight years past she had been annoyed by incessant noises in one ear. They never ceased day nor night, and were synchronous with the heart's beat. When the pulse intermitted, so also did the noises. To these statements, which all refer to April, 1896, may be added that she had never had jaundice. I prescribed small doses of mercury with nux vomica.

My notes in November of the same year record that her sick headaches had been less frequent since she had taken the pills, but that she was not better in other respects. She had become liable to attacks which would seize her in the street and oblige her to stand quite still for a few minutes, feeling as if she would lose consciousness or fall. On other occasions she would experience a feeling of faintness and her face would become momentarily of a claret colour and then white. She had also exaggerated sensations of horripilatio and "tinglings as of electricity." She had occasionally "flashes of electric light" in her eyes, and her hands and feet often became quite cold.

After the above note I did not see Mrs. R—— for eighteen months. When she came to me on April 22, 1898, I noted that she had lost her florid complexion, and looked pale, with a slight tinge of yellow. She had become liable to

attacks of hemiopia, during which she lost perception of objects on her left side. These attacks would often last half an hour at a time, and sometimes she lost all perception of things around her, although never in absolute darkness. Her custom was, when they occurred, to go to her bedroom, draw the blinds, and lie down until the attack passed off. Almost always severe headache followed. In addition to these she was frequently troubled with palpitation and had what she called "seizures." During these she would have to catch hold of some support to avoid falling.

On a subsequent occasion (June 1, 1898) I made the following note:—

"She complains very much of her heart. It is often rapid, and then does not intermit; but when it slows down, then she is troubled with painful intermissions. The pulse is often 120, and very feeble. When lying down, she says it is seldom that five beats occur without an intermission.

"She was feeling better than usual at Christmas. She once took the Vi-Cocoa, and it made her heart very bad. She has been liable to sensations in the top of her head, brought on by assuming the erect position and attempting to walk. It comes as a sort of wave up the top of the back of head and causes a dreadful sensation in the vertex, and makes it impossible for her to walk. The important point is that the recumbent posture quite relieves her. During the whole of January last this liability was so distressing that she never did more than just leave her bed, dress, and get to the sofa. She believes that nux vomica makes her worse, and so also digitalis.

"At present she is often obliged to sit up all night on account of noises in her ear."

General Comments on the preceding Cases.

I have ventured into considerable detail in describing the symptoms present in this case because I believe that it presents a good example in an exaggerated form of what is very common. It may perhaps be allowed to stand as a type of what is possible in connection with long persisting disorder of the liver. The xanthoma patches are valuable as affording the most conclusive evidence of such disorder. Although functional and only temporary in the first instance, we may reasonably suspect that organic tissue changes in the liver have been slowly set up. Or it may be that the organic and permanent changes

are in the nerves which regulate the hepatic functions rather than in its gland constituents. For clinical purposes the distinction is perhaps not of great importance. What we have to recognise is that liability to liver-derangement may induce in youth paroxysmal attacks attended by such symptoms as sick headache and the like, which in more advanced age may culminate in retinal epilepsy, migraine, hemiopia, and a variety of alarming nervous phenomena. Amongst these we may probably count some of the examples of Meniére's symptoms. The ancient popular creed which attributes a large proportion of human infirmities—especially those of the recurring or chronic class—to the liver, is probably well founded. This large and most important viscus is very prone to derangement from very various causes, and when disturbed in function reacts very seriously on the general health. This it does partly by reflex influence on the nervous system and partly by poisoning of the blood. As a revealing symptom, giving, as I have already said, conclusive proof that such agencies have been at work, we have the various forms of xanthoma.

No doubt in the production of the symptoms described in the case before us the heart and the circulation take a very considerable share. The derangement of function in the heart is, however, yet secondary to that of the liver, and not organic.

I am particularly anxious to assert, and if possible to prove, the influence of the liver in producing the disturbances of health alluded to, because it is possible to bring that organ into a better ordered condition by the use of drugs, exercise, and diet. More especially do we possess in mercury and taraxacum two remedies which, if used with judgment and at the same time with sufficient freedom, are capable of effecting wonders for those who are liable to recurring attacks of liver disorder. Many patients who have in the course of treatment for syphilis submitted to long courses of small doses of mercury obtain complete immunity from bilious attacks to which they had been for long previously subject.

CASES ILLUSTRATING EXCEPTIONAL FORMS OF HERPES.

(*Concluded from page* 131.)

Recurring attacks of Herpes, preceded by low spirits and irritability.

A medical friend has supplied me with the following interesting observation as to recurring herpes, of which he is himself the subject. He is of a somewhat melancholic disposition and spare habits. Although married, he leads, I believe on account of his wife's health, an almost absolutely celibate life. His age is about 48. For several years he has been liable to recurring herpes, sometimes on the penis, but more usually on the upper part of the right thigh. He seldom passes more than a month or six weeks without one. The attacks are, he says, always followed by a remarkable improvement in his temper and spirits. For some days before they occur he is moody, despondent, and irritable; as soon as the herpes begins he feels cheerful and himself again. He assures us that he often longs for an attack for a week before it comes. He has been quite unable to associate the attacks with any special cause. They do not, he thinks, appear to be catarrhal.

General remarks on cases of Recurring Herpes.

It can scarcely be supposed in such cases as that just narrated that the herpes is in itself any cause of relief to the system. The extent of the dermatitis is far too small to be productive *per se* of any material influence. It is rather to

be suspected that the herpes is itself caused by some more general change in the organism of which it is symptomatic.

The study of the phenomena of recurrence in herpes must be conducted broadly and with full recognition of the laws of both physiological and pathological periodicity. There is no doubt that changes in season have their influence on the animal organism, and remotely connected with them, but to a large extent independent, are also those of the sexual system. Although only females menstruate, there can be little doubt that the male organism also experiences periodically recurring excitement of a certain kind. Amongst pathological facts we have the well-known proneness to recur, after intervals, of epilepsy and of catarrh. We know also that those who have once suffered from a malarial fever are liable for many years afterwards to periodically recurring symptoms which are in dependence upon some influence then received by the nervous system. It is of causes such as these that we must think if we would explain the recurrence of herpes. A previous attack of syphilis is probably by far the most common cause. The sexual system and a liability to catarrhal explosions probably come next, each separately taking its share. In the English population malaria is probably not now a very frequent agent. Amongst maladies most nearly parallel with herpes in respect of recurrence we have erythema multiforme and cheiro-pompholyx. Of all three it is, I believe, true that a long course of arsenic will break the habit, and at the same time improve the patient's general health. A very remarkable case in proof of this is one which I have often quoted in which a mother used to give her boy his arsenical mixture whenever she observed him to be out of temper. It also always prevented attacks of erythema, to which he was liable.

A severe Herpes of the Penis, Glans, and Skin, after Ague and Syphilis—Very frequent recurrences.

That herpes of the glans and prepuce often follows venereal sores and may be very troublesome in its repeated recurrences is well known. What the state of health is

which favours its development we have not yet recognised. The case of Mr. V——, who consulted me in August, 1877, suggests that possibly the state left after severe ague may have sometimes a share in causing it. He has for the last eighteen months been seldom more than a week or two at a time free from herpes on the penis in some form. Sometimes it comes on the glans or prepuce in oval patches, and sometimes in long groups of vesicles on the skin of the organ. Each crop fades in a week and heals, but fresh ones recur so frequently that he is rarely well for long. He had syphilis some years ago, and three years ago he suffered very severely from ague in Bulgaria.

Recurring Herpes on the Cheek from æt. 4 to 17.

Miss H——. She is seventeen, and since the age of five has been liable to recurring attacks of herpes on the right cheek. Once she was a whole year without it. During the last year she has had it more than once a month. It has always been on the right cheek and near to the same place, but not exactly. In the present attack it curves forwards and downwards from ear to corner of mouth, just like zoster; but on former occasions she says it has been much more limited. She is well grown and in good health. She is not catarrhal, and does not associate the herpes with cold-catching. She is regular, and does not think that the herpes has anything to do with her periods.

Her mother once had shingles. (October 27, 1892.)

Recurring Herpes in the Nose in a girl whose mother and brother were liable to Herpes.

Miss S——, aged 15, has a crop of herpes spots on the edge of left ala nasi. On the tip of the nose is a red patch which has not developed vesicles.

Her first attack was a year ago, and she has had very numerous attacks since. During June and July she was exempt. The present attack has been one week, and the spots are healing. Sometimes the attacks are so near to each other that there is scarcely any interval of freedom.

Her mother has been liable to the same on the middle of chin. She has had recurring attacks with long intervals since girlhood. She feels sure that her attacks come from exposure to cold; not so much catching cold as exposure to cold wind.

A brother has very bad attacks of herpes labialis, and others in the family are also liable. In all it is believed to come in cold, damp weather, and to be in some sort a taking of cold.

CASES ILLUSTRATING HERPES FRONTALIS AND HERPES OPHTHALMICUS.

The following cases are additional to those which I have published in the Ophthalmic Hospital Reports, Vol. V., 1866, and in ARCHIVES, Vols. II. and VIII., 1866.

Herpes of the Forehead and Nose with affection of the Eye.

Mrs. G——, a thin old lady of seventy-four, was sent to me by Mr. L——, of I——, in August, 1884, on account of fronto-nasal shingles with inflammation of the eye. The eruption had been on the left side, and deep scars remained both on the forehead and side of nose. The whole of the side of nose had suffered. As regards the eye, it had been very painful and much inflamed, and although it was six weeks since the attack when I saw her, a condition resembling phlectenular ophthalmitis was still present.

Herpes Frontalis of great severity—Some years of after-pain—Extensive scarring.

Mrs. C——, aged 54, consulted me on account of the after-pain of herpes frontalis. It was three years since her attack. She said that it began by pricking pain in the eyebrow, "as if two little bits of glass were pricking or jagging in it." "I never had such a pain before." This pain was present for two days before any spots came. The pain increased when the spots came, and the skin sloughed. The diagnosis of herpes was given from the first. Dr. G——, a physician who saw her, advised the use of cocaine. Cocaine

made her, she thought, very much worse and increased the pain fearfully. So did carbolic acid.

I never saw such scarring from herpes. It looked at first sight like morphœa. A line ran straight up her forehead, and from it to the middle of the temple the whole was a white scar. She had had dreadful after-pain, which had lasted two years and had only recently abated. The pain was now a burning one, and came only when she was tired, but there was always some discomfort. Not the least scar was present on the lower two-thirds of nose, and not the least damage had been done to the eye itself, although the whole upper lid was in a state of scar. There was a scar on the side of bridge of nose, but it was abruptly limited.

Loss of Sensation (temporary) after very severe Herpes Frontalis.

Mr. W——, of Pontefract, aged 35, came to me in January, 1884. He had been through a most severe attack of herpes on the left forehead. He had been in bed a fortnight, and for a time was delirious. His forehead and scalp were deeply scarred, and he still experienced much pain and numbness. The skin had been so numb that at one time he could not feel the prick of a needle in the least, but after some months this had improved.

Severe Herpes Frontalis; much after-pain.

Mrs. N——, a lady of 63, consulted me on October 3, 1880, on account of the after-pain of herpes frontalis. She had been in bed three weeks and the attack had been called "erysipelas." It had left her right forehead and upper eyelid covered with scars.

Severe Herpes Ophthalmicus attended by congestion of the Eye—Severe inflammation of the Eye with Iritis three months later.

Miss McT——, aged 41, was sent to me on September 16, 1893, by Dr. McQuitty, of Belfast. On June 10th an attack of shingles had begun, involving the left forehead. She was

in bed a fortnight and was for a month in the dark. She was taking medicine at the time for neuralgic rheumatism of the right arm and right side of the face. There was little antecedent pain, but while the eruption was out there was much throbbing in the temple. The vesicles appeared on the whole side of the nose, with a group on the lower part of the cheek and on the upper lip, and scars had been left in these positions. Some vesicles also formed inside the mouth. The eye had suffered at first, but had got fairly well when, as she thought, she had caught cold in it. When she came to me the eye was acutely inflamed. The cornea was a little steamy and the iris very muddy and adherent at its pupillary edge, but the pupil dilated well with atropine. There was much congestion of the ciliary region and some thickening of the conjunctiva. There was very severe pain, especially at night. The sight of the eye, however, remained fairly good.

ILLUSTRATIONS OF ABORTIVE HERPES.

The dermatitis of Herpes must always be regarded as a sort of complication of neuritis. It is the latter which is the essential part. Following on this is the admission that very probably many cases of neuritis of what we may call the herpetic type do not proceed so far as to produce vesiculation over the end-organs in the skin. This latter being absent, there would be no "herpes" in the ordinary acceptation of the word. To such cases the designation of "incomplete" or "abortive" herpes may be given. It may possibly be the fact that they are far commoner than the completed cases, and that the eruption should be regarded as an exceptional complication, present only in severe cases. Thus many forms of localised pain, unexplained by any concomitants, may be of herpetic character. The following cases appear to bear upon these statements.

Abortive Symmetrical Zoster, from Arsenic.

Miss McR——, æt. 21. She has a very slight, quite abortive eruption on *both* sides, curving round about the hips like herpes. Has taken arsenic m. vi. for one month.

The spots have been present a few days, and have caused no pain. No vesicles have formed.

Zoster whilst taking Arsenic—Abortive Papular Eruption on neighbouring parts, bilateral but not symmetrical.

Mr. S——, aged 33, on May 20, 1893, presented on his back, curving round the right side of chest and crossing the lower angle of the scapula, the healing sores of a profuse herpes zoster. The curious point, however, was that the neighbouring regions, chest and arm, were covered with papules. These were almost solely on the right side (back and front), but there were also a few on the left upper arm. I thought that he had used some irritant, but he assured me that nothing stronger than vaseline had been employed. He had been in good health throughout. Three weeks previously he had felt a pricking in his back and arm, and for the last ten days had been taking Fowler's solution in five-minim doses, three times a day.

On May 27th, the eruption was everywhere better. The pustules were fading. There had been no pain.

Double and multiple Herpes Zoster arrested at the papular stage and then persisting for some weeks—Entire absence of irritation.

The subject of the following case was a man who was sent to me by Mr. Tay from the London Hospital, September 10, 1875. I print the notes as they were then written.

The peculiarity of this case consists in the fact that the patient has on various parts of his trunk large groups of papules arranged like herpes zoster, but which have, he states, remained exactly in present condition for six weeks. The resemblance to herpes zoster in an early stage is so exact that at first sight I made not the slightest doubt as to its being an example of that disease, nor was this similarity diminished on more careful inspection; but it is the early stage of zoster which alone is represented; there being papules only and no vesicles.

The chief patch, or rather group of patches, extends round

his right side about the level of the lower dorsal vertebræ to the middle of the abdomen close to the ensiform cartilage. It is a broad patch, and at its middle as large as the outspread hand. It is distinctly corymbiform, and there is a small patch a little below crest of right ilium. There are irregular areas of healthy skin between the principal groups of papules. He has another distinctly corymbiform patch half the size of the palm of the hand just over the middle of the crest of the left iliac bone, and there are some scattered groups of similar nature about the posterior margins of left axilla, on side of chest just below axilla, and over the posterior edge of deltoid. There are a few scattered spots also passing from axilla backwards over lower part of scapula and spine. There is a much less marked irregular patch just over inner side of right knee, and another smaller about six inches higher up on inner side of the right thigh. There are some ill-marked patches on inside of upper part of cleft of buttocks.

Thus it will be seen that the herpetic patches show a tendency to symmetry; *i.e.*, there are two groups on each side of the trunk, but not exactly on the same level. Those on the iliac crests coincide very closely, but on the left side the upper group is on a level with the lower border of the axilla, whilst on the right side it passes considerably below the nipple. There is no representative on the left knee of the patches on the right knee. Thus the right side suffers more than the left.

His statement is that the large patch on the right side was the one that first attracted his attention, and that all the others made their appearance almost immediately, or at any rate within a week afterwards. He is a healthy man, æt. 23, of fair complexion. Never had shingles before. The patches have been wholly unattended by irritation, and he states that unless he had seen them he should never have been aware of their presence. He thinks that they are now, at the end of six weeks, almost exactly in the same state as when they first appeared.

There is no suggestion as to cause. When I heard of its long persistence I suspected that it must be syphilitic, but

on inquiry it seems certain this is not the case. He had not been taking any medicine.

Numbness and Pain in one Hand and Arm, probably in connection with Herpes Zoster—Some senile changes in the Nerve supply.

Mrs. E——, a thin old lady of 81, came to me in January, 1866, on account of pain, with numbness, in her right hand. For about a year her little finger had been getting numb and contracted, and she now had scarcely any sensation in it. Within the last three months the other fingers had followed, those nearest to the little finger being most involved. Her thumb she could still use. In November, 1865, she had an eruption on the ulnar side of front of arm, from axilla to wrist, which, from her description and from the scars left, I should suppose to have been herpes zoster. It caused her great pain. She had also a few spots on the right chest and shoulder. Mrs. E—— complained very much of pain about the ulnar nerve behind the inner condyle, and said that it was tender when touched. All her fingers were somewhat contracted, and all swollen and glossy, but at their pulps somewhat shrivelled. They were tender when touched. The swelling did not affect the joints more than other parts. The arteries of the limb appeared to be in good condition, and I could not feel any rings of chalk in their coats. She could still see to thread her needle without a glass, and had only a moderate arcus senilis. It was a curious feature in her case that the pain came on only in the daytime. It was often very severe for hours together, but at night it went off and she slept well. The fingers ached very much if exposed to the air. She had noticed that they soon got chilled if exposed, and hot if covered. We kept her arm and hand enveloped in cotton-wool, and thus protected, she was fairly comfortable.

A few weeks after her first visit to me she began to have swelling of the right foot, and redness in the dorsum of the great toe, and I feared that possibly an attack of gout was threatening, or, worse, that she might have senile gangrene.

Herpes affecting the Cervical Plexus district and abortive on the Peripheral regions.

September 13, 1871. Amy S——, æt. 10. Mr. Tay sent me to-day a good example of herpes affecting the cervical plexus tract of skin. The spots covered all the side of neck and mastoid region, the whole also of the ear, and also extended just above the ear a little way into the skin of the hairy scalp. In front of the ear they covered the aural region of the cheek, and passed downwards towards the angle of mouth and chin. There were none between the eye and temple, and none on the nasal half of cheek, none on the lip-regions or within an inch of the angle of the mouth. On the front of the neck they came everywhere up to the median line. The spots ceased to be numerous a little above the level of the clavicle, but there were scattered groups of them on the clavicle and below it, and these were especially abundant just in front of the shoulder joint itself, and inwards over the tendon of the great pectoral. Behind, the eruption did not pass so low down as in front, ending for the most part just behind the upper edge of the trapezius, but there were a few well-marked clusters lower than this over the supra-spinous fossa, and one very ill-developed on the infra-spinous district.

I may note in this case, what I have often seen before, that the groups outlying the legitimate district were everywhere faintly marked. Some of them were scarcely vesicular, merely abortive papules. The further off the slighter was their development, whilst those in the middle of the district were acutely inflamed and contained bloodstained serum.

CASES OF HERPES AFTER CONTUSIONS.

Many observers have noticed herpes as a consequence of bruises and other injuries. I saw recently a lady who, after a severe fall down some steps in her garden, had great pain over one hip. For some days it was supposed to be from sprain or contusion, and she kept her bed, being quite unable to sleep. After about four days of this pain and the use of many forms of anodyne there appeared an eruption of

herpes, which ran its usual course and ended the more deep-seated pain. I had myself seen this lady before the herpetic vesicles made their appearance, and quite failed to predict their advent. The pain was not referred to the skin, and there was at first not the slightest redness.

Mr. Clouting, of Thetford, once reported to me a case in which a woman who had received a severe blow on the side from the handle of a windlass had zoster come out on the bruised part.

Mr. Alfred Kebbell, of Flaxton, York, has given me the notes of a case in which a boy was kicked by a horse on the side of his chest. There was no proof of fractured rib, but he had great pain in inspiration. Six days after the kick zoster was well out. It was reported that some appearance of spots was observed as early as thirty-six hours after the kick, but possibly this was a mistake.

Dr. Hirosa, of Buenos Ayres, was kind enough some years ago to send me the notes of a case, with a sketch, in which herpes of both arms had followed the use of the interrupted electrical current.

MISCELLANEOUS CASES ILLUSTRATING EXCEPTIONAL FACTS.

Herpes of Cervical Territory in Cheek.

Mr. C——, aged 42, was the subject of herpes in front of the ear and on the chin; regions supplied by the cheek-branches of the cervical plexus. There was one vertical patch midway between the tragus and the eye, another in the whiskers and another under the jaw. There had been severe pain and stiffness of the neck, and there was still much swelling. (October 25, 1880.)

In 1884 I learned that Mr. C—— had had no further attack of herpes. There was then a scar-leaving acne on his forehead and temples.

Symmetrical and severe Herpes of both Ears in association with a severe Rigor and Sore Throat.

A young man, aged 21, liable to sore throats, had on a Thursday a severe rigor with a commencing sore throat. It

proved to be a worse throat, and was a far worse rigor, than he had ever had in his life before. He shivered till his teeth chattered. This was on a Thursday, and on the following Saturday he found both ears hot and covered with little red pimples. On the Tuesday following, Dr. Sangster sent him to me, and he then had ulcers in his tonsils and a copious eruption of herpes on both ears. The latter was remarkably symmetrical. It affected both lobules severely, and spread over the helix and antihelix, but not to the upper parts of the latter, nor did it pass into the concha. The back of the ear on both sides was affected. It had been developed a little more rapidly on the left than the right side and was already fading there, on Tuesday, whilst still in perfection on the other; but perhaps this was due to the circumstance that it was more severe on the right. On both sides the vesicles were in groups, and on both some small groups occurred on the skin of the cheek just in front of the tragus.

No doubt in this case the herpes was symptomatic and part of the consequences of the severe rigor. Probably herpes of the ears may not unfrequently be in this relation; but I do not recollect ever to have seen it so definitely such as in this instance. Nor have I ever, I think, seen it so symmetrical. The young man told me that he had often had spots on his lips (herpes) when he had colds.

A febrile illness with high temperature — Herpes of the Pharynx.

A gentleman, aged 36, whom I had attended twelve years before for syphilis, came to me with the following curious history. He had been four days in bed with a febrile illness and much sickness. His temperature had one evening reached 105°. He had had no pain anywhere excepting "just a little catch in my throat now and then." He looked ghastly pale, and he had indeed very improperly left his bed to come to me. I found a crop of herpetic sores on the right side of his pharynx and one or two on his lip; but on careful examination, could not find any evidence of visceral inflam-

mation. In proof of his good health previously he had presented himself for examination for life insurance on the day before his attack commenced. (October 5, 1894.)

Extensive Herpes of the Lips and Chin in a child—Deviations from symmetry.

Herpes is almost never present round the mouth on both sides. In the following case, one might have at first sight been inclined to exclaim "symmetrical herpes," but on carefully looking it became evident that it was most definitely non-symmetrical. The patient was a little girl aged 8. The right upper lip was involved; but the left side had escaped. The lower lip was involved everywhere excepting just below the oral commissure. The eruption was also present below the chin on the left side, reaching to the middle line but not beyond it in the least. There was an oval patch in front of the right ear. (January 31, 1877.)

It is to be observed that this case was not an example of herpes labialis only. Branches of the cervical plexus were also affected.

Case in proof that Herpes labialis may be symmetrical.

I have to-day (October 21, 1862) seen herpes labialis acute, severe, and most characteristic whilst quite symmetrical. It involved both upper and lower lips, and completely surrounded the mouth, extending, as usual, to some distance from its angles.

The patient was a healthy-looking boy aged 13, and the rash had only shown itself one day before I saw him. He said that his lips had never been sore before. He had otorrhœa from right ear. He stated that on the day of the outcome of the eruption he had much running from the nose. He did not, however, to me, appear to have much catarrh.

Zoster affecting branches of the Cervical Plexus.

Miss R——, aged 26, was the subject of severe herpes zoster on the left side of the back of the neck, extending in

an almost horizontal bar lengthwise over the whole clavicle. The eruption was very abundant over the whole length of the back of the neck, and there were some ill-developed spots on the deltoid, but they did not extend on the chest lower than the clavicle, and there was a free space between the back of the neck and the affected area over the clavicle. The important point was that the patch over the clavicle ran almost horizontally (just like morphœa in my portrait). It had begun a week previously. (November 1, 1893.)

Bilateral but unsymmetrical Eruption of persisting pustules.

Mr. R——, aged 40, in good health, was the subject of numerous and large groups of ulcerating pustules arranged exactly like herpes zoster. Two groups on the left side of the chest curved downwards and forwards just like those of zoster, and there were other groups on the neck, arms, and thighs and one just below the left knee. The eruption was bilateral, but most definitely non-symmetrical, and no two patches corresponded. The pustules left scars, but had never ulcerated extensively. They did not coalesce, but remained as separate papules.

I am sorry that the above note is a very imperfect record of the case, but I cannot give further particulars. It appears to be important as an example of a most unusual form of herpetic eruption. It had persisted for some weeks, but I cannot state exactly how long, nor do I know the sequel.

A case in which Facial Paralysis followed immediately after Herpes of the Temple and Ear.

On July 12, 1888, Mr. F. M. Corner, of Manor House, Poplar, sent me an interesting example of paralysis of the portio dura in association with herpes zoster. The eruption had affected the auriculo-temporal branch of the fifth nerve, and had been severe. It had lasted three weeks, and was fast disappearing when facial paralysis on the same side occurred. The latter was very definite but not quite complete. By strong efforts the patient could bring down the upper eyelid so as to nearly touch the lower one. He could

not raise the lower one at all. The lower one drooped so as to expose the conjunctiva. The mouth was drawn to the left, and he had little or no power of moving the cheek. He could wrinkle the forehead on both sides.

The patient was a man of about fifty, the superintendent of a Sailors' Home. I believe that he recovered in the course of a few weeks.

Severe Herpes of the Lesser Sciatic Region during the use of Arsenic.

A very marked case of herpes during treatment by arsenic occurred to me in May, 1876. A young man, the subject of psoriasis, was under care at the Skin Hospital, and had taken Fowler's solution in doses of three minims three times a day for one year. He was just well of the psoriasis and in good health, excepting that he had somewhat lost flesh, when his herpes occurred. It affected the back of his left thigh, and a group of vesicles occurred also just below the popliteal space, whilst other small ones were present on each side of the ankle, just below each maleolus. The calf wholly escaped, and there were no spots on the perineum or scrotum. The region of the lesser sciatic nerve was that chiefly affected. I admitted the man into the London Hospital in order to demonstrate to our students the very unusual distribution of the herpes, as well as to illustrate its apparent connection with the use of arsenic. We had cured this man of his psoriasis eight years before, and he had remained quite well for five years. On that occasion arsenic agreed with him well.

It is difficult to explain anatomically why with herpes of the lesser sciatic region a few vesicles should occur below the maleoli, but no doubt they proved that, in this individual at least, some of the nerve twigs found their way there.

Two examples of Recurring Zoster.

Mr. Davey, late of Romford, related to me the facts of a case of persisting shingles. It occurred in a lady of 65, who for a year and a half was liable to herpes in a belt on the left side of the chest. Vesicles formed over and over again,

but always on the same area. At the end of the time mentioned the tendency ceased, and she lived ten years longer, in fair health.

Mr. Davey also told me of another case, in which an elderly gentleman had had three attacks of shingles with intervals of a few years. They were all on the same side, and nearly on the same region.

On Cases in which the healing of Herpes is delayed.

Now and then, with extreme rarity, we encounter cases of herpes in which the sores are slow to heal. When this occurs we may almost take it for granted that the patient is the subject of syphilis. The only other cases which I have met with in which herpetic sores lasted longer than their usual duration, were one or two in which the herpes had been caused by arsenic, and in which that drug was continued after it had appeared. This happened in the case of a young lady named B——, for whom I had prescribed arsenic in very full doses for the cure of psoriasis. After some months' use of it she had a most copious eruption of common zoster on the right side of the chest. She left off her arsenic for a week only, and then resumed it. Instead of disappearing, the scars assumed the condition of scaly papules, and in this state they persisted, I believe, for two or three months. They were not in the least irritable, and Miss B—— was in good health and had no other symptoms of arsenical disagreement.

The study of herpes as an illustration of peripheral neuritis, and in reference to pathological doctrine, is of extreme interest, quite apart from its clinical aspects.

Arsenic causing Zoster. (*A note written in May*, 1876.)

"Some years ago I published the opinion that arsenic, given medicinally, might produce herpes zoster. No year passes without my having under observation cases in confirmation of this belief. It is of much interest to note that sometimes it occurs only after a long course of the drug, which has not disagreed in the least. Indeed it is, I think,

never attended by the more common symptoms of intolerance of arsenic, and the patient may resume or even continue the drug without fear of a repetition of the herpes, and without in the least interfering with its usual course."

Case of constantly recurring Herpes on the skin of the Penis and on both sides of the Buttocks—Recurrences so frequent that he was scarcely ever well—History of an indefinite sore four years previously, cured by local treatment and not followed by constitutional symptoms —On the Buttocks scars left by the Herpes—Arrest of Herpetic tendency by the use of Arsenic.

ARSENIC-KERATOSIS AND ARSENIC-CANCER.

AT page 63 of the present volume, the case of a patient under the care of Dr. Bullock, of Notting Hill, is briefly recorded as an example of Arsenic-Cancer. The patient, a man of forty-six, had been from boyhood the subject of psoriasis, and had taken arsenic liberally for many years. Finally two of his psoriasis patches had taken on cancerous ulcerations, and in connection with one of them a large gland growth had developed in the right groin. It was only for about a year that the ulceration had attracted much attention, but it had been present for a longer period. So deceptively like syphilitic ulceration had the disease appeared, that, under the advice of a distinguished physician who had been consulted, although the history of syphilis was wholly absent, a long course of mercury had been given. The same history has, I may remark, been present in most of the examples of arsenic-cancer which have come under my observation. I am now enabled to record the conclusion of this case and also to cite some others.

By the courtesy of Dr. Bullock I visited this patient at his own house in February, 1898. He was now confined to his bed, and very ill. We noted some important features in the progress of the sores. The gland mass in the groin had broken down, and formed a large excavation, at the bottom of which masses of firm granulations projected. This excavation involved Poupart's ligament, which stretched as a bridle across it. There appeared to be also a large gland-mass within the brim of the pelvis. No enlarged glands were to be found in other parts. The original cancerous ulcer on the abdominal wall had to a large extent lost its features. Its elevated border had softened down, and its surface showed florid low granulations. It might indeed

have been supposed that it was about to heal. The sore on the back had undergone similar changes, and was no longer characteristic. It also looked clean and florid, as if about to heal, but it had during two months made no progress in scarring. The man's skin generally was harsh and dry, and in many parts of the abdomen and limbs there were little dry scaly pits as big as a small finger-nail, with slightly raised edges not unlike those which occur on senile skins and sometimes precede epithelioma. Yet the process which had produced them was in the main one of atrophy, and the evidences of growth in their edges was exceedingly slight. All traces of the original psoriasis had disappeared.

A few weeks after my visit I heard from Dr. Bullock that the man was dead. He had died from exhaustion and pain. It was not possible to obtain permission to make an examination, and no specimens were obtained for the microscope. I have, however, already recorded that a microscopic examination of portions excised from the ulcer for diagnostic purposes had formerly been made by a highly skilled histologist with only negative results. Exactly the same had occurred in another case. Yet, in spite of the microscope, both cases had run a malignant career.

Arsenic given in early life—Liability to Epilepsy—An eighteen months' course of Arsenic—Subsequently Keratosis of the palms and soles—Excision of Ulcers from the palms—Cancerous implication of cervical glands—Multiple Keratosis with ulceration—Rapid extension and death.

A lady, aged 45, was sent to me with a very peculiar combination of symptoms. She had long suffered from keratosis of her palms and soles, and recently a growth had developed under the skin of the left mammary region, and a large glandular mass in her right neck. There were also smaller gland tumours in the left groin. The keratosis had been diagnosed and treated as specific, but the surgeon who sent her to me wrote that there was no history of syphilis, and that she had three healthy children. She had been from time to time under several specialists. Her own

account of her case was that her skin ailments had begun twelve years ago by a loosening of the nail of her left middle finger. The nail fell off, but the part did not become sound. Three years later her heels and palms became dry and hard, and she was sent up to London to see Dr. L——. Syphilis was not at that time diagnosed. The palms and soles subquently became very troublesome, and in 1894 she went to Harrowgate, where the opinion was given that the disease was due to syphilis. Treatment on that hypothesis, however, did no good. About a year before I saw her she recognised a lump in the middle of the right neck, and a little later another under the breast. About the same time warty growths appeared on several other parts. There was something in the appearance of the palms and soles which, together with the multiplicity of the lesions, led me to at once suspect that she had suffered from arsenical poisoning, and this suspicion derived some support from the facts that new growths were developing independently in two distinct regions, and that she had formerly suffered from epilepsy. She told me that she had taken much medicine, but did not know what. In her younger days she said that she had taken arsenic for several years to clear her complexion. I communicated my suspicion to the surgeon who had sent her to me, and he was good enough to search out her old prescriptions, and found that during the years 1879 and 1880 for twenty months consecutively she had taken ten minims of Fowler's solution a day. It was given her for her epilepsy, and this was five years before the affection of her palms and soles began. From admissions which the patient made to me, however, there were grounds for suspecting that she had taken more arsenic than her medical attendants knew of. As has been said, she admitted having taken it for several years in girlhood for the sake of her complexion, and not improbably it had been the cause of the epilepsy which it was afterwards prescribed to cure. This, however, is the sum of the evidence that was obtainable, and it is to be added that her friends doubt much whether she had taken any arsenic later than 1880. My diagnosis was that the gland mass in the neck was of a sarcomatous nature. It was

very firm, and was in the middle of the neck; not, as usual, under the jaw. The glands composing were firmly welded together. The mass altogether was as big as a child's fist. The tumour under the left breast did not implicate the gland itself, but was developed apparently in the cellular tissue. It was somewhat ill-defined, and not very hard.

The sequel of the case may be briefly told. The gland mass in the neck was excised. I was not present at the operation, which was done in the country. It was attended, I was told, with much difficulty, as the tumour had grown rapidly since my consultation, and had become adherent to the adjacent parts. It adhered both to the carotid and subclavian, and was probably not completely got away. A portion of it was sent to the Clinical Research Association for examination. The report was that it was not sarcomatous as I had suspected, but "a squamous-celled epithelioma, either in or closely attached to a lymphatic gland. There are very few cell-nests, and in places the growth is degenerative."

The operation wound healed for a time, but the growth quickly recurred. It grew most rapidly, and spread up the neck to the side of the head. The patient became insane, and subsequently comatose, and so died, about four months after the consultation and three after the operation. It was believed that growths had developed within the skull. There was no autopsy.

In view of the verdict that the gland mass in the neck was epitheliomatous, we had to seek for some primary growth on skin or mucous membrane. There had never been any growth in the mouth or throat, though at one time she had had difficulty in swallowing. A not improbable supposition seemed to be that the infection had come from the hand. On two occasions thickened and ulcerated portions of skin had been excised from the palm. These unfortunately had not been examined microscopically. On each occasion the wound had healed well, but the disease had soon returned. In these features the course of the disease had closely resembled that of the patient who was the subject of my first report on Arsenic-Cancer. It was indeed the resem-

blance of her palms to his which made me suspect arsenic. They were, however, in a less pronounced condition. For the reader's convenience I here reproduce the portraits of the hands in the former case. In the present instance we had no opportunity for taking a sketch. The suggestion that the growths in the palm were the source of infection to the glands in the neck is supported by the fact that the axillary glands had not wholly escaped. In my former case the gland tumour appeared in the armpit according to rule. It is clear, however, that in these cases of arsenic-cancer the infection is not quite according to rule. In the former case, growths were found at the autopsy in the chest and adherent to ribs. There is a definite tendency to multiplicity, the tissues of the body generally appearing to have been predisposed by the arsenic to take on the cancerous process.

I may state that not only were my own suspicions as to arsenical causation at once aroused when I saw this patient's palms, but that when I showed my drawings of my original case to Mr. L——, the surgeon who had excised the ulcers from Mrs. L——'s palms, he at once remarked that the conditions exhibited were exactly alike. We may therefore fairly assume that the appearances presented by arsenical keratosis and arsenical cancer are peculiar, and that they are to some extent trustworthy as a means of diagnosis.

In my next case, as yet, no cancer has been developed. We have only the condition of arsenic-keratosis. The arsenic has been wholly relinquished for some years, yet the keratosis persists. In this we have an illustration of a most important possibility. It would appear—for several other cases confirm the fact—that the influence of arsenic upon the skin in predisposing it, first to keratosis and next to cancer, is not limited to the time during which the mineral is in use, but may be evidenced years afterwards. It is, indeed, not impossible that the prolonged use of arsenic gives to the tissues a proclivity towards cancerous processes which may last through the remainder of life.

In one of the cases above cited, although the evidence is open to some question (since it is not certain that the

patient had not taken arsenic on her own account and unknown to her medical friends), the interval between the disuse of the drug and the appearance of the cancerous ulcers in the palms would appear to have been several years. All the stages of the disease are, indeed, peculiar and especially prone to delay. The early periods of the cancerous process are ill-marked, develope very slowly, and infection of the lymphatic glands occurs only after a long interval. Even when the disease reaches the lymphatic glands it is erratic in its course, and may be either very slow or very rapid. In the case just referred to the patient came under my observation for a large gland-mass in the neck, which at first was thought to have been primary. It was only on careful inquiry that the facts came out that she had formerly had enlarged glands in the armpit, and before that ulcerations in her palms, which had been excised and repeatedly scraped.

Arsenical Keratosis of Palms some years after the disuse of Arsenic—Conditions persisting without change for two years.

Miss C——, aged 35, a nurse, was in the first instance sent to me in January, 1896. I saw her for a second time in February, 1898, when she was good enough to attend for demonstration at one of my Conferences. Her condition during the two years had undergone little or no change. She was the subject of keratitis of the palms and soles consequent on the use of arsenic. The arsenic had originally been prescribed for the benefit of an erythematous acne of the face, and at that time the palms and soles were soft and quite free from irritation. The prescription was continued steadily for two years or more. Towards the end of that time the palms and soles had become dry and horny, and this condition had continued ever since.

At the present date, five years have elapsed since the arsenic was left off. The soles of the feet now show, under the tread of the toes, thick and large plates of induration like widely spread-out corns. The same are present under the heels. At other parts the skin is dry and

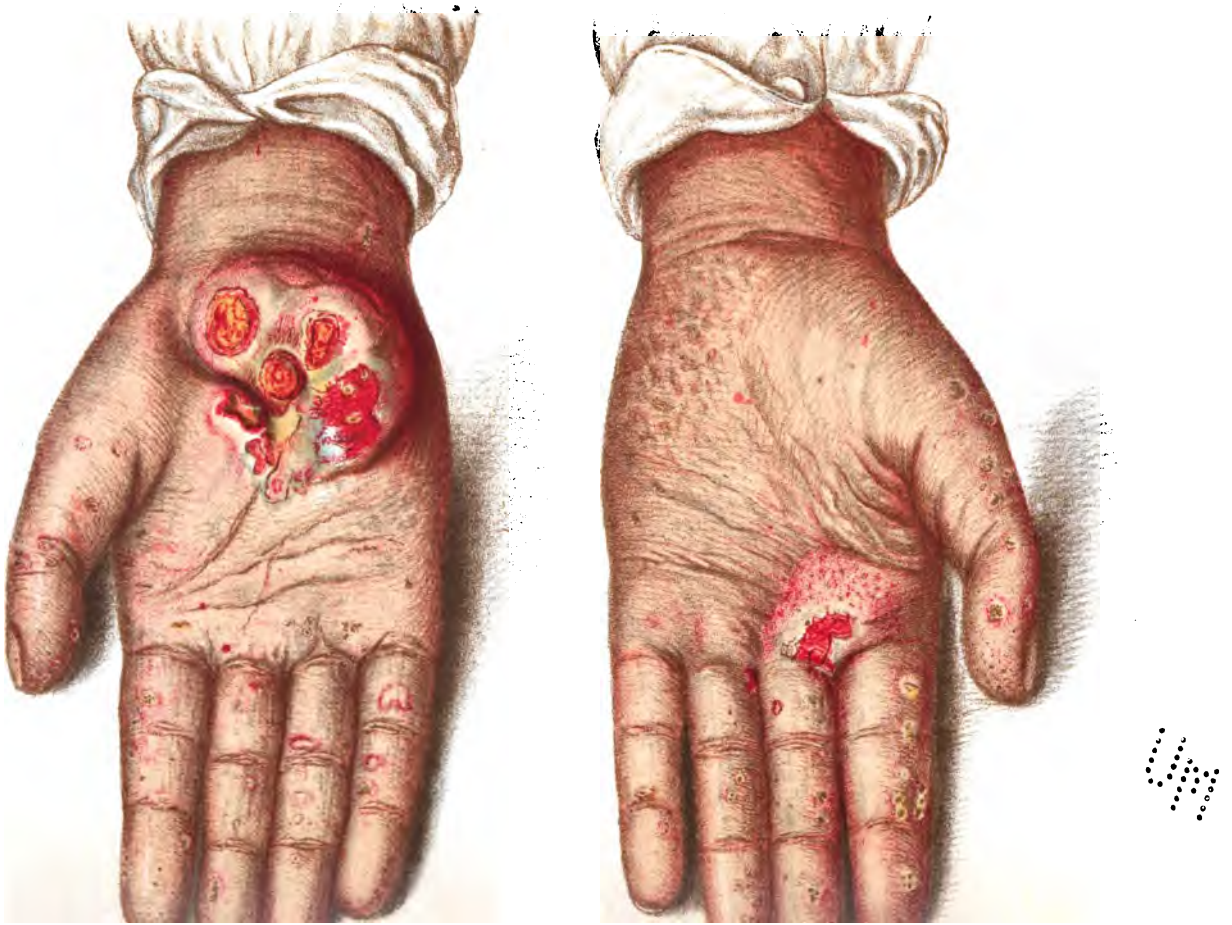
PLATE XX.

ARSENIC-KERATOSIS AND ARSENIC-CANCER.

The palmar surfaces of the two hands of Dr. W——, who became the subject of arsenic-cancer. It will be seen that the palms are exactly like that of the hand shown in Plate XVIII., but with the addition of a fungating growth in each. That in the right palm is of considerable size and thickness, and is placed just above the wrist. That in the left is much smaller, having been of more recent development, and shows only a reddened excoriation between the index and middle fingers, beneath which there is a certain amount of thickening. In this case common psoriasis had been present in the first instance, and arsenic had been given in large doses over a long time for its cure.

After this portrait was taken, Dr. W——had his right hand removed by amputation through the forearm. He died within a year, with recurred malignant growths in the glands and viscera. The form of cancer was a modification of epithelial.

The case is narrated in full in the 'Pathological Transactions,' and I possess reprints of the paper.



rough, and shows little corns and pits. Immediately under the arch of the foot the skin is comparatively soft. The palms of the hands and palmar aspects of all her fingers are harsh and dry, and the skin uniformly a little thickened. There are also numerous low corns, most of them slightly excavated in their centres.

At my Demonstration I placed several drawings from other cases by the side of Miss C——'s hands, and the changes present were seen to be most strikingly similar. It should be added that the arsenic had in Miss C—— left no other ill consequences. The rest of the skin was soft and healthy.

SOME FURTHER NOTES ON BAZIN'S MALADY.

ONE of the chief features of interest attaching to what are now known as Bazin's legs is the deceptive resemblance to syphilis which they present. I have seen many in which the simulation was close, but none more instructive than the following:—

Ulcers on the Legs spreading serpiginously and assuming the Horseshoe form—No history of Syphilis—Diagnosis of Scrofula.

The Rev. Mr. B—— brought to me his daughter, aged 16, a blooming girl of florid complexion and fair skin. I had previously heard respecting her that "a large horseshoe-shaped ulcer" had formed on the right calf, and "some smaller ones on the left, deeply ulcerated and sloughing, their edges blue and congested." My informant added, "These ulcers have gradually taken a healthier tone, and the large one is healing in its centre. In spite of this improvement there seems to be forming a line of ulceration outside the original sores, and taking the same shape." These expressions well described the principal features, but did not give an adequate idea of the extent of the disease. On both legs the child had ulcers as large as the palm of the hand, healing in their centres, but spreading and very unhealthy at their margins. Outside the margins were also a number of smaller ones with undermined edges and very unhealthy surfaces. The horseshoe form and the punched-out character were conspicuous features. In some places the edges were ragged and flabby. I was told that the ulcers had been present and advancing for four months,

and that the earliest condition had been a sort of chronic, painless boil which broke down in the centre. The child had not been obviously out of health, and she lived at the seaside under favourable conditions. Her appetite was, however, always very poor, and her circulation feeble. She had had chilblains.

Now against the diagnosis of syphilis we had in this case the facts that all history of it was wanting, and that the girl's physiognomy and teeth showed nothing whatever in the least suspicious. Add to these that the ulcers on her legs were just like those in other cases of Bazin's malady.

In support of the diagnosis of scrofula her mother, who came with her, showed me extensive scars of scrofulous ulcers in her own neck, and told me that several near relatives had died of lung disease. Further, the child had had inflamed eyes and eyelids of the strumous type.

There is a symptom which I always inquire for as corroborative evidence in these cases. It is the condition which Dr. Tilbury Fox named cacatrophia folliculorum, and is usually present as little hard, livid, lichenoid papules on the backs of the arms just above the elbows. Many persons have this who have no ulcers on the legs, but few who have the latter fail to show also this cachectic or scrofulous form of lichen. It was present in a marked degree in our patient.

The question of treatment is very important in these cases. With such extensive ulceration, and with a general condition of slight œdema of the legs, it seems an obvious thing to insist on confinement to the recumbent position. It is, however, most certain that no definite improvement results from that measure. I have seen several cases in which it failed completely, and in which the ulcers finally healed whilst the patient was walking about. Exercise and fresh air are indeed important measures. It is well, however, to insist on the recumbent position whenever, under other circumstances, the patient would be sitting, and a good deal of time should be spent in bed. Warmth is essential. Tonics, wine, cod liver oil, small doses of opium, are all valuable; but, above all, it is important to use ointments or lotions

containing mercury. Great benefit sometimes accrues from caustics, such as pure carbolic acid or the acid nitrate of mercury.

As regards the association of these scrofulous ulcers on the legs in children with scrofula in a parent, the explanation is of great interest. It is difficult to believe that the inheritance is solely that of tissues of a vulnerable kind. There is not the slightest probability that any external infection is necessary to evoke the malady. On the contrary, indurations under the skin are almost always its first stage. This is the second case in which the mother of the patient has shown me her own neck seamed with scrofulous scars. The probability is, I think, very great, that at the time of conception the bacilli of tubercule do in some form pass over from parent to child, and that they remain in the latter latent until roused into activity by local conditions pertaining to the legs. The cacatrophia folliculorum to which I have adverted is probably a form of scrofulous lichen.

The results of treatment in this case were very satisfactory. I prescribed an ointment containing several salts of mercury, and advised that the legs should be carefully bandaged and the patient allowed to go out. The diet was to be liberal, the clothing especially warm. Six weeks later I heard that the ulcers had been soundly healed for a fortnight, and that the general health was much better since exercise had been allowed.

Bazin's indurations on one Leg in association with Lupus Vulgaris on the other.

I saw with Dr. George, of Brondesbury, a very interesting example of this affection, the point of exceptional importance being that the patient had the typical erythema induratum knots on one leg without any ulceration, and on the other a large patch quite indistinguishable from superficial lupus. Our patient was a young woman of about twenty-six, who had a scar in one side of her neck which had been left by an abscess in childhood. She had lost a paternal aunt in chronic phthisis and a brother in "consumption of the bowels." She

herself was stout, but pale, and her shoulders were covered with acne. She had never been suspected of lung disease. The affection of her legs had existed for three years, but had several times been nearly well. It had been wholly confined to her left leg until within the last eight months. It was during about the same period that the sore on the left calf had assumed the condition of lupus.

A peculiar form of infective Ulceration of the Skin of the Thigh in association with Scrofula.

A most peculiar, indeed in my experience unique, form of infective disease of skin and subcutaneous cellular tissue was presented in the case of a young lady whom I saw in March, 1898. She was twenty-six years of age, and had come over from New Zealand with a letter giving a full description of her case. She was tall, of rather dark complexion, and bore not the slightest indication of inherited taint. Her teeth were perfect. I mention these facts because there had been doubts expressed, and her father had admitted that he had, in youth, had a chancre. He had since enjoyed excellent health, and none of his children had shown anything. One of his sisters and "all her family, one after the other," had died of consumption. Our patient showed no signs of scrofula, but had suffered very much from cold feet and headaches.

The affection for which Miss R—— had been sent to me consisted in a large, very irregular area of ulcerated cicatriced and indurated skin in the front of her left thigh, about its middle. It extended from near the great trochanter downwards and forwards to the inner side. There were no crusts, and only the very smallest ulcers, at the time of my seeing it, but the skin was in the condition of a hard, seamy scar, with very irregular prolongations in various directions. The induration was as great as that of cicatricial keloid, but it involved the subcutaneous tissue rather than the skin itself, and nowhere rose above the general level. It had been diagnosed as an example of Bazin's malady, affecting the thigh, and in some respects this name seemed appropriate.

It did not appear, however, that there had ever been the inflamed subcutaneous nodules which characterise that affection. It seemed that there had been continuous infection and no separate foci. The history was that it had begun insidiously as "a rough, hardened spot" at the age of seventeen, and had been slowly advancing ever since.

Erythema induratum of the Scrofulous under exceptional conditions and in unusual positions—No Ulceration.

A most instructive example of subcutaneous indurations which became erythematous, and which occurred in association with scrofula, occurred in the person of a gentleman who came to me from Southampton in May, 1898. He was fifty-three years of age and in good health, but from boyhood had been unable to digest fat, and nine years ago he had required an operation for fistula. These facts were, I must admit at once, all that I could get as justifying the belief that he was scrofulous. Nor was there any known history of tuberculosis in his family. He had never had syphilis.

The conditions shown me by Mr. H—— when he called on me on May 26, 1898, consisted of a number of indurated plaques in the subcutaneous cellular tissue. There were six of them, and in various stages of development. There were also some depressions in the skin where others had formerly been, but as none of these had ever actually ulcerated, there were no scars which really involved the cuticle. The initial condition was a rather deeply-placed knot, very hard and but little tender. These knots gradually spread out and became closely adherent to the skin, but for a considerable time without obvious congestion. In the later stage the skin overlying the induration became of a dusky red. Some of the plaques which I am describing had attained the size of crown pieces, and the largest was as big as the palm of the hand. Their edges gradually shelved off. In their centres the induration was probably half an inch in thickness. This largest one was threatening to soften in its middle and to ulcerate.

Five of the indurations described were on the left lower

extremity, one of them being behind the hip, two on the thigh, and two on the leg. The sixth, which was of quite recent formation, was on the right leg, and as yet showed no redness. Thus it will be seen that the left lower extremity had chiefly suffered, and it may be added it was on the left side of the anus that the fistula had been present. Mr. H—— told me that it was five years since the first induration (in his left leg) had formed, and from that time onwards he had never been wholly free. Those which had disappeared had vanished completely, leaving a thinned spot in the skin. They had been very slow in their stages, occupying many months in progress. None had ever looked so much ulcerating as did the one now present in the left thigh just above the knee. It was indeed the threatening condition of this patch which had caused Mr. H—— to seek further advice. The indurations had never been painful, and Mr. H—— had throughout continued his occupation and enjoyed good health. He had lived liberally, but not too freely.

At first sight I was disposed to suspect that these indurations were specific gummata, not observing that none of them had shown any tendency to spread infectively at their borders. My mind soon relinquished that suspicion, and noted their similarity to the multiple strumous abscesses of young children. We had, however, the obvious difference that none of these had ever formed abscesses, and that although one now threatened ulceration the inflammation was quite superficial. The theory which finally I was inclined to adopt was that they were really of the same character as those of children, and that their differences resulted from the age of the patient and the vigour of his health. Suppuration occurs far more readily in the young, whilst in the sixth decade most inflammatory processes are slow. It seemed very probable that the original tuberculous infection had spread downwards in the lymphatics from the fistula in ano. The case differed from the more ordinary forms of Bazin's malady (Erythema induré des scrofuleuses), in that although it had begun on the legs on both sides, yet it had spread to the thighs, and in that the tendency to suppurate

had been restrained. In this latter feature, however, the case fits better with what Bazin described than do the large majority of examples of the disease as observed in English practice. Bazin, as the name chosen by him implies, recognised erythema rather than ulceration. With us, however, in England the erythematous indurations almost invariably break down, and the resulting ulcers constitute the most characteristic feature.

CANCER AND THE CANCEROUS PROCESS.

Keloid caused by a hot poultice—Family history of Cancer.

A young lady at a boarding-school had a sore throat. A hot linseed-meal poultice was applied just over the top of the sternum. She complained of the heat, but was told to bear it. Next morning there were blisters, and sores followed. Three months later she was brought to me with a group of glossy keloid buttons on the scar of the scald. Some of them were a quarter of an inch in thickness. There was a history of two relatives having suffered from cancer. A grandfather had died of cancer of the tongue.

This is the third case in which I have seen keloid follow the use of poultices applied too hot. The history of malignant growths in other members of the family is quite usual. It gives strong support to the belief that peculiarity in vital endowment, and not the attack of any parasite, is the cause of cancerous modes of growth.

Rodent Ulcer on the same part with similar peculiarities, and beginning at the same age, in a brother and sister.

I have had under observation for eight years a gentleman of upwards of sixty of a very fair skin, who has had a rodent ulcer on his right malar region. After repeated cauterisations it has soundly healed, and has now needed nothing for two or three years. It was always somewhat remarkable for its exceedingly superficial spreading. My reason for now recording the case is in order to mention that a sister of the patient, ten years younger than her brother, has just consulted me for a precisely similar ulcer on the same cheek and exactly in the same place. I never saw conditions more precisely repeated, and it will be observed that in each

case the disease has commenced at about the same age. Such cases make a strong impression in favour of the hypothesis which attributes cancerous action to congenital peculiarity of tissue and not to parasitic attack.

On the prospect of life in cases of Cancer of the Lower Bowel, and on the inexpediency of premature operations.

I fear that I sometimes very reluctantly hurt the feelings of my younger and more energetic colleagues by giving my vote against what seem to me premature operations for malignant disease of the lower bowel. Sometimes the operation proposed is for artificial anus, and sometimes a laparotomy in the hope of being able to excise the diseased part. I am told that I much overrate the dangers attending this latter procedure and the inconveniences of the former. It may be so, but we must all base our judgment in these matters upon the facts which have come before us. My mind is so framed that I find it impossible to yield implicit faith to statistical statements when they are at variance with my own experience. I am frequently seeing patients with cancer of the bowel, easily detected from the anus, in whom the symptoms are but trifling, and the general health is well maintained from year to year. One such used to call on me once a year for four or five years without getting materially worse, and the disease of which he finally died was a catarrhal attack on his lungs. In another, although at one time much reduced by bleeding, the patient recovered and had two years of good health before any serious symptoms set in. During these two years he had enjoyed field sports and lived as others. I have just seen an old gentleman of 80 whose case has prompted me to write this note. He is in excellent health, but is troubled by a bearing down in the rectum and a feeling as if he had not completely relieved the bowel. This is all that he suffers from. Yet it is more than two years since I first recognised malignant ulceration with much induration and polypoid growths. I might record many such examples, but the following one must suffice.

Mr. K——, whose case is published in ARCHIVES, Vol. V., was brought to me for a second time on September 24, 1895. It was then four years since I had recognised malignant disease of the rectum rather high up, It had then caused so much bleeding that a state of very serious anæmia had been produced. The hæmorrhage having been arrested by ergot and steel, Mr. K—— had regained good health and resumed his ordinary mode of life. He had experienced very little trouble from his bowel until within the last few months. He lived two years longer. His death occurred on the 28th of December, 1897. It was thus six years since the cancer had been first discovered, and during the greater part of this period he had suffered little or nothing.

I can only repeat that in consultations in cases of this kind, I often encounter statements which seem to me exaggerations in two or more directions. The danger of the operation is put at much lower than it really is, whilst the probable duration of life without it and the possible freedom from pain are much under-rated. The facts which come under my observation, as well in reference to the performance of operations as to their avoidance, do not incline me to recommend them excepting in cases in which the patient's sufferings are considerable and not relieved by drug treatment.

Rodent Ulcer on the same part, with similar peculiarities, and beginning at the same age, in a brother and sister.

I have had under observation for eight years a gentleman of upwards of sixty, of a very fair skin, who had a rodent ulcer on his right malar region. After repeated cauterisations it has soundly healed, and has now needed nothing for two or three years. It was always somewhat remarkable for its exceedingly superficial spreading. My reason for now recording the case is in order to mention that a sister of the patient, ten years younger than her brother, has just consulted me for a precisely similar ulcer in the same cheek and exactly in the same place. I never saw conditions more precisely repeated, and it will be observed that in each case

the disease has commenced at about the same age. Such cases make a strong impression in favour of the hypothesis which attributes cancerous action to congenital peculiarity of tissue and not to parasitic attack.

Epithelial Cancer on the skin of the abdomen in a young woman—Paget's Malady.

A very important and unusual case was brought to our Demonstrations on May 26 by Dr. Jekyll, of Leytonstone. The patient was a married woman of twenty-six, of spare frame, but in good health. On the left side of the trunk, just above the iliac crest, was a large patch as big as an outspread hand which, with some hesitation, had been called "Lupus." It had been slowly spreading at its edges for two years, but recently in the middle of it a fungating bossy growth had developed which had ulcerated in its centre, and now presented a very unhealthy, almost sloughy surface. It must be understood that this tendency to fungate had been present only two months, and was quite a new feature. The rest of the involved area was congested and discoloured, but not ulcerated, and was crusted in parts by a thick scab which could be detached without causing bleeding. These crusts were more like those of psoriasis than of lupus. Nor was the margin of the patch like lupus. It was most abruptly defined, and consisted of a low, sinuous roll like that of a very superficial rodent ulcer. There was not the least trace of apple-jelly-deposit nor of the flabby granulation masses which occur in lupus. The part which had been left by the advancing edge was not in a characteristic condition of scar. It remained dusky and discoloured, but it was not easy to demonstrate that there had been destruction of tissue. The skin adjacent to the borders of the patch was quite sound and white; not the slightest congestion preceded the advance of the disease.

The diagnosis of granuloma fungoides suggested itself, as also that of cancer of scar. Under either hypothesis it seemed very desirable that prompt extirpation should be effected, and with this object I procured the admission

of the patient under the care of my son into the London Hospital.

The operation performed consisted partly in excision and partly in deep erasion.

Microscopic examination of the parts removed demonstrated that the growth was epithelial, and of the type met with after eczema of the nipple and now recognised as "Paget's Disease." In connection with this histological diagnosis, for which I am indebted to my son, the description of the naked eye conditions acquires increased interest. The character of the spreading edge was very similar to that of the most superficial forms of rodent. It may perhaps, indeed, be doubted whether there is any real difference between some of these and "Paget's ulcer."

A good portrait showing the appearances referred to has been preserved for the Museum.

ON THE POSITION OF LICHEN SCROFULOSORUM AMONGST TUBERCULOUS AFFECTIONS.

THE affection of the skin which Dermatologists recognise as Lichen Scrofulosorum presents a very interesting problem to the students of tuberculosis. What is the nature of its connection with the bacillus? Why is it so easily curable? Why does it never merge into some one of the other forms of tubercular disease of the skin such, for instance, as lupus? There does not seem to be any doubt that it occurs chiefly to the scrofulous or to those in whose near relatives other definitely tubercular disorders have shown themselves. The worst examples of it that I have seen have been in the subjects either of lupus vulgaris or angular curvature of the spine. Yet here we see a very superficial and insignificant skin affection which never runs on to ulceration, is scarcely attended even by congestion, and which seems to get well of itself. We have in the Clinical Museum an excellent water-colour drawing which all authorities recognise at a glance as exhibiting this disease in a typical form. It was shown at the Congress two years ago and was accepted by all. It is perhaps the best delineation of the disease extant, for Hebra's plate and some others show it in an exaggerated and not very typical form. It may be of interest if I briefly record the facts as regards the patient who was the subject for this portrait.

Mrs. W—— is a widow, whose husband died of pneumonia within a few years of marriage, and left her with two fair-haired, blue-eyed, very delicate-looking boys. It was the younger of these who developed the lichen scrofulosorum. His elder brother has recently become the subject of enlarged cervical glands. The boy with lichen was seven years of age when the portrait was taken. He had then

had the eruption out for about a month. On more than one occasion I produced him for inspection at a Clinical Demonstration.

The following description of his eruption was written out when I first saw him :—

Grouped minute lichen spots in areas as large as pennies, but not abruptly margined, and with no tendency to form rings. The spots in the middle of the patches persist, and are usually rather larger than the more recent ones at the periphery. No comedones. The spots where subject to friction become polished, but do not show any tendency to enlarge or to coalesce.

The patches occur most abundantly over the outer parts of thighs and about the region of the great trochanters, but they are seen also on the shoulders, upper arms, abdomen, elbows, and sides of knees. They do not itch in the least. The skin upon which the lichen spots occur is pale or but very slightly congested. The spots themselves are scarcely reddened. They make the skin rough and produce "the nutmeg-grater condition," though on a very minor scale.

I prescribed for Master W—— as usual, giving him tonics and using externally a weak ammonio-chloride ointment. The spots remained just as they were for several months, or rather increased in number. We tried various other ointments, and used cod-liver oil both externally and by the mouth. Nothing did any definite good, and as the boy remained in good general health, his mother at length got tired and desisted from treatment. I saw no more of him until, two years later, he was brought to me with his brother as the latter had enlarged glands. I now found that every trace of the eruption had disappeared. I begged his mother to tell me honestly and without any attempt at compliment, whether she thought that anything prescribed either by myself or any one else had helped the cure. She replied that she did not think that anything had exercised any influence. The eruption had, after lasting nearly a year, gradually faded away of itself. Its disappearance had, however, been especially rapid during a month that the boy was at the seaside.

As regards duration the eruption was, I believe, in this instance exceptionally prolonged. All authorities agree that it is usually quickly cured, some attributing its disappearance to one remedy and some to another. That the eruption, slight as it is, is yet really tuberculous can scarcely be doubted. Nor can there be any reasonable hesitation in believing that it is, in the early stages, contagious. A parent patch originates others on the surface of the patient's skin, in connection, in all probability, with the transference from place to place of germ-material. The outbreak is always sudden and the spreading rapid.

In these features it much resembles what I have repeatedly insisted on as the first stage of lupus vulgaris when it occurs in multiple patches. In the rare examples of the latter, in which the multiplicity is great, there are in fact often many lichenoid pustules. Nor is it unknown in these cases for many of the patches developed in the outset to disappear spontaneously, leaving only a few, as persisting lupus, to spread at their borders, and last, unless cured by treatment, the rest of the patient's life. The outbreak period, that of contagion and great multiplicity, is only a short one. In these features lichen scrofulosorum and lupus vulgaris have a parallel course. The same is perhaps true of all forms of tuberculosis. Those which occur in glands and those which affect bones, and those possibly of internal organs as well, have all an early stage of virulence and manifold development, then lapse into quietude, cease to be infectious, and undergo cure so far as local cure is possible. The tubercle bacillus in symbiosis with living tissue has not an unrestricted period of activity, but as a rule runs riot only for a limited time. It must be admitted, however, that in some of these forms, notably in lupus, local growths remain permanently which are persistently locally contagious. In this lupus multiplex and lichen scrofulosorum differ.

It must, after all, be freely admitted that lichen scrofulosorum is by no means a well-defined malady. It is probable that it is present in a great number of children in whom it is never diagnosed, and that it exists in conjunction with a great

variety of other scrofulous manifestations. That it is almost solely a disease of childhood seems clear. Any one, however, who has been accustomed to inspect the skins of naked children frequently must have often recognised, when not looking for them, groups of little lichen papules in no respect distinguishable from those of the most definite examples of the malady in question. We have recently, at our Demonstrations, had two remarkable illustrations. In one of these the patches were found in association with lupus, and in the other in conjunction with others which took the form of lichen planus. In this latter we have been obliged to hold the diagnosis still in doubt. Whilst some groups of spots retain all the characters of L. scrofulosorum, others have coalesced and acquired the polished surfaces of L. planus.

ILLUSTRATIONS OF THE TERTIARY STAGE OF SYPHILIS.

THE clue to the right comprehension of the sequelæ or tertiary symptoms depends upon recognition of the fact that during the secondary or humoral stage every tissue in the body comes under the influence of the poison. The evidences of this have already been discussed. We have next to accept as a probable law that something is left behind in the tissues, or that their mode of vitality is permanently influenced, so that they are liable ever afterwards to develope inflammatory or degenerative processes of a peculiar type. The tissues are left, so to speak, with a specific vulnerability, and may, under the varying influences of the after-life, take on various forms of morbid action. No limits as to time can be assigned to the occurrence of these manifestations. They may begin almost before those belonging to the secondary stage have ceased, or they may be deferred for many years.

Severe Bone-pains in the Tertiary Stages of Syphilis preceding the development of Nodes—Long continuance of specifics—Ataxy (?)—Aix treatment twice.

In the following case mercury was begun very early, and secondary symptoms were almost wholly prevented. The patient, however, had a prejudice to the drug, and did not take it regularly. Specifics were, notwithstanding, never wholly left off. He became, within two or three years of the chancre, liable to pain in the bones and to severe pain in the limbs. His own expression was that he had "lived on mercury and iodides," and that he could never for long keep clear of

the pains unless taking one or the other. In the tenth year of the disease the pains were so severe that he went to Aix. He was very liberally rubbed. In the following year he went there again, and now saw Dr. B——. His symptoms were so entirely subjective that Dr. B——, who had not treated him on the first occasion, doubted whether he had ever had syphilis, and only reluctantly allowed him to be rubbed again. After this he continued internal treatment. When he came to me three years later he had a large osseous node on one tibia and some small ones on the skull. I thought that he had suffered ataxic pains as well as those of periostitis.

He appeared to have suffered severely from *bone-pains* before he had nodes, and it was difficult to distinguish them from tabetic pains. He described them as "toothache pains," and said that they often kept him awake at night. They had occurred in both arms and legs. His pupils were small and sluggish, but they certainly did act. He had fair knee jump.

YEAR.	AGE.	DETAILS.
1886	36	Syphilis. Mercury very early. Eruption, &c., very slight.
1887	37	"I was erratic, and had a strong prejudice to mercury."
1888	38	
1889	39	
1890	40	
1891	41	Pain in skull, &c. "Living on mercury and iodides."
1892	42	
1893	43	
1894	44	
1895	45	Was at Aix (for tabetic (?) pains). "Was overdosed by inunction."
1896	46	Was at Aix again under Dr. B——, and again rubbed.
1897	47	
1898	48	March: comes to me. Large node on tibia, and liable to them on head.

Good health for thirty years after mild Syphilis—From thirty-first to thirty-sixth year a succession of Tertiary phenomena—Gummata of Testes—Phagedænic Ulcer of Leg—Lupus on Neck.

The following case is a remarkable example of tertiary phenomena, in different parts, developed after a very long period of good health. They were amenable to treatment, but continued to recur. The patient was sent to me by the late Dr. Ramskill in 1895. He was much out of health, and had an enormous superficial ulcer, with phagedænic edges, in his right leg. It involved the whole of the outer side of the limb almost from knee to ankle. I prescribed iodoform externally and the three iodides internally, and sent him home to keep his bed. It is to be noted that this ulceration was not that of a gumma breaking down, but was quite superficial and distinctly phagedænic. It had advanced rapidly during six months, but there had been a chronic lupoid patch present for many years previously.

After a single consultation, I saw nothing more of him for four years. In 1898 he again consulted me on account of swelling of his remaining testicle. He reminded me of his leg, and showed a thin, supple, perfectly sound scar, one of the largest I have ever seen. He told me that he had continued the remedies I had prescribed, and remained in bed under the care of his family medical man for about two months. At the end of that time the healing was complete. No doubt the iodoform was the chief agent in the cure. During this treatment the testis diminished much in size, but it was never restored to a normal condition.

The condition of the remaining testis at the present date (June, 1898) is very peculiar. It is very large and very hard, but presents an irregular lumpy surface and nodulated form quite different from the smooth roundness which usually denotes gummatous infiltration. Nor has it shown the least tendency to soften. The skin is not adherent to it. Above the gland is a large encysted hydrocele. The testis itself is as large as a child's fist, and the two together make up a very inconvenient bulk. Excepting its size, it does not cause him much trouble. I have suggested its removal, but

he is not inclined to submit to another operation. It appears to be beyond hope of cure by specifics. He has taken them on and off for several years.

The subjoined schedule will afford a clear view of the case.

YEAR.	AGE.	DETAILS.
1860	21	Had a chancre and open bubo. Took mercury.
1861	22	Does not remember any secondary symptoms. Iodides.
1862	23	
1863	24	
1864	25	
1865	26	
1866	27	Married. His wife remained well, and was living in 1898. They had only two children, both of whom retained good health, and in 1898 were strong men.
1867	28	
1868	29	
1869	30	
1870	31	
1871	32	
1872	33	
1873	34	
1874	35	
1875	36	
1876	37	In good health, and wholly free from symptoms.
1877	38	
1878	39	
1879	40	
1880	41	
1881	42	
1882	43	
1883	44	
1884	45	
1885	46	
1886	47	
1887	48	
1888	49	
1889	50	
1890	51	
1891	52	
1892	53	Lupoid ulcer on leg and sarcocele of left testis.
1893	54	The testis had suppurated.
1894	55	Left testis excised on account of gumma.
1895	56	April: came to me for ulcer on leg.
1896	57	Phagedænic ulcers. Cured by iodides, idoform, and rest.
1897	58	Well, but with persisting enlargement of testis.
1898	59	Consulted me second time. Sarcocele.

Additional Memoranda.

The surgeon who excised the testis stated at the time that he did the operation in order to rid the patient of a trouble, and not because it was absolutely necessary. There was no suspicion of malignancy.

During the last year (1897–8) he has developed a patch of syphilitic lupus on the side of his neck. A sister of his died of lung disease.

He has always gained in health on the iodides, and got stouter.

In 1898 he looked in much better health than he did in 1895.

The ulcer on the leg had been present in a lupoid condition several years before I saw him in 1895, but it had only been rapidly spreading for a few months. Its freedom from relapse when once entirely healed was most instructive.

ILLUSTRATIONS OF HEMIPLEGIA IN SYPHILIS.

(Continued from Vol. VI., p. 349.)

A distinguished neulogical friend and colleague is never tired of telling me that there is no such thing as "Syphilitic Hemiplegia." I sometimes let slip that expression in our consultations, and he always corrects me by the assurance that hemiplegia from syphilis is the same as hemiplegia from other causes. I accept his correction, but am never quite convinced that the expression is inappropriate. It is quite true that there is no form of hemiplegia which is directly due to syphilis and directly curable by specific treatment. Intervening pathological changes are necessary, and some of these are not peculiar to syphilis. It would, it may be admitted at once, be more correct to speak of "the forms of hemiplegia which occur in the subjects of syphilis," but at the same time it would be more roundabout. The question as a practical one is this: Are there any cases of hemiplegia the symptoms of which, taken alone, would suggest the diagnosis of syphilis, and for which a prompt resort to specific treatment is urgently demanded? To this question I incline to reply with a strong affirmative. In a majority of the cases in which hemiplegia occurs in direct association with syphilis there are peculiarities in the mode of onset which, if carefully studied, give valuable aid to diagnosis. The prognosis of such cases differs in important features from that of other forms, and the welfare of the patient depends to a large extent upon the vigour of the treatment.

The explanation of the peculiarities of the syphilitic forms as regards symptoms is to be found in the peculiarity of the pathological changes. If we leave aside for the present all traumatic cases and all cases of tumour, and confine our

attention to cases in which a sudden "stroke" occurs, we may, I suppose, say that the ordinary causes of non-syphilitic hemiplegia are three—hæmorrhage, embolism, and thrombosis. Now of these three, the last is the only one which occurs to syphilitics. They are not, with rare exceptions, liable to rupture of blood vessels, nor is there in them any source of supply of embolic plugs. Thrombosis they are very liable to, and it is often, indeed usually, of a peculiar kind. The disease of the vessels which induces it is usually external, and it has often been present for some time before it induces anything approaching to complete stoppage of the blood-stream. This involves the consequence that in many cases premonitory symptoms precede the final attack. It is these premonitory symptoms which so frequently stamp with peculiarity the cases referred to. In all other forms of hemiplegia premonitory symptoms are, I believe, exceptional and vague; in syphilis they are the rule, and are often more or less peculiar in character. In any given case in which it is wished from a patient's history to decide whether a bygone attack of hemiplegia was really syphilitic or not, careful attention should be given to the narrative of the advent and development of the symptoms. If there have been one or more attacks of numbness and tingling in the limbs which were finally paralysed, and if these conditions passed off for a time and recurred possibly more than once, it may be inferred that the arterial obstruction was from without, and that for a time it did not wholly stop the blood-stream. This is the condition which exists in a large majority of examples of syphilitic peri-arteritis. Small gummata are present in the arterial sheath which gradually press upon the vessel, and finally may induce coagulation of its contents, or, by increasing pressure, complete occlusion of its canal. When this occlusion from either cause is complete, then comes the paralysis; but before the advent of the latter there have usually been, as just stated, certain half-results which rank as premonitory symptoms.

Another feature which characterises many cases of syphilitic paralysis, consequent as it almost always is on arterial obstruction, is its complicated type. This results

from the fact that several arteries at different parts of the same hemisphere, or it may be on the opposite sides, are affected at the same time. When syphilitic arterial disease occurs in the early stages of syphilis it is almost always multiple, and it is therefore in these early stages that multiple and mixed forms of paralysis are more usually met with. In the tertiary stages one vessel is usually affected alone, and the case will then approximate in this respect more closely to the non-specific forms.

At page 319 I have described a case which was perhaps one of the first in which hemiplegia from syphilis came under my notice. It was in 1861. The symptoms did not present any marked peculiarity, and had I not known beforehand that the patient was liable to gummata I might not have suspected the real cause.

Following the above another (page 320) was recorded, which illustrated prognosis, the patient being in good health twenty years after his attack, although still to a large extent hemiplegic. This case was of great interest, because more than a year before his hemiplegia the man had gone through a brain illness (with coma), from which he was not expected to recover. This illness was within a year of his syphilis, and probably denoted extensive disease of the arteries at the base of the brain. The hemiplegia was probably due to a return of gummatous disease at one focus, and the occlusion of one large vessel.

At page 321 of the same volume is mentioned the case of a man who in the fifth year of syphilis had facial paralysis occur in association with defective articulation and inability to write. No warning symptoms had occurred.

Case IV., given at page 322, is one in which left hemiplegia happened to a man who had suffered from syphilis thirty years before. It was by no means certain that the paralysis was caused by thrombosis, or that it had any connection with the preceding syphilis. As, however, the patient had had other tertiary symptoms, it was very likely

that he had local arterial disease at the base of the brain. The attack had been preceded by temporary weakness in the affected arm, and some discomfort in the head. He was the subject, four years after the hemiplegia, of very painful spasms in the affected limbs, which were brought on by sleep.

In Vol. VI., at page 340, I have written some general remarks on hemiplegia in syphilitics, and have recorded two series of case-headings. One series comprises seven cases in which the hemiplegia occurred within two years of the primary disease. A second series consisted of twenty-five cases in which the interval varied from two to sixteen years.

(To be continued.)

THE VASCULAR SYSTEM.

Vascular Tumours in the Fingers.

I HAVE long been acquainted with the occurrence of little isolated vascular tumours in the ends of the fingers and the palm of the hand. These little growths are seldom much bigger than a large pin's head, but they are very prone to bleed. The epidermis over them is often broken away so as to leave a little pit. Probably they result from some slight injury, or they may be formed in congenital nævi which have never been noticed. Minute nævi in the palms are not very uncommon. I had two such myself placed with the most precise symmetry in the lower part of the palm. They were not bigger than pins' heads, and could be easily emptied by pressure. When I closed my palms the one exactly fitted upon the other. They never bled. At about the age of forty I one day noticed that one of my little nævi had disappeared, and a few months later its fellow had vanished also.

I have had to treat one of the little bleeding growths above described on the forefinger of one of my daughters.

My son Roger showed me in the finger of one of his patients at Haslemere an unusual example of this vascular disease. The patient was a woman of about 50, accustomed to use her hands in household work, but who was not aware that she had ever pricked or otherwise injured her finger. It was, she thought, at least nine years since she first drew the attention of her husband to the fact that there were some little holes in one of her fingers. They gave her no trouble until, three years later, they became liable to bleed. Recently the spots had increased in number and the patch in size, and on many occasions rather troublesome bleeding had occurred.

The above statements may seem to suggest a rather formidable condition, but really when I examined the fingers on November 10, 1894, there was nothing more than a little plum-coloured patch the size of a threepenny-bit in the pulp of her right forefinger, and wholly free from thickening. It was absolutely painless, and I was allowed to squeeze it, very firmly, over and over again. The epidermis over it no longer showed the ridges characteristic of the finger pulp, and was a little rough as if pricked by a pin. The patch was made up of an aggregation of little pin-head-sized spots of deep tint. It was clear that these spots were in a state of thrombosis, for the blood in them could not be discharged by the firmest pressure. By pressure the skin could be made white excepting these spots, which, thus isolated, became more conspicuous. On removal of pressure the intervening tissues of the patch filled quickly with venous blood and restored the plum-colour to the whole of it, merging in general congestion the separate spots. I counted at least twenty-five of the spots but they were placed close together and occupied only a very small space. There was no tendency to bleed when I examined the finger, and my experiments in pressure did not cause any ecchymosis. I was told that sometimes the finger-end would swell and ache, especially after much washing.

I could feel no doubt that the little spots described were vascular and not pigmentary, and that the whole should be regarded as a form of acquired nævus. It appeared to be placed in the substance of the true skin, and had not improbably had its origin in some slight injury. If the patient's account could be trusted, there was something allied to an infective process going on, for the patch was increasing in size at its periphery. It had been cauterised with nitric acid before I saw it, but no scar was perceptible and the original condition had recurred.

The subsequent treatment of this case proved of much interest. Nitric acid was applied several times, and yet the nævus returned. It was not until it was used so freely that a small portion of the terminal phalanx exfoliated that the disease was finally cured.

I have witnessed this difficulty of cure and proneness to redevelopment in several other cases. It is often needful to apply nitric acid several times, but they are always cured eventually.

Spontaneous obliteration of a large Nævus after an attack of Acute Inflammatory Swelling.

At page 131 of the Sixth Report of the Vaccination Commission a case is described by Dr. Skinner, in which a congenital nævus inflamed and assumed the conditions of a large tumour. This growth occurred after vaccination, at the age of six weeks, and was attributed to it. The tumour was diagnosed as sarcoma, but in the course of a year it underwent atrophy, and entirely disappeared. Apparently the tumour had attained its largest growth at the age of eight months, when it measured 4½ by 6 inches, and was estimated to have a thickness of two and a half.

The case is an interesting example of what is by no means unknown, the inflammatory enlargement of a subcutaneous nævoid structure, leading to spontaneous cure. I have recorded several such, and have suggested that these attacks of inflammation are ordinary events in the life history of these tumours.

NOTES ON CASES ILLUSTRATING SYMPTOMS.

(*Continued from page* 138.)

No. XXXVI.—*On Teethache as distinct from "Tooth-ache."*

In common toothache the pain is in the fang of the tooth, and soon involves the jaw itself. More commonly one tooth fang only is affected, and in the first instance this is almost invariably the case. The pain occurs usually in "lunges," although it is more or less present between times. It is sometimes unbearably severe. All these conditions are reversed in the affection which I would like, for the sake of distinction, to call "teethache." In this all the teeth in both jaws, or at any rate all the front ones, are affected together. The exposed parts of the teeth, and not the fangs, are the seat of the pain. The jaw is not at any stage involved. The pain is continuous for hours together, and although it may be attended by a sense of pricking, it is never unbearable, and is never attended by lunges. It is as if ice had been kept in the mouth, or the mouth had been opened in a biting wind. I have described this symptom at page 51 of Vol. V., under the heading "A Peculiar Form of Generalised Ache in the Teeth in association with defective tone." I recur to the subject now in order to add a few facts, and possibly to modify a little what was then said. I feel less certain as to its being always indicative of low tone, and am also less inclined to associate it with such influences as set the teeth on edge. In a case recently under observation it has persisted during spring weather and east winds for ten days in spite of champagne and port and sea-air. It has been at times sufficiently annoying to prevent applica-

tion to any subject, but has never prevented sleep. It is, I think, always relieved by a full meal with wine, and almost always made worse by tea. It is still a doubtful point whether it is in connection with gout and should be treated with abstinence and alkalis, or whether quinine and wine should be trusted to. I have no evidence in support of the hypothesis of gout, and incline to the latter creed.

No. XXXVII.—*Clear complexions in connection with phthisical tendencies.*

The three Misses Gunning, so renowned for their beauty and their successes in marriage, all died of consumption.

Horace Walpole, in a letter dated August 1, 1760, writes: "My Lady Coventry is still alive, sometimes at the point of death, sometimes recovering. They fixed the spring; now the autumn is to be critical to her." This latter prediction was realised. On October 5th Walpole wrote: "The charming Countess is dead at last; and as if the whole history of both sisters was to be extraordinary, the Duchess of Hamilton (Elizabeth Gunning) is in consumption too, and going abroad directly. Perhaps you may see the remains of these prodigies; you will see but little remains. Her features were never so beautiful as Lady Coventry's, and she has long been changed, though not yet, I think, above six-and-twenty. The other was but twenty-seven."

The popular belief that clear complexions, bright eyes, and silken lashes imply delicacy in the direction of tuberculosis need not in the least conflict with modern knowledge as to the bacillus. They reveal the tissue-peculiarities which favour its growth.

No. XXXVIII.—*Lichen Planus affecting the Palms.*

I have just had a good opportunity for observing lichen planus affecting the palms of the hands. The patient, a man otherwise in robust health, had been for two months the subject of lichen planus in a most characteristic form. It was very irritable, and was still not subdued by treatment

in any degree, when one morning he drew my attention to the palms of his hands. In the middle of each was a little group of spots somewhat larger than pins' heads, and presenting in their centres a distinct excavation. There were perhaps twenty or thirty of these spots in an area as large as a halfpenny. They were quite dry and made the surface rough. They were very much like what I have occasionally seen on other regions in other cases of lichen planus. I have described them in an unusual case brought by Dr. Ferrace, and of which we have preserved a drawing at the museum.

No. XXXIX.—*Double Morbus Coxæ Senilis.*

Amongst the patients which Mr. Hopkins, the resident medical officer at the Sick Asylum, offered me for a clinical lecture to post-graduates on May 11th was a most interesting example of double disease of the hip joints. It was indeed almost the counterpart of the one which I recorded at p. 347 of Vol. VIII. of ARCHIVES. The patient, an old man of 66, has both his hips quite stiff in the straight position. He walks with crutches, and can only shuffle along with very short steps. When lying in bed on his back the limbs are quite straight, but both feet are everted, and the patellæ look outwards. This position cannot be rectified. Although by effort the great toes can be made to touch each other, it is solely by movement of the feet at the ankles. If one limb is lifted into the air it lifts the pelvis and the opposite thigh also. Very little movement in any direction can be elicited at either hip. On examining the groins it is found that large lips of bone have been developed quite symmetrically from the upper borders of the acetabula. These crests project upwards, and at first suggested the diagnosis of exostoses. The femoral artery is on both sides lifted up, and being a large thick vessel the suspicion of aneurism occurred. The pulsations of the vessels can not only be felt on the slightest touch, but can even be seen. The thighs cannot be abducted, and it would be quite impossible for the man to straddle a horse. (It may be remembered

that difficulty in doing this was the first symptom in Colonel ——'s case.) The patient is a tall, well-made man, and although now a workhouse inmate, is of good family, and has long almond nails with smooth surfaces. His father and grandfather suffered from gout. He himself has had rheumatism, and on two occasions acute gout, once in one elbow, and once in one wrist. Excepting one finger joint, no joints other than the two hips are crippled. The disease in the latter has been in gradual process of development for the last ten years, and has not been attended by any severe pain.

ON WARTS, CORNS, AND VARIOUS OTHER FORMS OF GENERAL OR LOCAL PAPILLOMATOSIS.

THE papillæ of the skin and mucous membranes are prone to overgrowth under a variety of causative influences and may assume very different conditions. Warts, corns, cutaneous horns, frambœsoid vegetations, condylomata, etc., offer us examples of the various types assumed. The names Frambœsia, yaws, acanthosis nigricans, pemphigus vegetans, ichthyosis, papilloma senilis, tuberculosis, papillomatosis, and some others, have been given to various special forms of disease attended by proneness to hypertrophy of these structures. In attempting a general review of the facts at our disposal in reference to them, it may be well to commence with the most simple forms, premising that the term papillomatosis, although not unobjectionable, is probably the best at our service by which to designate the process in general.

Thus the word "papillomatosis" may be allowed to designate the state of body in which, from any cause, there exists a tendency to the overgrowth of papillæ, and the consequent production of warts or any form of papilloma. We have papillomatosis occurring as part of youthful or of senile proclivities in connection with some definite failure in health, as in acanthosis or pemphigus vegetans, or consequent upon the introduction of a specific poison into the blood as in syphilis and yaws. Whatever may be its cause, it probably reveals, as a fundamental condition, a certain degree of weakness of vital control in the individual organism. The endowments of each individual animal ought to be of such power, that every tissue and every special structure or organ in the body shall grow no otherwise than for the general good, and as parts of a whole the

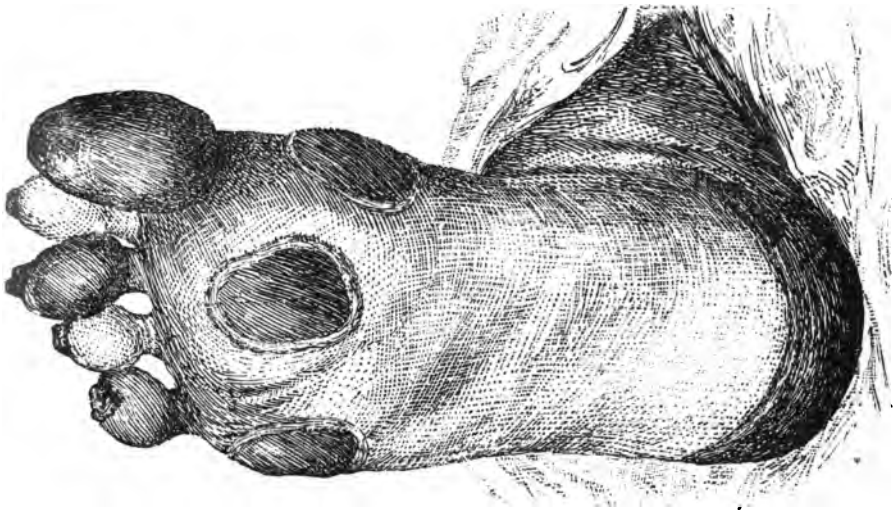
perfection of which is the final aim of all. If any tissues or structures take on, as it were, independent growth, and develope to a size which is not helpful, but injurious to the whole, we may recognise in the fact a tendency to reversion to vegetative type. It is fair to assume that under such circumstance the life-power of the individual must be feebler than in one in whom all growth is subordinated to the general good. The government, so to speak, is weak. In common warts we have perhaps the simplest instance of this defective control, which attains its highest in the acute forms of malignant new growths. That the two, although apparently so different, are really allied in a common basis of somatic peculiarity there are abundant facts to prove. There are plenty of connecting links. In all, it may be repeated, the tissues lapse into a mode of growth more nearly allied to that common in vegetables. What has been said as to tissue proclivity and individual peculiarity by no means excludes the recognition of local exciting causes.

On the Relation of Corns to Warts.

One of the best illustrations which can be offered of what has just been said as to local influences is afforded in the phenomena of corns. Although we distinguish a corn from a wart, by saying that in the one the process is mainly a keratosis or thickening of the epidermic layers, yet it is certain that the papillæ are at the same time involved. Their hypertrophy is concealed under the thickened epidermis, but it is there. The painfulness of a corn, the freedom with which it may bleed when cut, and, finally, the appearances presented on a deep section prove this. In certain positions also, where comparatively exempt from pressure, the papillary basis of a corn is well shown. Thus they are often seen under nails, sometimes in association with warts on the hands and sometimes with corns on the feet.

The appended woodcuts exhibit this association. The patient's soles showed large corns, and all his toe-nails were lifted up by the formation of horny and papillary growths

under them. The patient was a young man who consulted me in August of 1897, and who at that date attended at



one of my Demonstrations in order to show his feet. I could not persuade him to stay and let Mr. Burgess make

a portrait, and the woodcuts are copied from very imperfect sketches which a friend of the patient made in the country. They must not be regarded as showing more than just the position and size of the corns.

The following are the notes which I wrote out at the time :—

Mr. G. E——, aged 21, shows the largest development of corns on the feet which I have ever seen. It is coincident with chronic inflammation of the nail-beds of his toes and the formation of subungual corns and accumulations of epidermis. He is engaged in farm work, but if he takes a tool or cricket-bat in his hand his hands at once blister. After the blisters hard callosities follow. His palms, however, do not suffer nearly so severely as his feet, no doubt because not exposed to such constant pressure.

He has six sisters, none of whom suffer materially from corns. He has himself suffered as long as he can remember. He has had much treatment. He attended a London specialist for three months, and was for six weeks kept in bed five or six years ago. He says that paring the corns does them no permanent good, for they thicken again very quickly. His father suffers from gout badly.

He reports that he has never had a day's illness, his feet being his only trouble. His feet sweat "profusely" until he could wring his socks. His feet often feel hot and burning.

The callosities involve the heels, curving round their borders ; they occur also under the tread of the toes as three large separate corns as big as halfpence and a quarter of an inch thick, and almost touching each other. On the toes they affect the very tips and under-surface of the pulps, being evidently located by his boots. The nails are thick, fibrous, and lifted up by accumulations of epidermis under them. One of them is raised at right angles. The great toe has a large corn under its nail, but none on its tip. His finger-nails are not conspicuously affected, but there is a slightly excessive accumulation of epidermis under their free edges. He was liable to acne when a boy, and still is so to a slight extent.

The skin on other parts of the feet is soft and supple

and perfectly healthy, there being nowhere the slightest tendency to ichthyosis. His feet are always worse in summer.

Papillomatous growths around the Anus in an elderly man, with family history of Cancer.

The association of tendency to common warts with hereditary proneness to cancer was well illustrated in the case of Colonel F——. This gentleman had lost his mother after colotomy for epithelial cancer of the bowels. In youth he had been much annoyed by warts on his fingers. At the age of 58 he came to me on account of a large growth of warts about his perineum and anus. Many of them were low and flattened, with a great tendency to coalesce into patches. None had as yet ulcerated, but some showed very critical conditions. They advanced just within the orifice of the anus. He had no doubt subjected them to much rubbing and scratching. Under the influence of an anæsthetic I used Pacquelin's cautery very freely, and with the result of getting rid of most of the warts, though I am not certain that the cure was complete.

A case of Senile Papillomatosis—Peculiar arrangement and form of the patches—History of Cancer in the patient's mother.

Mrs. L——, aged 58, a stout woman, was sent to me from Brighton by her surgeon, Mr. W. Taylor. She had on chest and upper part of abdomen some brown spots and streaks which had attracted much interest. They were peculiar in form and arrangement, nearly all being long ovals or comet-shaped, and sloping downwards and forwards towards the middle line. Some were round spots. All were attended by some slight thickening, and were somewhat roughened on the surface. They differed only from the ordinary senile papilloma, or senile wart, in their form, and in the slight amount of papillary development. They were very conspicuous. Mrs. L—— had very few on her sides and shoulders, but on examining her neck I found a great number of minute pedunculated warts. These were most of them

not bigger than large pins' heads, and could easily have been snipped off.

On inquiring for the history of cancer in the family—which is, I believe, almost always present in these cases of aggravated senile papillomatosis—I was told that the patient's mother had died in old age with a large open cancer on the side of her abdomen.

As regards the explanation of the peculiar arrangement and form of the patches in this case, I was inclined to attribute it to the patient having scratched herself by thrusting her hands downwards into her dress. She said that the skin of the parts had itched very much, and that when in a warm room she had often been obliged to leave her company in order to undo her dress and rub herself. It is only fair to say that she denied having scratched.

Senile Papillomatosis—Abundant development of Warts on neck and trunk—Cancer in patient's mother.

Another case, very similar to the above, came under my notice a few weeks later. Mrs. W——, a lady of just fifty, undressed in order to show me what she called eczema. I found that her abdomen, back, and sides of chest were covered with low warts, which had become much discoloured. She said that she had noticed their presence for two years or more. As in the preceding case, her mother had died of cancer. The warts had been somewhat irritable, and more so of late, and she had scratched and rubbed the skin until it was almost eczematous in parts. On her neck and shoulders Mrs. W—— had many small pedunculated and fimbriated warts, quite different in these respects from those on the parts covered by her clothes.

NOTES ON BEES AND ON SEX.

In connection with recent discussion as to the influence of diet on sex and growth, the following memoranda respecting bees may not be without their interest for some of my readers.

There are no "neuters" in the beehive. The workers are all females, in whom the sex-organs are present but undeveloped.

The development of the sex-organs depends upon the food supplied to the young bee when in the larval stage.

A certain stimulating food "jelly" is given by the bees to any larva which it is wished should grow into a developed female, in other words a "queen bee."

Under the influence of this food the larva grows more quickly, both as regards size and development, than one fed from the common food, and, as a most special feature, its ovaries grow and become capable of forming eggs without fecundation.

The queen bee attains her full growth in a shorter time than a worker does.

Neither the developed females nor the males (drones) ever concern themselves about work.

The males are called drones on account of their having no instinct for self-preservation by work. Unless fed by the workers they die.

The drones, or males, always form a very small proportion of the inhabitants of a hive, and at some seasons of the year they are wholly absent, having been killed off by the workers.

The queen bee can at will, if she has been once impregnated, produce eggs which will hatch out either as workers or drones.

If a queen bee have not been impregnated, she can produce fertile eggs, but they will all hatch out males.*

Sexual impregnation is absolutely necessary to the production of females.

A single impregnation serves a queen for the rest of her life. A store of semen is preserved in her, and it would appear that she can at will allow it to impregnate the eggs or not.

Thus it might be said that a single impregnation makes the queen hermaphrodite; she can in her own body discharge the functions of both sexes.

Although in this sense hermaphrodite, an impregnated queen bee retains, however, her parthenogenetic endowment, and can, as before, produce eggs which are fertile, but which have received no influence from the semen.

Thus if a queen wishes to produce drones, she deposits unimpregnated eggs; and if workers are desired, eggs which have been impregnated.

Copulation in bees never occurs in the hive, always in the air. The queen bee when fully grown takes what is termed her "nuptial flight," in which she is accompanied by males. A single impregnation suffices for her life. The store of semen may be demonstrated by dissection.

If a queen bee, when fully grown, be unable from any cause to leave the hive, she will lay eggs, but only drones will be hatched.

* This is a marvellous fact, and suggests strange considerations. It may be, after all, that there is some truth in the popular creed that males take chiefly from the mother and females from the father. We are sometimes consulted about very curious matters. The fungiform papillæ of the tongue have brought me many fees, the projecting end of the metatarsal bone of the little toe a few, and more than once a young man has made application in the belief that the frœnum preputialis requires to be divided before marriage. One of the most bootless consultations which I have ever had, however, was by a married man, whose wife had brought him five sons in succession, and who wished for a daughter. His friends had found out his weakness, and had made his life miserable by reminding him of the proverb, "It takes a man to get a girl." I of course assured him that there was nothing in the proverb but an obvious truism, and that he ought to make himself happy. With, however, such facts as the above before us, it is impossible to feel sure that prepotency on the part of one or other parent may not have some influence in determining the sex of offspring.

Sometimes workers will deposit eggs, but in these instances the bee is to be regarded as a partially developed queen, and its larva has probably partaken of the "jelly." This may have happened from the circumstance of the cell of the queen-larva having been close to that of a worker.

The eggs deposited by workers produce only drones. Such workers, although fertile, are yet insusceptible of impregnation.

Beeswax a result of Seborrhœa—Its production caused by modification of diet and exercise.

Beeswax is not a substance collected by bees from flowers, but a secretion formed by their own bodies. It may indeed be regarded in the same light as the smegma of the prepuce or the "wax" of the ear. To form wax, bees eat honey very freely and then go to rest in clusters. The wax exudes on the sides of the abdomen, and is scraped away either by the bee itself or one of its companions. Unless the bee has fed to repletion on honey, it cannot secrete any wax. Several pounds of honey taken as food are said to be required for one pound of beeswax.

These facts suggest that possibly diet may be of more importance in the treatment of seborrhœa, as a disease, than has been supposed. Those troubled with greasy skins, comedonous acne, wax in the ears, &c., ought perhaps to reduce their consumption of sugar, bacon, butter, fat of meat, and, above all, of honey. These several conditions, I believe, not unfrequently go together, and are indicative of general tendency to physiological seborrhœa.

ON INFECTIVE DISEASES OF THE LYMPHATIC GLANDS.

(*Continued from page* 51.)

In now resuming the series of cases illustrating infective diseases of the lymphatic gland system, it is not necessary to say much in the way of comment. My preliminary remarks, and more especially the "Conversation" given in Vol. VIII., p. 174, have sufficiently explained the main lines of my argument. Since the time of Hodgkin, many able observers have contributed to our knowledge of the disease with which his name is associated. If I have been fortunate enough—which I can scarcely hope—to add any novel suggestion, it has been in the direction of the recognition of predisposing causes. I have endeavoured, so to speak, to look at these maladies from behind as well as from before. It is not very difficult if we concern ourselves only with fully developed cases—with those which have run their course and brought out all their peculiarities in full perfection—to classify them into different groups, and to believe that such terms as scrofulous disease, lymphadenoma, and lympho-sarcoma may be applied definitely to them. The successful accomplishment of such a classification does not, however, go the length of proving that these maladies are really and *ab initio* distinct. My contention is that they are not so, but rather that they all of them take their origin in common inflammation, and acquire their peculiarities, as they proceed, from the inherited proclivities of the patient. The quality of infectiveness which enables them to spread more or less quickly to other parts of the lymphatic system is the all-important one which they have in common. It is not, however, a quality which conclusively denotes either tuberculosis or malignancy,

but which both these share with processes which it is impossible to name otherwise than those of chronic inflammation. I cannot think that in contending for this view of the facts I am arguing for what is a merely verbal matter. If we admit that these several maladies may have a common origin, that they are excited by similar influences, and are in their early stages indistinguishable, we shall, I think, be on a sound basis, and shall be prepared for that which we shall see in practice. Although in many cases the course of the disease may be typical, we shall be prepared to find that in many others it is not so. We shall expect transition stages, mixed forms, and connecting links, and these we shall find.

It will of course be suggested that by appeal to the microscope we may make conclusive decision as to the special class to which any case should be assigned. Without doubting in the least that it is possible to recognise by its aid a sarcomatous form of growth, and to distinguish it from a tubercular inflammation, I yet venture to assert that there are early stages of both in which it is impossible. The microscope comes to our aid just when the battle of diagnosis is won, and not sooner. Prone to deceive us in all cases, it is especially so when lymphatic glands are in question. On this point I speak from a good deal of experience. The most recent item of it may perhaps be here fittingly introduced since it concerns one of the cases in my present series. Case No. III. at page 151 will be admitted by all to be a most typical example of lymphadenoma with its final accompaniment of development of nodules in the spleen. As such, the patient had twice been the subject of clinical lectures. I sent some of the glands and a portion of the spleen to the Research Association, not because there was any sort of doubt as to their nature, but hoping to secure some good sections from which drawings might be made. The report returned was to the effect that the conditions were not those of lymphadenoma, but more probably those of syphilis. Apart from the fact that the man had never had syphilis, there had not been the slightest resemblance to syphilis in the clinical

history of the case. About the same time I sent to the same association—and I know of no higher authority—a portion of skin which I had excised under the conviction that it was primary sarcoma, and received a detailed report to the effect that it did not show any evidences of sarcoma, but was probably a mole or nævus. Yet within six months of that report the patient developed melanotic sarcoma in the lymphatic glands. I mention these facts not in the least as wishing to reflect on the ability of the Clinical Research observers, but rather to show that in attempting to pronounce upon the nature of new growths in early stages, and of the results of chronic inflammatory hypertrophy, the microscope is put to a task which it is impossible for it to accomplish. It is needless to point out that had measures of treatment been in question in the cases which I have mentioned they might have gone lamentably wrong.

If, however, it were possible—which I do not believe that it is—for the microscope to tell us in the early stages of gland enlargement what will be the course of the disease, it would still remain unavailable as a diagnostic resource. At that stage we cannot obtain the specimen for examination. Nor are we in a better position as regards the patient's blood changes. These are usually the consequences of the gland mischief, and do not become demonstrable until the disease is well advanced. The conclusion, then, is that we must rely upon the patient's antecedents, the family history, and a careful observation of the present conditions as the basis both of prognosis and treatment. Nor is it, I think, desirable that we should trouble ourselves too much with minute pathological classification. If we can, taking each case on its own merits, predict fairly well the results of treatment and the final tendencies, we must be content.

(To be concluded.)

DIET AND THERAPEUTICS.

Recovery from severe Spinal Caries under treatment by mechanical support and Sea-air.

In 1872 I was consulted in the case of a boy, aged 6, for spinal abscess and angular curvature in the lumbar region. He was fitted with a spinal apparatus, and sent to live first at Swanage and subsequently at Margate. Three years later he went to the Cape for a time. I saw him occasionally for six years. At the end of that time the sinuses had been for some time closed, and there was a strong angular projection a little above the level of the iliac crests. He was dwarfed several inches in height, and his chest was thrown forwards, but he stood erect and no hump was visible through his clothes.

I did not see anything more of this patient for twenty years, when he consulted me for syphilis. I was interested in learning that he had had no relapse of spine symptoms. He had been married, was the father of one child, but had lost his wife. He told me that he had been a good football player and rower, and that he could walk thirty miles a day. His back never gave him any material trouble. There could be no doubt that the destruction of the bodies of the vertebræ had been considerable, for the angular projection was great as well as the loss of stature.

I cite the case as a good example of recovery and repair after disease of the bodies in the lumbar region, and a fact in favour of treatment by the steel apparatus and change to seaside. It is also an excellent illustration of the well-known fact that even severe strumous disease, when once cured, does not tend to relapse.

Severe Pruriginous Eczema, protracted from childhood to adult age—Cure under the influence of tar lotions and Antimony.

There are certain very rare cases in which the general eczema of infants is protracted through childhood, and remains uncured even to adult age. These go to supply a contingent to what is known as "Hebra's prurigo," for they are almost always very pruriginous, and they take their origin in early life. They are, however, not absolutely incurable, but may, if the patient will submit to treatment, usually be got quite well. Sometimes, however, the malady has lasted sufficiently long to interfere with the integrity of the skin and in some degree with the general development of the frame. Such patients are often very pale, of earthy complexion, lean, and defective in sexual endowments, with thin hair and badly formed nails. All these statements are well illustrated in the case of a lady whom I have recently had under care. Miss D——, now æt. 22, has been for eighteen months absolutely free from a pruriginous dermatitis which had been present from early infancy. Two years ago, when she came for a second time under my care, the skin of her face, neck, and arms was thickened and fissured by long-persisting diffuse eczema. She had been more or less constantly under treatment all her life, and although often better for awhile, had never got well. Although well grown, she was thin and extremely pale. Her final recovery took place under the patient use of tar lotions and an antimony mixture. The latter was taken for six months continuously, and I believe that to it much of the credit of the cure is due, for the external applications had been used previously without success. Miss D——'s cure is now so complete that her skin is everywhere soft and supple and shows not a trace of eczema. Nor has there been during eighteen months past, and at various places of residence, the slightest tendency to relapse. She is, however, still very pale, of a somewhat pasty complexion and slightly muddy skin. The hair on the chin and upper lip shows a tendency to grow, and her menstruation is scanty and irregular. Her fingers are thick and flabby and the nails stumpy and thin.

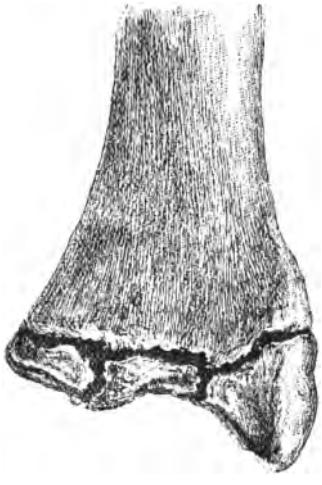
Antimony in the treatment of Lichen Planus.

One of the most interesting cases brought to my Clinical Demonstration on June 14 was that of a man of about 50, who had attended one month previously. On both occasions he was brought by Dr. Sequeira, of Aldgate. He had been for nearly six months the subject of severe Lichen planus. On the first occasion the eruption was still, in spite of much treatment, in full vigour and the cause of much irritation. He had taken arsenic and used a variety of local applications. I suggested that antimony should be used. Mr. Sequeira brought him on the second occasion in order to demonstrate the success of the remedy. Within a few days of its commencement the irritability of the eruption had almost wholly ceased, and the progress had since been uninterrupted. Although still covered with stains, some of them in the legs being almost black, not a single characteristic papule remained. The dose given had been an eighth of a grain of tartar emetic three times a day: It had not caused any sickness.

ON THE AVOIDANCE OF SPLINT-TREATMENT IN COLLES' FRACTURE.

When I was on the acting staff of the London Hospital I used to encourage my house-surgeons to treat many cases of Colles' fracture without any splint whatever. My instructions were never to put on splints unless there was displacement which could be removed by extension and which returned when extension ceased. In all such cases —probably a very small proportion—continued extension by straight splints is clearly indicated, but even in these they ought not to be kept on long. During the last twenty years, my practice having been confined to private consultations, I have seen little or nothing of recent injuries to the wrist. I have, however, seen a great many at the end of long treatment by others which the patients considered to have been more or less unsatisfactory. The result has been a very decided conviction that if the routine treatment by splints could be wholly laid aside, it would be greatly to the advantage of the patients and to the credit of the surgeons. Case after case is brought under observation in which the orthodox treatment has been patiently and skilfully carried out, with the result that the wrist and the fingers are stiffened and the hand painful and useless. Nineteen-twentieths of these would, I believe, have done quite well and escaped all stiffening if the wrist had been simply kept for a fortnight between two cushion-pads, and at the end of that time wholly freed from encumbrance. It is, I know, exceedingly difficult to rid our minds of the idea that there is a necessary connection between a fracture and a splint. The public, as well as ourselves, are under the spell of the same superstition. The surgeon who is bold enough to be

rational is in great danger of adverse criticisms in the later stages of his case. Even if his patient is well satisfied at the time, sooner or later some one is sure to recognise the fact that the bone has been broken, and to express astonishment that it was not put up in splints. The end of the radius is always left somewhat thickened, and the patient is but too ready to entertain the belief that if only splints had been used and the fracture "properly set" this thickening would not have been there. As a matter of fact, some thickening is unavoidable if the carpal end of the radius has been



fractured, and the main question is whether it shall be thickening plus stiffening. The latter addition, so common and so damaging, is, I am convinced, caused usually by the treatment and not by the injury.

We have but to reflect upon what is the real condition of things in a Colles' fracture to be convinced of the truth of the above remarks. In many cases there is no displacement whatever, and no movements on the part of the patient could possibly produce any. In others there is definite displacement of the carpal fragment or fragments backwards and to the radial side. If this is present, and can be removed by extension, and returns when extension is remitted, then a splint is necessary, but not otherwise.

FOREIGN BODIES IN THE RECTUM.

A MIDDLE-AGED man, whose face expressed much distress, came into my room with the laconic statement, "My fissure has come back again." When asked to explain himself, he told me that ten years ago he had been the subject of a very painful fissure in the anus, and that, having been advised to take to his bed and have it cut, he had called on me, and that then and there I had stretched the sphincter and cured him. "But," added he, "it has come back, and is worse than ever." A little further inquiry elicited the fact that he had been, through the ten years, quite free from discomfort, and that his present symptoms had set in suddenly the night before. He said that he had been awake all night, and that the pain was unbearable. On inspecting the part I found the anus red and irritable, and on telling him to bear down he shrieked with pain, but succeeded in protruding some enlarged veins, between two lobes of which there certainly was a superficial but apparently quite recent laceration of the mucous membrane. I was about to advise him to foment and use some ointment, when my good angel whispered, "Don't neglect to use the finger." I had some difficulty in persuading him to let me, for he flinched and declared that I gave him pain which he could not endure. Having, however, at length got my finger well within the external sphincter, I came upon a fish-bone about as long as a common sewing needle, and almost as sharp, lodged transversely across the gut. Having succeeded in extracting this, the case was at an end.

It may perhaps be usefully added to the above narrative that, owing to the impossibility of persuading the man to

keep still, the removal of the bone was very difficult. On another occasion I would certainly make no attempt without an anæsthetic.

I well remember many years ago in a similar case, but with a much longer history of discomfort, removing from the lower bowel part of the breastbone of a bird. In another instance, in which constipation had been the chief symptom, I found the rectum of a woman occupied by at least a pint of maize, the corns of which had been swallowed whole. They had finally accumulated, unmixed with feces, just above the anus and completely blocked the bowel.

CASE OF VESICATING FIRE-STAINS.

Miss J——, aged 30, has both her legs mottled all over their fronts and inner aspects by dusky "fire-stains." The peculiar feature in her case is that in winter these stains inflame, vesicate, and become covered with adherent crusts. This state is quite confined to the tibial aspect of the legs. On the other parts there is neither congestion nor staining, although the orifices of the follicles are a little dusky. Her feet are very cold, and always red. Formerly she had bad chilblains on her feet, but never on her hands or ears. She is of fair complexion and delicate skin.

I have never before seen legs in the condition which Miss J—— showed me on February 24, 1898. The stains above referred to mapped out the whole of the fronts on her legs, and on all the bars of these stains were thick, dry-pus crusts. The crusts were thickest on the lower parts. I was told that the legs would get quite well in summer, but in winter always relapsed. During the mild winter of 1896–97 she was six weeks in bed with them. This last winter they had been just as bad, but she had concealed their condition, fearing that she should again be ordered to bed.

In seeking for the cause of the condition, I learnt that Miss J——, suffering always from feeble circulation and

cold extremities, had been in the habit of sitting much with her legs exposed to the fire. She had been born, and still lived, in a place where ague until very recently had been prevalent, but it was not known that she had ever herself suffered from any definite malarial fever. She was a twin, and her twin brother did not display any obvious peculiarities of circulation. Some of her mother's relatives had suffered from phthisis. Miss J—— herself looked delicate, and was losing flesh. She had always been a chilly subject, but until the last four years had not observed any tendency to sores on her legs.

The measures of treatment recommended were—(1) warm clothing and warm rooms, but careful avoidance of exposure to fire-heat; (2) if practicable, a prolonged change of place of residence to a warm and non-malarious district; (3) cod-liver oil and quinine, minute doses of opium, and Dublin stout; (4) a weak mercurial ointment.

The diagnostic importance of fire-stains depends upon the fact that they are fire-stains, and that they reveal the habit which the patient has yielded to of sitting very close to the fire. The next step is to find the explanation of the chilliness which has induced this habit. The influence of the malarial poison is undoubtedly one of the most potent and persistent. The worst fire-stained legs which I have seen have been in the subjects of ague. Many other quite different influences may, however, produce the undue susceptibility to cold which is at the bottom of the matter. It is, further, obvious that fire-stains can be acquired only by those whose family circumstances permit of personal indulgence. Girls at school and servants engaged in household work do not get them, because, whatever may be their subjective chilliness, they are not allowed to sit close to the fire. It is not a slight or occasional exposure which will cause them, but the habit of cowering in front of a fire for hours together, and this can be done only by those whose time is at their own disposal, who [illegible] much of it alone. In Miss J——'s case it [illegible] had left school and gone to keep an un[illegible]ndition was produced. It is very pos[illegible] may

also have had its share in aggravating the tendency. Many young women suffer much from chilliness which is increased at the monthly periods. It is a curious fact that marriage and pregnancy give complete relief and may indeed induce the opposite. Pregnant women are seldom chilly subjects.

In Wilson's Atlas of Skin Disease there is a good illustration of this form of Melanopathia. It is labelled "*syphilitica,*" but if, as is probable, a syphilitic dyscrasia and the consequent use of iodide of potassium caused the chilliness, I have no doubt that exposure to fire heat produced the discoloration. It is to be noted that the discoloration in these cases always takes a definite pattern. It is arranged like the stains which appear in the skin of a corpse, or the bands of dark hair on a dappled-grey horse.

MISCELLANEOUS.

No. CCCVIII.—*Tabetic pains induced by Cold.*

Mr. W—— told me that he used formerly to be quite unable to sit down in a cold leather chair without its producing immediately nerve pains. These pains would shoot through the hips and thighs. Now he has got rid of this liability. The patient who thus described his peculiar symptom was a very intelligent observer. He had suffered from syphilis some years before, and had taken iodides and mercury for very long periods. He had become liable to severe pains in his limbs, which it was difficult to diagnose as to whether they were tabetic. Some years later he was the subject of possibly a form of tabes. His pupils were small and sluggish, but acted somewhat. He could walk well with his eyes shut, and his knee reflexes were tolerably good. He had nodes. His description of the pains which he had suffered was exactly that of tabes.

No. CCCIX.—*Pain in Stomach and Abdomen, very severe and constant—Tabes probable—Pain caused by warm bath.*

Mr. B——, whom I saw on November 19, 1889, with Dr. E—— and Dr. H. J——. We then ordered only nux vomica and bromide of potassium. He has got much worse in walking. He spent the winter in Monte Carlo. At Aix les Bains he was promised a cure, but did not get one. He walks on his heels, and very badly.

Last February a very bad attack of sciatica, right side. He has of late had very troublesome pain at stomach. He has taken antipyrin for a year for their relief, under Dr. E——'s advice. He has never had developed crises, that is,

no severe vomiting. He is never free from the pain, but it is always worse after making water. He can only pass water sitting, and with some straining. He takes food well, and always feels better after it. Sleeps well. He once had a fixed pain in two inches of the tendo achillis, "like a hundred toothaches rolled into one." He has long used morphia injections, which always relieve most when made near the spot. A warm bath of ordinary temperature would give him great pain all over. He can only bear it just tepid. Much pain between his shoulders. He has had pains in his great toe very like gout, but without swelling. He is married, and says that he is quite competent, and does not experience any ill results.

No. CCCX.—*Hysterical (?) affections of the Spine.*

In the Report of the Hunterian Society for 1834, under the head of "Hysterical Affections of the Spine," the following occurs: "A case in which there is loss of sensation, as well as of motion in the lower limbs. There is tenderness of the spine. Though menstruation is regular, the young lady is highly hysterical, and the paralysis is imputed to that cause."

We have, I think, learned to be very careful as to calling paraplegia "hysterical." A case recorded at page 311 of Vol. V. may be read with interest in reference to the above.

No. CCCXI.—*Some Aphorisms respecting Inheritance.*

Although all maladies which can be inherited tend to assume peculiar features when so transmitted, they but rarely keep to a simple or uniform type.

Transmutation in transmission implies relationship in nature and descent.

Whatever conditions are capable of frequent transmutation in hereditary transmission are probably closely allied, if not the same—*e.g.*, gout and rheumatic gout, the varieties of ichthyosis.

When two different morbid states are frequently observed

to be transmuted the one into the other in hereditary transmission, then it is safe to infer close relationship, if not essential identity.

When two diseases appear to spring by common inheritance, *i.e.*, the one in one child and the other in another of the same family, and this is ascertained to be of frequent occurrence, we may assume that there is some basis of relationship between the two—*e.g.*, different types of cancer, or of skin disease, or of arthritis.

No. CCCXII.—*Fragmentary Notes on various subjects.*

The Bengalees have no lunulæ. Jews, as a rule, have large ones. In Greeks the thumb only has one.

There is an important portrait in the collection of the Dublin College of Surgeons showing gangrene of the ends of the fingers (acro-sphacelus) in an infant suffering from congenital syphilis. It has been copied for the London College collection.

The poison of syphilis enters into partnership with the previously existing proclivities of the individual.

A tendency to perspire on the slightest exertion is not unfrequently coincident with habitual chilliness, and both are indicative of want of tone.

In elderly persons acne never occurs on the shoulders.

Amongst the maladies for which the climate of Pontresina is unsuitable I find, according to a circular which has been sent me, the following: "Heavy diseases of the heart, fatheartedness, arteriosclorose, crispation of the kidneys, strong emphysema of the lungs, heavy cachectical dispositions. Disposition for articular rheumatism."

An Aphorism.—Don't try to make the diagnosis yourself; let the symptoms do it.

A man aged 49 has had four attacks of ecchymosis of the conjunctiva; always in the right eye. No cause can be assigned. He is in good health.

No. CCCXIII.—*Diseases of the Skin in connection with Gout.*

Dr. William Corlett, of Cleveland, U.S.A., read before the Ohio State Medical Society, in 1886, a report of three cases which he cautiously named "Disease of the skin in the subjects of gout." One of the three, of which a woodcut is given, presents some features of similarity to the cases which I have adduced. An Irish woman, aged 62, was the subject of chronic rheumatism, which was apparently complicated with true gout. She had had repeated attacks of inflammation of the great toe, coming on in the night and attended by great pain. Although she knew of no history of gout in her ancestors, one of her brothers, who was dead, had suffered from symptoms very like her own. Her face was pale and puffy. She had been troubled for seven years with an eruption on her legs, the spots being of a dark reddish colour, slightly scaly, and moist only when scratched. Some of the patches had ulcerated. Dr. Corlett gives a woodcut to show the location of the patches and ulcers, but it is unfortunately impossible to tell which are ulcers and which otherwise. It shows the eruption on the backs and fronts of the forearms also; but no detailed description is given of it in these parts. A circumstance which produces some doubt as to whether the case is really similar to my own, is that although the eruption had been present during so many years, it is stated to have disappeared rather quickly under treatment.

No. CCCXIV.—*Albinism as a family peculiarity.*

Albinism may occur as a family peculiarity, and may be perpetuated by breeding. White rabbits, rats, mice, and ferrets are examples of the latter, and all are complete albinoes. Birds are but very rarely complete albinoes; that is, they very rarely have pink or fiery eyes, which is the final character. Some instances are, however, on record in

which the condition is said to have occurred in more than one of a clutch of birds, and one at least in which there was a probability of inheritance. Mr. White, of Bongate, found white thrushes in two successive years. The nests were within fifty yards of each other. In one nest of four young, two were normal and two white with red eyes. In the other nest only one bird was white, and its eyes are stated to have become darker as it grew up. Mr. J. Marshall, of Belmont, has supplied a very curious observation. A pair of thrushes had, in the summer of 1861, three broods. In the first there were three young ones, one white and two normal; in the second, three all white; and in the third, one white and three normal. Mr. J. W. Lukes observed an instance in which two young birds in the same nest were of a light yellowish-brown colour, their breasts showing incipient marks of the usual spots. Both parents were of the normal colour.

I take these facts from Morris's "British Birds," vol. iii. p. 63. The thrush family would appear to be especially prone to albinism. It is to be observed that the facts seem to indicate that partial albinism is really a minor stage of the complete form. Thus in Mr. Marshall's case, in which several complete albinoes had been observed, one was of a rich fawn colour; and in that of Mr. White, in one bird the eyes evidently were not red, since "they became darker as the bird got older." Some facts as regards our domesticated birds and animals might have seemed to imply that whiteness of the feathers or hair may occur without any tendency to find a climax in red eyes. White oxen are common, and so are white ducks and white fowls, but in none of these does complete albinism ever occur.

No. CCCXV.—*Danger of Meagre Statistics.*

Sir Algernon Borthwick (now Lord Glenesk) once remarked to me, respecting some operation statistics, "You surgeons seem to me to trust to too small numbers for your calculations. Before you speak of a percentage you should at least get your centum."

No. CCCXVI.—*Spontaneous improvement in Hypermetropia in Children.*

In some statistical tables given by Landolt, it appears that nearly 30 per cent. of hypermetropic children experience spontaneous improvement. In some the condition is simply reduced, in others enmetropia is attained, and in a third group the state overpasses the line and myopia is the result.

No. CCCXVII.—*Infective Materies generated in the act of Inflammation.*

Whilst there can be little doubt that the introduction, at the time of the injury, of some living germ matter (bacillus) developed in connection with the process of inflammation in the contributor, very greatly adds to the risk, and gives character to the inflammation induced, there are good reasons for doubting whether any such material is essential. It is highly probable that in some instances a chemical product of decomposition may take its place, and further that in some cases no poison of any kind has been introduced. In the latter group, we have to suppose that the tissues of the person wounded are capable of generating, as the result of merely mechanical irritation, a poison which shall prove infective. We have to accept the proposition—in all probability a truth—that the inflammatory process, however initiated, is always attended by the production of a virus (living or chemical, or both). Inflammation in its early stages always leads to multiplication of modified cell organisms which may prove infective; in its later stages it leads to death of cells, and may favour the access to the blood of chemical elements, the result of decomposition, which may prove very injurious. All inflammations attended by conspicuous gangrene are productive of fever and accompanied by "poisoning of the blood."

No. CCCXVIII.—*Erysipelas without Incubation Period.*

In a case (one of an epidemic) in which erysipelas followed

vaccination, redness was observed within twenty-four hours of the operation, the infant's arm being inflamed from shoulder to elbow. (See Appendix to Vaccination Commission Reports, p. 230.)

No. CCCXIX.—*Deformities of the Teeth caused by Mercury.*

We have recently had at our Museum Demonstrations some excellent illustrations of mercurial teeth. I use the word mercurial because the teeth in question are, I believe, almost always caused by the use of mercury in infancy, though I by no means intend to deny that other forms of stomatitis may produce similar results. The peculiarities are damage to enamel of all the permanent teeth excepting the pre-molars. The exemption of the latter is usually most definite. These teeth present white, clean enamel, whilst all the others are pitted, uneven, and discoloured. I take especial interest in demonstrating these teeth and insisting on their peculiarities because they are constantly mistaken for syphilitic teeth.

No. CCCXX.—*Osteitis Deformans in a Mulatto.*

I have received from Dr. Knott, of British Guiana (for the Museum), photographs illustrating a case of osteitis deformans in a native of the colony. They show a very large head and much bending of the femora and tibiæ. The lower jaw near to its angle on the right side is much enlarged. The tibiæ are not apparently much thickened, but the bend outwards and forwards is very marked. The patient is obviously of negro descent, and almost black. Dr. Knott's notes state that she was aged 46 and a native. Her head had been progressively enlarging for eight years, and, owing to the curvature of the spine and lower limbs, she had lost several inches in height. There were no changes in the upper extremities or clavicles. She had suffered from aching in her limbs, but the affected bones were not tender.

As a contribution to international pathology the case is valuable.

ARCHIVES OF SURGERY.

OCTOBER, 1898.

EXTRACTS FROM MY DIARY.

June 9, 1898.—I have just seen Mr. W——, who was one of those whose cases are recorded in my first Report on Vaccination Syphilis. It is twenty years since that occurrence. Mr. W—— suffered rather severely from the syphilis; in consequence, I believe, of his not having persevered with treatment. Two or three years afterwards he had some cerebral symptoms, which were cured by specifics. He is now seventy-five years of age, and looks ten years younger than his age. Not having seen him for ten years I mistook him for his son. His son also had syphilis at the same time, and curiously both in father and son the vaccination-scars showed a tendency to recurrence of induration several years later. The son is now a healthy man and the father of a healthy family. Such cases are of value in reference to the question of Life Insurance and Syphilis.

June 16.—I have received this morning a letter from Mr. Royds, of Andover, informing me of the death, at the age of 75, of Mr. W. D. B——, at Dunedin, New Zealand. Now I had removed this gentleman's tongue for sclerosis and epithelial cancer in August, 1879. I am informed that he has never since had any trouble in connection with the tongue, but that he has died from some internal disease, possibly cancer of bowel. His tongue is Fig. 3 in Plate LII.

of my Illustrations of Clinical Surgery. He has lived since the operation nineteen years.

June 26.—Miss L——, of R——, has just called on me "merely to let you see that I am quite well." I removed her right breast and axillary glands for scirrhus on August 14, 1889. The tumour had then been growing two years, and she was 58 years of age.

July 11.—Mrs. G——, formerly Miss C——, who is the subject of lupus erythematosus, has called on me to report progress after a four years interval. Five years ago she came under my care with the usual symmetrical patches on the cheeks, on the nose, and in the ears. She developed a troublesome cough, lost flesh, and looked so much like phthisis, that I urged her to try a complete change of climate. She accordingly went to Natal, and has lived there ever since. Her general health has very much improved. She tells me that the first effect of the sunny climate of Africa was, apparently, to make her lupus worse, but that after a time it improved. The patch on her nose has coalesced with those on her cheeks, and the latter have somewhat advanced towards the ears. In the concha of each ear is a large scar. No new patches of lupus have developed, and over the greater part of those on the face the condition is that of a sound and not very conspicuous scar. These patches have, it is true, an erythematous border, but it is not advancing. The disease may be considered to have come to a standstill. This is according to rule, and it is probable that there will not now be any relapse.

March 3, 1897.—I have just seen Mrs. D——, whose portrait is in the Museum and is Pl. 72 in my Smaller Atlas. The whole cheek is now one large scar, but perfectly sound, and without any trace of lupus growth at its edges. The scar extends more widely than the appearances shown in the drawing would suggest, passing on to the side of nose.

Mrs. D. is now the subject of most peculiar cake-like induration of the skin on the posterior parts of the deltoid regions and extending upwards from them towards the neck. I examined these four months ago at Park Crescent, and they were, I think, larger then than now. They are not inflamed and do not threaten to soften. Each patch is as large as an outspread hand and of much the same shape. The induration involves skin and subcutaneous cellular tissue, and a process of atrophy is at work which makes the surface uneven, producing irregular depressions. Over the spines of the scapula the skin adheres to the bone. The boundaries of the patches are indefinite, especially towards the neck. Mrs. D. thinks nothing of them and is under no treatment.

It is still a question whether the original disease of the cheek was an ulcerating gumma, and whether the present indurations are of the same nature.

In company with my esteemed friend Professor Boeck, of Christiania, I have just inspected a dozen London children, the inmates of a holiday home. My companion noticed that several had scaly patches on the face, and told me that he felt sure that these patches were indicative of the presence of the tubercle bacillus in the child's system. He added that the subject had attracted much attention in Norway of late, and that the evidence was, he thought, conclusive. The patches referred to were such as are very frequently seen on the faces of delicate children, and are attributed to using hard water and irritating soaps. Dr. Boeck seemed inclined to go even further than I have myself done in his suspicions as to the widespread prevalence of the tubercle bacillus, and its frequent connection with very minor phenomena. None of the children in question were regarded as invalids.

It is very desirable to record facts which give encouragement for early operations for cancer. I have mentioned above, one in which a patient whose tongue I had removed

nearly twenty years ago has only recently died of other disease. I have just seen the Rev. Dr. A. S. F——, whose tongue I removed eleven years ago. Two years previous to the final operation I had removed by superficial excision some sclerosed patches which were in a doubtful condition, but not positively cancerous. At the date of the second operation there was no doubt whatever as to the nature of the disease. Dr. F—— is now seventy-one years of age and in excellent health.

July 16th.—Dr. S. B—— has just called on me with a plentiful eruption of herpes on his forehead and side of head. He is anxious lest his eye should suffer. I console him on this point, for there is not a single vesicle on the side of his nose, the oculo-nasal twig having escaped. His conjunctiva for the present is not even congested, although there are spots on the upper lid. Although the vesicles are very abundant, they are very superficial and have the thinnest possible walls. This fits well with his statement that it has not been very painful, "only a little pricking pain." He is only thirty-five, and his youth probably explains the mildness of the inflammation. He tells me that his father, when an old man, had shingles on his chest and suffered most severely. This suggestion of inherited tendency is interesting, and so also is the fact that Dr. B—— has been recently taking arsenic. He thinks that he took his last dose of arsenic—it was only a single minim three times a day—at least three weeks ago. His herpes has, however, now been a week out, and we do not know how long its incubation stage may have been.

June 10.—An engineer who had been engaged in a South American gold mine, working amongst fumes of arsenic, gave me the following facts. He said that the metal was deposited on the grass, and that the mules and asses died from eating it. In them the symptoms were loss of flesh, general drooping, with hanging heads, and death apparently from pain and debility. In men a sore nose was usually

the first symptom, and next a sore mouth and spots on the face. Scarcely any one escaped a sore nose and choked nostrils. He had himself suffered, and had taken iodide of potassium as a remedy, which had made him weak, and brought out boils. He looked sallow in face, but the skin of his trunk was white, and not in any way pigmented.

August, 1898.—I have just heard of the death of a patient who was the subject of Acromegaly, and who was indeed the first in whom I had observed the curious characters of that malady.

His case is published in ARCHIVES, Vol. I., p. 141. It was one in which the features of the disease were extremely well marked. I am informed by Dr. Birch, of Newbury, that Mr. B—— had since my report of his case enjoyed fair health, though still suffering from his headaches. He was a man of keen intellect, which to the last did not in the least fail him. His death was preceded by profuse hæmatemesis. This was supposed to have depended upon ulcer of the stomach rather than upon varices of the œsophagus. For some months previously he had suffered a great deal of pain, sometimes in the epigastrium, sometimes in a spot opposite the third dorsal vertebra. The blood vomited was dark and probably venous. There had been no reason to think that he was suffering from cirrhosis of the liver.

I find that practical dentists are in the habit of speaking of the first permanent molar tooth as the "six-year molar." It might be convenient if this term were generally adopted, as it serves to emphasise the fact that it is one of the first of the permanent set, and that it comes up simultaneously with the lower central incisors. It is the tooth which usually shows the influence of mercury given in infancy (or of other forms of stomatitis), the explanation being that it is developed, and its enamel calcified, long before its fellows.

I have recently been consulted by a gentleman who has just returned from Matabeleland, and has his hands covered

with dusky stains, which become conspicuous in the depending position and give him much annoyance. There are no actual scars and no traces of remaining inflammation. It appears to be simply a condition of weakened capillaries easily permitting of over-distension of the venules. The patient is a very tall man and, although in good health, of a somewhat feeble circulation. He tells me that when in Africa his hands were covered with sores caused by slight bruises and exposure to sun, &c. He says that such sores are very common there, most persons suffering from them more or less. He will not admit that they are due to pricks of thorns or to the bites of insects; but attributes them entirely to mechanical injuries and to exposure of the hands to weather.

I conversed with a surgeon who had practised in Africa, in a Yaws district, and suggested to him that it was very difficult to distinguish between yaws and syphilis.

"In some cases," he said, "it is impossible to tell which the disease is, but in others it is quite easy.

Ego. Is not that because you have determined to call a certain group of symptoms Yaws and another group Syphilis, and thus artificially put examples of the selfsame malady into two classes?

Ille. Very likely it is so.

Ego. It is said, for instance, that in yaws there is never any sore throat; but may it not be that if it was a sore throat you would at once class the case as syphilis?

Ille. It is very possible. I may repeat that I have seen many cases in which I could not decide whether the disease were syphilis or yaws.

Ego. Speaking of sore throats, may it not be that in the tropics the mucous membranes are not so prone to suffer as in colder climates?

Ille. I am sure you are right there. We very rarely see sore throats from anything. I was myself very prone to sore throats when I lived in England, but I never had one in Africa.

MULTIPLE FRACTURES IN YOUNG CHILDREN WITH TUMOUR GROWTHS.

THE two cases which I have to narrate bear a remarkable resemblance to each other. In both, numerous fractures of long bones occurred in early life. In both, symmetrical deformations existed at the elbow joints suggesting a want of development of the external condyle and consecutive dislocation of the radius. In both, enlargements of bones had occurred, more especially of the femurs. In one case the enlargement of the femur, first of one, then the other, had not been persistent, but in the other, what appeared to be a very large intra-osteal cartilaginous tumour has developed.

In each case the tumour in one femur was at one time so large and so suggestive of malignancy that amputation was contemplated. Both patients were girls, and one was aged 12 and the other 10 at the time that amputation was advised. In neither was there any evidence whatever in support of the suspicion of congenital syphilis. In one of the cases I much regret that I am not able to complete the notes, and am obliged to be content with describing the patient's condition as it was at the date of my last seeing her, twenty-eight years ago. It is possible that she may subsequently have come under the observation of some one of my readers. If so, the supply of further particulars will confer an obligation not, I feel sure, on myself alone. The child's name was Emma Mackinnon. Although in this case I remember that I was at the time disposed to suspect syphilis in consequence of the rapid development of the osteal swellings and their disappearance under treatment by iodides, yet on further thought, and especially on comparing the facts with those of the second case, I do not think that this suspicion can be sustained. It seems more likely that the cases are to be assigned to a

small group in which interference with bone development and tendency to cartilaginous outgrowth, occurs in connection with some ill-understood inherited tendency. Although by no means the same, they are probably allied to those osteo-plastic conditions which sometimes result in dwarfdom.

CASE I. — *Numerous fractures of various bones in a young child — Symmetrical deformity of elbow-joints (congenital ?) — Enlargement of lower part of right femur.*

The patient whose case is recorded in the following notes was first brought under my observation by Mr. F. M. Mackenzie (then my House Surgeon) before the enlargement of the femur had occurred. On a second occasion she was sent to me by Mr. Oswald Baker in September, 1869, when the following notes were taken :—

September 19, 1869.—Emma M——, æt. 10½. The two elbows are almost exactly alike. In each the head of the radius at the elbow-joint can be easily felt and seen, owing apparently to an absence of the external condyle. The internal condyle is well formed, and in due relation with the olecranon, but the external appears to be wholly absent, and the finger can be placed in the cup of the radius. This cup of the radius does not present a cavity as usual, nor does it appear to be quite so large or so evenly rounded as in the normal state. It is not at all closely confined to the ulna, and can be made to project at least as far as the extremity of the olecranon, being thus too long for its corresponding bone. At the back of the lower part of each humerus on its radial border is a strong ridge of bone with its convexity backwards. This apparently represents the external condyle. When the arms are extended they are not perfectly straight, but are bent a little inwards, and the extremity of the displaced radius then projects considerably. The ulna itself is in each arm considerably bent in its upper third. She is reported to have had three fractures in the right forearm and two in the left, three times of the right leg and once of the right thigh. Of none of these fractures do any very evident traces remain. The power of pronation and supination is limited, and the flexion also is incomplete. The child cannot put her arm behind her, nor to the back of her head.

Her mother states that nothing was ever noticed amiss with her elbows before her arms were broken. The upper arms are both of them very thin, but, as far as can be tested, all the muscles are present. Her first fracture occurred at the age of fifteen months, and implicated her right leg. The left arm was broken at the age of two years and three

months, and before the splints were removed she broke the other. Her last fracture, three years and a half ago, was of her right thigh, and she was treated at the London Hospital. A year and a half later she had some effusion into the right knee-joint, which disappeared after treatment. During the last two months the lower half of the right femur has been slowly enlarging. The femur is now much enlarged in its lower third, the enlargement implicating all parts of the bone to the joint itself, the condyles being involved. It is very hard, as if from a growth within the bone. There is no redness, and scarcely any heat of surface. Her mother states that it has been very painful, and has often kept her awake at night. "Jumping pain" is described. She is said to have lost her flesh since the bone began to enlarge. Girth of the right thigh above the knee, 11½ inches; of the left, 8½. There is no effusion into the knee-joint at present.

She is the eldest of a family of seven, only one having died. There is no history of mollities ossium, of rickets, or of cancer in the family. None of her brothers or sisters have had fractures. The paternal grandmother had a fracture of the leg. There is nothing about her indicative of inherited syphilis, nor are there any suspicious facts in her early history. The conditions presented by the elbows are possibly consequent upon fractures of the ulna with injury to the humeral epiphysis and unreduced dislocation of the radius in early life. The enlargement of the femur is suggestive of a myeloid tumour, but the severe pain, jumping, &c., must be kept in mind as possibly in connection with inflammation and abscess in bone.

Some months later a very large swelling (periosteal) formed on the middle of *left* femur, and went through the same stages as the other had done.

December, 1870.—The swelling has almost wholly disappeared from the right femur; but the one on the left remains. Another swelling has developed on the left tibia.

After the last date I lost sight of my patient, and I have now no clue to her address. The treatment under which some of the bone tumours had to a large extent been absorbed was the iodide of potassium, but it will be observed that it did not prevent the development of others. It may possibly have been the fact that the growths were in some connection with the fractures, but on the other hand they did not follow them immediately, and most of the fractures had united well and without "callus." The tumour of the right femur was at one time as large as an infant's head, and it will be noticed that it grew three years after the fracture. Neither in this case nor the one to follow were there ever any

periosteal swellings on the skull. In both the limb bones were those which alone were affected.

I have recorded in a former volume of ARCHIVES some other examples of deformities at the elbow very like those which were present in these cases.

For the opportunity for investigating the following case I was indebted to my friend Mr. Hastings Gilford, of Reading.

CASE II.—*Numerous fractures of long bones in early life—Malformed elbows—Large enchondroma of one femur—Severe cramps in legs—Fractures of ribs from coughing.*

YEAR.	AGE.	DETAILS.
1865	1	A small child. Not suckled. Got on well. "Double jointed" at elbows from birth.
1866	2	Broke her arm when just able to walk. Could walk at twelve months.
1867	3	Good health. She cut her teeth early and well.
1868	4	,, ,,
1869	5	,, ,,
1870	6	Broke the opposite humerus in a fall, and the first a second time.
1871	7	Broke a rib in fall from sofa.
1872	8	
1873	9	
1874	10	
1875	11	
1876	12	Great pain in left thigh and a swelling developed. In St. Bartholomew's Hospital.
1877	13	Amputation urged, but parents refused. She was very ill at the time.
1878	14	Menstruation commenced and has since been regular.
1879	15	Broke her right leg in a fall.
1880	16	During these years the tumour, which involved the whole of the left femur, persisted or even increased. It became finally of enormous size and extended from knee to hip. It ceased, however, to be painful, and became harder.
1881	17	
1882	18	
1883	19	
1884	20	
1885	21	
1886	22	
1887	23	
1888	24	
1889	25	
1890	26	
1891	27	Became liable to cramp in one leg.
1892	28	The cramp occurred in the other leg, brought on by walking.
1893	29	
1894	30	Seen by me with Mr. Hastings Gilford.
1895	31	Two ribs broken.
1896	32	
1897	33	
1898	34	Good general health. Conditions stationary.

Additional Memoranda.

She is the first-born. The next child died of diarrhœa ætat 2. The third always strong. Rickets has never been mentioned in respect to any of them. There is no family history of brittle bones or of tumours. She is about 4 ft. 9 in. Her hands and feet are well formed. Wrists not in the least thickened. The sternum projects forward a little above its middle. Both tibiæ are bowed outwards and forwards. At both elbows the radius is dislocated.

Her teeth show no indications either of syphilis or mercury. Her physiognomy can scarcely be said to be suspicious, but the skin is pale and dry and the frontal eminences a little more elevated than ordinary.

In August of the present year (1898) Mr. Gilford kindly reported to me on the state of his patient. The tumour of the femur has not grown. Although the patient appears to be in excellent health, yet her bones remain very brittle. In November of 1895 she broke a rib in the act of coughing, and whilst Mr. Gilford was applying a bandage another fit of coughing occurred and another rib on the other side gave way with an audible snap.

Cartilaginous Tumours of the Digits in association with Epiphyseal Exostoses, and dwarfing of one lower limb (possibly after fracture)—Enormous development of the cartilaginous growths so as to completely disable the hands.

The following case is an example, not only of the unusually free growth and multiplicity of cartilaginous tumours of the digits, but of their association with tendency to outgrowth at the epiphyseal cartilages. The dwarfing of one lower limb amounting to nine inches was obviously caused by arrest of growth of the femur, and although there was no known history of fracture, it seemed very probable that some injury to the lower epiphysis had been sustained.

The notes given below do not record anything as to the toes, but I remember clearly that there were some small tumours and that they appeared to be attended by much thickening of skin.

The case may be profitably compared with that of a man whose lower limb I amputated on account of disabling growths many years ago, and whose case is recorded in the

Pathological Society's Transactions. In him, also, one lower limb only was severely affected.

The Clinical Museum contains portraits of both these cases, and of several others in which there was remarkable multiplicity of cartilaginous growths.

Mary Jane N——, then aged 19, was in the first instance sent to me by Dr. Elder, of Nottingham. Ten years later I was taken to see her, when an inmate of the Nottingham Infirmary, by Mr. Thomas Wright. The following notes describe her condition when I first saw her:

"Her fingers are occupied by large, smooth, knobby outgrowths, looking at first sight like chalk-stones. The largest, on the left thumb, has distended the skin until it looks tense and shiny like a scar, and in one spot, apparently from mere tension, the skin has ulcerated. This mass is as large as a hen's egg, and occupies the back of the thumb, leaving its palmar surface quite free. As a rule the terminal phalanges escape.

"There is a very remarkable deformity of the left lower extremity. The femur is much shortened, and there is an obtuse curve in its lowest fourth; with convexity outwards as if it had been broken. The knee is so much displaced outwards that the patella has left the inner condyle. I think it most probable that there has really been a fracture, or displacement of epiphysis, in infancy.

"There is a marked family tendency to chilblains, and some of her brothers and sisters suffer severely, but she has not done so in any extreme degree.

"She looks well. No family history of similar conditions or of tendency to gout. Her right leg was supposed to ail nothing, and is quite straight. I found, however, just above the ankle on both tibia and fibula, little bony outgrowths, quite definite and very hard. Also some near the knee, very small. The symmetrical arrangement is very definite, but the size of the growths on the two sides is very different. Although both hands are extensively affected and alike so, yet the size of the growths on corresponding fingers differs much. Most of the growths occur near to epiphysis, but some in the middle of phalanges. Right limb from anterior superior spine of ilium to inner maleolus measures 33½ inches, left 24 inches.

"In the hands it is to be remarked that whilst all the phalanges are occupied by tumours, all the metacarpal bones are free, as also all those of the carpus. There is some little exception to this statement as to the distal ends of some metacarpal bones which show ridges, but none have tumours in them. The hand on each side is pushed over by overgrowth of the ulna or arrest of that of the radius."

CASE ILLUSTRATING THE NEURO-CATARRHAL NATURE OF ERYTHEMA MULTIFORME.

THE appended brief Schedule gives the particulars of an instructive example of erythema multiforme. The patient was a young lady, aged 26, when in 1895 she first came under my observation. It was her fifth attack, and was so well characterised that I asked her to attend at one of my Demonstrations, which she kindly consented to do. I have recently seen her in another attack, and during the present year, 1898, she has had no fewer than three. Previous to these she had had an interval of two years without any. In 1895 I had prescribed arsenic in the hope of preventing the attacks, but she took it only for a few months. We cannot attribute her immunity during the two years to that treatment, for, as the schedule will show, she had had periods of freedom quite as long previously.

YEAR.	AGE.	DETAILS.
1888	19	Her first attack. Saw her doctor. It was only unsightly.
1889	20	No attack.
1890	21	No attack.
1891	22	A second attack.
1892	23	No attack.
1893	24	No attack.
1894	25	Spring and autumn attacks.
1895	26	April 6, Erythema multiforme. Arsenic given.
1896	27	No attack.
1897	28	No attack.
1898	29	March 1, attack. May 2, attack. June 21, another.

It would appear that the attacks had rather increased in severity than otherwise. Her first affected the hands only, and although it was bad enough to induce her to consult her doctor, it did not cause her much trouble. On subsequent

occasions the face as well as the hands had been affected, and during the last attack, when she came to me, there were vesications not only on the hands and face, but on the tips of the elbows and on the chest. On the elbows precisely the psoriasis positions were affected, a fact which it is important to note. On all occasions the eruption had disappeared spontaneously after a very short duration. The earlier attacks usually occurred in the spring. In 1894 she had an autumn attack also, and in 1898 one in spring and two in summer. The summer of 1898, it is to be noted, was cold and wet, the weather being throughout much like that of spring.

I have taken much interest in endeavouring to associate these eruptions with the ordinary causes of catarrhal outbreaks, and with influences brought to bear through the nervous system.

In reference to these theories Miss P—— gave me some items of evidence. She said that in girlhood she had always been liable to "heat-spots" on the lips (herpes labialis). She thought that she was liable to catch cold, but said that her colds did not cause running at the nose, &c., as in other people. "When I get a cold I never show it, but only feel chilly and starved, and have a cold feeling down the middle of the back." Now the association of herpes labialis with rigors is well known, and the symptoms described by Miss P—— are precisely those which would be likely to precede an eruption of neurotic causation.

TWO CASES OF AN UN-DIAGNOSED DISEASE OF THE SKIN OF THE FACE.

Case I.

Miss B——, æt. 20. In August, 1896, "a little pimple" was noticed on the middle of lower eyelid. Nothing was done to it, and after two or three weeks "the lids swelled so that I could not open them." This subsided and left the present condition.

There is now (December, 1896) a long, oval, elevated patch running lengthwise of the lower eyelid and without the slightest inflammation around it. Almost from the first there has oozed from the surface from different points a considerable quantity of clear watery fluid. The patch shows some little yellowish granular dots. (Portrait preserved.) It is a quarter of an inch in elevation, and might be taken for keloid, but is not so glossy and not so hard. It is firm rather than hard, and a dull plum colour. There are no enlarged glands nor any other form of eruption.

Her father is not in good health, but not consumptive. The girl herself has been very hysterical and weak, but not otherwise ill.

This patient attended on three occasions at my Demonstrations, and her case excited great interest. At first iodide of potassium was given, but subsequently steel. The patch gradually and very slowly softened away, and in March, 1897, although still visible as a discoloration, it had no appreciable thickness. A few months later there was nothing but a thin whitish scar.

Case II.

The following is an example of an induration almost exactly like that above described, but less raised, and in precisely the same position, the right lower eyelid:—

Mrs. S——, æt. 75. She first noticed a little spot on the lower eyelid. It has not been painful, but has increased. It was at first "under the skin and quite loose." At present there is an induration which involves the skin, and is smooth and glossy on its surface. It is conspicuous as a smooth, brownish-red patch, but is but little elevated. It is about as big as a filbert flattened out, and is very hard. It is a long oval in shape. She once had a violent fall and bruised her cheek, but that is six years ago. There is no history of tumours in her family, but much rheumatism and gout.

When this patient consulted me her patch had been present about two months. It was extending, and she had been strongly urged to have it immediately excised, and had been told that it was probably malignant. Remembering the previous case I felt justified in advising delay, and prescribed only the iodide of lead and a tonic. A month later it was much less hard, and in the course of three months it had disappeared. Just, however, as it was disappearing, another similar one began to form in the skin of the forehead, a little above the eyebrow (on the same side). My patient lived at a great distance in the country, and I had no opportunity for watching the course of the second patch. She wrote me some months later that it also, under the use of the same ointment, had disappeared.

Comments on the two Cases.

The two cases which are briefly recorded in the above notes were, as far as external appearances go, very closely alike. In each case the patch was on the lower eyelid, and of a long oval form. In each it was raised above the level of the skin, in one very considerably so, and in both abruptly circumscribed. The patient in one case was a girl of 18, and in the other an old lady of nearly 70. In the girl the

patch disappeared slowly in the course of five or six months, leaving behind it a very thin but quite definite whitish scar. This patient was seen repeatedly by many observers, and very carefully examined. She attended not only on several occasions at my Demonstrations, but also once at a meeting of the Dermatological Society of London. No nominal diagnosis was ventured by any one. The girl was somewhat out of health at the time, being anæmic and hysterical. The disappearance of the patch occurred under no more vigorous local treatment than keeping it covered with iodide of lead ointment. Under a long course of tincture of iron the general health was much improved.

In the older patient the process of involution was much more rapid, and in the course of two months from its commencement the patch had disappeared. Just as it was disappearing, however, another similar but smaller one showed itself above the eyebrow, on the same side. It also, after a few weeks' duration, underwent spontaneous absorption. I have not seen my patient since the cure, but in reply to a recent letter of inquiry she assures me that both patches have quite disappeared, and have left little or no trace. As indicating the threatening aspect assumed by the disease in its early stage, I may mention that Mrs. T—— came to me in consequence of having had an immediate excision urgently advised to her under the diagnosis of sarcoma. I will not venture on any diagnosis of the disease, whether nominal or essential. In each instance I was at first disposed to regard the malady as probably lupoid, that is of tubercular nature. The conditions were, however, not at all closely similar to any recognised form of lupus, and the almost spontaneous disappearance in each case was more rapid than is ever seen in lupus. It was also much more complete, for in neither instance is there any trace of the original growth remaining. I cannot speak with certainty as to the elder patient, but in the younger one the skin affected has been disorganised, and a scar has resulted. In this the process has resembled that of lupus. In the older patient there is no reason to suspect tuberculosis, for she is in excellent health.

In the younger one, although there is no very definite evidence of it, the state of health by no means precludes suspicion.

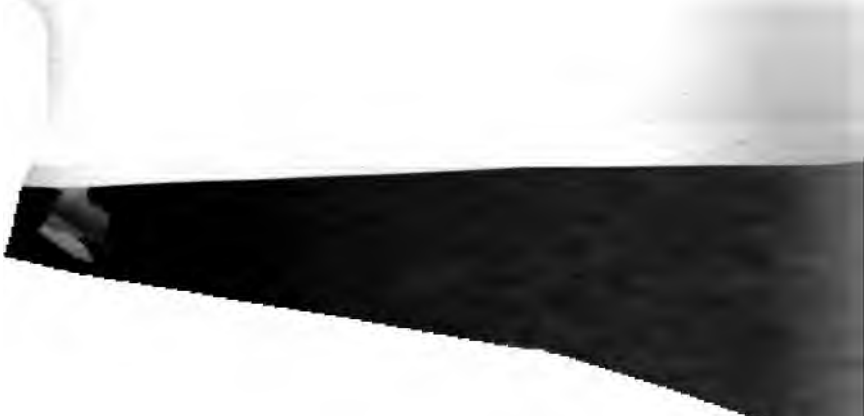
These two cases are not, as regards the local appearances, unlike those of which I shall treat in the following paper. In the absence of multiplicity, however, and in the tendency to spontaneous cure they differ widely. I may add that in each instance I proposed excision of a part for microscopic examination, but by both patients this method of diagnosis was declined.

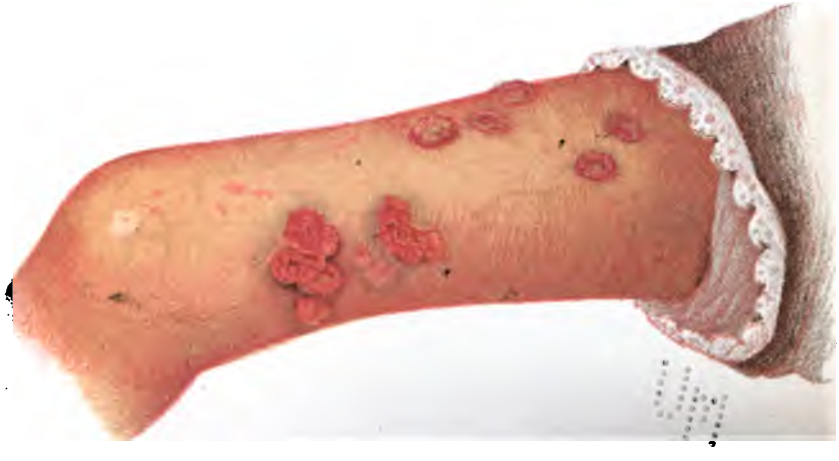
PLATE CLII.

MORTIMER'S MALADY.

THE upper of the two figures shows the condition of Mrs. Mortimer's face four years ago. At that time the disease had existed only one year. It subsequently increased considerably, but during the last two years has been almost stationary. Six months after the portrait was taken the bridge of the nose was involved in a large subcutaneous soft swelling, which subsequently underwent spontaneous involution and disappeared. The lobules of both ears also became involved, and presented a fleshy thickening, such as is seen in the next Plate.

The lower figure shows the back of the right upper arm of the same patient. On this part also the patches subsequently attained a larger size; but still later, some of them have disappeared. Both on the face and upper arms the patches occurred with almost exact symmetry. The patient is still living, and in fairly good health.





West, Newman

CASES OF MORTIMER'S MALADY

(Lupus Vulgaris Multiplex non-ulcerans et non-serpiginosus).

I HAVE to describe a form of skin disease which has, I believe, hitherto escaped special recognition. It may not improbably be a tuberculous affection and one of the Lupus family, but if so it differs widely from all other forms of lupus, both in its features and its course.

Of the four cases which I am about to relate, the first two are by far the most definite examples of the malady in question. The other two, as well as the two which have formed the subject of the preceding paper, are of much interest as probably presenting allied conditions, but I by no means wish to claim them as identical.

The disease is characterised by the formation of multiple, raised, dusky-red patches which have no tendency to inflame or ulcerate. They are very persistent, and extend but slowly. They occur in groups, and are usually on both sides and almost symmetrical. The multiplicity of the patches, their occurrence in groups, their bilateral symmetry, and the absence of all tendency to ulcerate or form crusts, are features which separate the malady from lupus vulgaris. To none of the other forms of lupus has the malady any resemblance.

The malady might perhaps be named *Lupus Vulgaris Multiplex non-ulcerans*, but for the present I prefer to recognise it, by the name of one of its subjects, as Mortimer's Malady.

CASE I.—The first and as yet the most marked example of the disease which has come under my observation is that of a very respectable elderly woman named Mortimer. The condition of her face and of one arm are shown in Plate CLII. The portraits from which this plate was executed were taken by Mr. Burgess in August, 1894. At that date

she was sixty-five years of age, and her skin disease had been present about a year. The latter consisted of a number of quite separate patches arranged in groups on her cheeks and on the backs of her upper arms. The arrangement was accurately symmetrical, but the patches were larger and somewhat more abundant on the left cheek and right arm than on the opposite parts. The patches were considerably raised and abruptly defined, on skin otherwise healthy. They were of dusky-red colour and rather soft structure. Although nowhere ulcerated, and quite unattended by pustules, some of them showed a slight formation of exfoliative scale-crust. (The portrait gives a much more definite impression of this than was really the case.) None showed any approach to the apple-jelly condition, nor was there any definite scarring, though some of the patches were depressed in their centres as if in process of cicatrisation. Six months after this portrait was taken the patches had increased in number and in size. The lobule of the right ear had become involved, and presented almost precisely the condition often seen in this part in cases of common lupus. Her nose, however, presented a very peculiar condition. It was much swollen across the bridge, but without any implication of the skin, presenting a thick, soft tumour. At this stage the patient, who had often attended at my Demonstrations, was presented at one of the meetings of the Dermatological Society of London. The general opinion was, I believe, that the disease was sarcoma, and it was strongly urged that portions should be removed for microscopic examination. This I subsequently suggested to my patient, and with the result that I did not see her again for two years.

The above notes present a summary of the case, but have been written out from memory recently. The two following are transcripts of records taken at the dates given.

Mrs. M——, whose por as take out three months ago, came again to-day er 9 Her eruption has somewhat advanced, ot it shows not the least tendency to ulc e p the backs of the upper arms are quit ic and have scarcel ne any nes have

appeared interspersed with the principal group. The tendency to symmetry has also been shown on the face, by the appearance of another patch in the middle of the right cheek. It is, however, much smaller than that on the left cheek. The several groups on the left cheek have advanced and coalesced so as almost to cover the whole of it, and the patches on the left eyebrow have very much increased in size and coalesced. The upper part of the external ear on the left side is involved in general thickening with some deep-seated indurations. There are, however, no tubercles or other form of eruption on its surface. The other ear is quite pale and not in the least inflamed. A soft swelling has formed over the bridge of her nose. It adheres to the skin, but implicates chiefly the subcutaneous cellular tissue. There are some little sores just within the nostrils. The characters of the tubercles are everywhere the same as before. They consist of rather firm papules, which by coalescing into patches form tubercles, some of which are quite flat-topped and others nodular. The thickest are about a quarter of an inch in thickness. They are of a dull red colour and scarcely desquamate at all. They have not the semi-transparent quality of apple-jelly. On the back of the right arm there are thirteen or fourteen separate patches, and on the back of the left nearly as many, but smaller ones. All the spots are much smoother looking and more tuberous, *i.e.*, more elevated than they appear in the drawing. A very remarkable feature in the disease, supposing it to be a form of Lupus vulgaris, is its tendency to symmetry. There is no history of tubercle in the patient's family, but her mother died of cancer.

July 3, 1895.—She reports herself in fair health, but looks thin. The patches in the middle of left cheek have now coalesced, but still remain nodular and to a certain extent distinct. Those on the sides of cheek, near to the ear, are still quite distinct. On the right cheek the middle is quite free, and so is the part in front of the ear. Nor has the ear on this side ever suffered. Many of the nodules are distinctly withering; especially that in the lobule of the left [illegible] is much smaller and paler than it was, and so also are

those in her eyebrow. No new spots have developed lately. The disease seems to have reached its height six months ago. She herself feels very certain "that it is going." The evidence is also very definite on the backs of the arms, where many of the nodules have shrivelled and left only thin scars. [In 1897 the conditions were much the same.]

CASE II.—The subject of my second case was a man aged about forty-five, apparently in good health. His eruption had been present several years, and he had of late paid but little attention to it. It did not disable him from his occupation, and he regarded it as an incurable disfigurement, but nothing more. He was willing to believe that he had many years ago had syphilis, but this was not certain, and unless the eruption was of that nature he had had no reminders. He was married, and had children who showed no signs of taint. His own eruption was not in the least benefited by specific treatment.

The eruption in this case is fairly well shown in Plate CLIII. His face was covered with patches just like those of Mrs. Mortimer, but more numerous and of smaller size. They showed no tendency to coalesce, and none whatever to ulcerate or form pustules. Many of them were disc-like, and had slightly depressed centres, but none had left definite scars. The lobules of his ears were swollen and dusky, as in lupus vulgaris, but in addition there were ill-defined patches on the helix and anti-helix. A very important feature which I think definitely connects this case with lupus has yet to be mentioned. On both his legs were very many large areas of scar, at the borders of which the skin presented the conditions seen in lupus exfoliativus. Here again there was not and never had been any obvious ulceration. There were no pus crusts, but yet it was clear that a serpiginous disorganising inflammation was present, which left a scar behind it. This condition involved the greater part of both legs, and extended somewhat upon the thigh.

Under three years of observation, with more or less of treatment, this patient's condition has changed but little. At first I gave mercury and iodides, thinking that it might be in part syphilitic, but subsequently tonics with very

small doses of mercury were relied on. The local disease on the whole improved. It will be seen that it was too extensive and of too little importance to justify severe local treatment. Various ointments were of course employed.

Whilst the man was under observation, one of his sons suffered from diplopia and pain in the head, and the diagnosis of meningeal tubercle was suggested. The symptoms, however, passed off. The boy did not present any indications of inherited syphilis.

CASE III.—*A case of Lupus Vulgaris Multiplex, with very peculiar features.*

L. M—— consulted me on July 8th for very unusual conditions. Just below and to the right side of her right nostril were two detached and quite isolated patches. The upper one of the two consisted of a streak an inch long and a quarter of an inch wide. It had an elevation of a quarter inch, was quite smooth, but not so firm nor so glossy as keloid. It had rather the brownish semi-transparent appearance of lupus apple-jelly. Near to this, on the upper lip, was a patch made up by the coalescence of two small beehive-like papules of exactly the same structure as that just described. If these patches had been all, I should have diagnosed lupus vulgaris, though fully recognising unusual features. Some spots in the palm of the left hand, however, made the diagnosis much more perplexing. Here was a little group of four smooth, brownish tubercles, each the size of a small pea and quite devoid of inflammation. They were like those on the upper lip, but smaller and tending to be pointed rather than beehive-shaped. The skin around them was pale and quite free from congestion. The patient told me that if she pressed suddenly on these spots a sensation of pins and needles was produced. My touching them, even firmly, did not elicit this sensation, but I was told that the sudden grasping of a door handle would be sure to cause it and to give "quite an electric shock."

L. M——'s own account of her spots was that those on

the face had made their appearance about three months ago, when she was recovering from a confinement, and had gradually progressed. They were, she thought, on the site of scars which had resulted from scratches received in a fall in childhood. These scars could hardly be demonstrated.

L. M—— was tall and of fair complexion. She had a feeble circulation, and had suffered much from chilblains on her feet. She had, however, never had chilblains on her ears or face. There was much gout in her family, and she herself had been liable to pains in her joints which had been considered gouty. There was not the slightest reason to suspect syphilis. She had one child—a fine, healthy boy six months old.

The patches in the palm of the hand reminded me of the nodules on the ears, &c. ("gelatinous tophi") sometimes met with in gout. I believe that it is a feature of certain forms of gouty inflammation that a sensation of pins and needles is elicited by sudden pressure.

August 10th.—It is a month since L. M——'s first visit. I have now little doubt that her spots are lupus vulgaris, but the conditions are very peculiar. I am told that a brother is in consumption, and that a sister has also spat blood. L. M—— herself, as well as her sister who comes with her, looks very delicate. They are both tall, thin, and of very transparent skin.

L. M——'s first patches were those on her face, and one of these certainly developed in an old scar. The two spots are much raised, semi-transparent, like those of Mrs. G—— and the girl B——. They are red and semi-transparent, like currant-jelly. To-day, however, L. M—— shows me others, one near one knee which she has observed only a few days. It is a flat, lupus-like patch as big as a shilling, not raised and not ulcerated. The third group is in the palm of one hand, just below the wrist. It consists of four or five nodules which join each other in two lines. They look semi-transparent. A point as regards the patches on the face is that the surrounding skin is not in the least infiltrated; the growths stand up abruptly on perfectly sound skin.

CASE IV.—*A case in which the diagnosis between Lupus Vulgaris Multiplex and Lichen Planus is in question.*

I append the notes of the following case with some hesitation, not feeling sure that it belongs to the series under consideration. By one distinguished dermatologist, who had seen the patient before I did, it had been diagnosed as Lichen planus. Reasons for dissenting from this opinion will be found in the notes, and, taking all the facts into consideration, I am inclined to think that the sequel will show that it belongs to the present group. It will be seen that the eruption had been present about eighteen months when the patient came under my observation. I transcribe the notes as taken at the time of my consultation.

Mr. H——, aged 32. He says that he has always been delicate, suffering chiefly in his bowels. Never suspected of phthisis. No known tuberculosis. In childhood he was not expected to live. He had probably a pericæcal abscess (æt. 20). He is very tall and thin.

His first spot occurred in January, 1897. It was on his right thigh behind the trochanter. He was in Australia, and suffering at the time from "catarrh of the bowels." Other spots followed within a few weeks on the same thigh, and soon afterwards some appeared on the other thigh. Next a few, only two or three, showed themselves on the front of the chest. Of these last he soon got rid, and only the very faintest scars have been left. He has none lower than the knees. He once had one on the front of right elbow, but it was cured, and has left no trace. On the right thigh is a large group of very conspicuous patches. Some of them are more or less ringed, but most of them show no subsidence in their centres. Some seem to be leaving small scars. They are elevated patches varying in size from a pea to a shilling, and irregular in form. Their close juxtaposition in groups might seem to indicate local contagion, but there is a very definite tendency to symmetry. He has had none whatever on the forearms or legs. One occurs over the sacrum.

He took arsenic at one time until it disagreed, and he was obliged to leave it off. It did no special good. He has indeed had no advantage from any treatment, but a few of the patches have disappeared, apparently spontaneously. The patches do not ulcerate or inflame. They are of a dusky plum colour, and with here and there a slight scale crust. Some are rather rough, and all are firm to the touch. In their early stages they itch much, and he scratches them, but the skin shows no evidence of injury from this, being perfectly smooth and quite pale between the spots. The case is certainly not one of psoriasis. The patches are constituted by infiltrated skin, which is raised above the

level of what surrounds it, and they are not surmounted by scale crust, nor are they in the psoriasis positions.

It is not like lichen planus in several features, although some of the individual patches might be supposed to much resemble the rough papillary form of this disease. None of the patches at any stage show the least tendency to polish. The patches are distinctly grouped, being closely set on the right thigh, but there are none whatever on the wrists or ankles. They developed rapidly, and have remained *in statu quo* for more than a year.

In some respects the case closely resembles lupus vulgaris multiplex. The grouping of the spots, their persistency, their multiplicity, and their somewhat irregular approach to symmetry might easily fit with this diagnosis. None of them, however, show any characteristic apple-jelly, nor do they spread at their edges so fast as is usual in lupus; nor are the scars which are left so deep as those usual in lupus.

The subject of the above narrative came to me again on September 20, 1898. We both of us thought that most of his patches were receding, but the change was not very marked. They were all less elevated than they had been. Many showed a central depression of pale skin or scar. Superficial slightly marked scars were certainly left where patches had disappeared. No new patches had appeared, and they were still restricted to his thighs, with a single one over the sacrum.

Comment on the Series.

I feel the less scruple in thus placing in juxtaposition cases which are possibly not identical in nature, because I hold it to be important not to attempt to constitute species in nosology. The truth is probably that the various pathogenetic influences are capable of the most various combinations, and that we have on all sides connecting-links between maladies which have gained distinctive names. We do not, for instance, know enough as to the causes of what we call lichen planus to be sure that it may not have a lupoid form when occurring in a tuberculous patient. Patient investigation and great care in the observation of phenomena are needed before we can hope to arrive at truth on these matters. I have therefore thought it well at the present time to place these cases on record, hoping that the future may furnish materials for their better elucidation.

ON ERUPTIONS WHICH OCCUR IN CONNECTION WITH GOUT.

I HAVE figured in "Illustrations of Clinical Surgery" the hands of a man in whom abruptly margined patches of a blue-black tint formed, in the first instance, on his hands. During subsequent years the eruption became general, but did not interfere with his ordinary health. He had suffered from gout, and he finally died of contracted kidney. I was inclined to consider the skin-disease as essentially connected with gout, although it undoubtedly displayed infective qualities. Reference was made to a drawing shown me in Christiania, exhibiting precisely the same condition of things on the hands of a Swedish sailor. Since then I have published several other cases bearing upon the subject, but none of them so definitely characterised. I have also endeavoured to trace a connection with another group of cases, of which Dr. Judson Bury's well-known case is a type, in which somewhat similar conditions are met with on the hands of those who inherit gout tendencies, and chiefly in early life. The blue patches now under consideration occur chiefly to adults who are themselves gouty. The conditions appear to be halfway between chronic inflammation and new growth. By some they have been claimed as sarcoma, and I have but little hesitation in identifying Hebra's portrait of "Sarcoma Melanodes" on the two hands of a brewer as being of the same nature. The disease, however, does not run the clinical course of a malignant sarcoma. It usually begins symmetrically on the two hands. It is very slow in progress, does not affect the health, nor does it tend to ulcerate or to implicate lymphatics or viscera.

I make these remarks as introductory to the narrative of

a case in which I have been fortunate enough to obtain a microscopic examination, and to some others which have recently come under my observation, more or less cognate.

Purple-tinted patch on the Skin in connection with Gout—Excision and Histological Report.

A man, aged 43, was sent to me in January, 1897, by Dr. Baber, of Brighton, with one of these patches behind his right ear. It was of irregular shape, and about as large as a small almond, slightly granular on its surface, but preserving a uniform level. It was raised about the twelfth of an inch, and had a very abrupt border. It had given him no trouble, and had been present about four months. He had none elsewhere. He was a rather stout man, of bloated aspect, and clearly a free liver. He said that his grandfather and great-grandfather, both of whom had lived freely, were reputed to have suffered much from gout, and that his father, who lived carefully, also suffered frequent attacks, though not often disabled. An aunt was at the present time crippled with rheumatic gout. Asked as to his own habits, he replied, "I have been obliged to give up beer, because it always goes to my toe. Curiously I can drink a little stout without its affecting my feet, but as soon as I try beer, which you would think was lighter, my toes become painful, and I am obliged to leave it off."

My diagnosis in this case before I knew the history was the pseudo-sarcoma of gout. The patch was in all respects exactly like those shown in the illustration to which I have referred. The tint was not the coal-black of melanotic sarcoma, but had a peculiar bluish tint. Nor did the patch tend to thicken in its middle as sarcoma does, but rather to spread at its borders, producing a flat area. The man attended at one of my Demonstrations, when special attention was asked to these features and portraits of my other cases were produced for comparison. Recognising the fact that in former cases the patches had appeared to possess some power of infection, I advised a free excision. This was done by Dr. Baber, who was good enough to send me

the portion of skin removed. This latter I forwarded at once to the Clinical Research Association, and in due course received a mounted section and Report which I append.

"The specimen consists of a portion of skin a little over half an inch in diameter, and circular in shape. It shows faint bluish-black pigmentation to the naked eye.

"On microscopic examination, the upper layers of the cutis are found to be irregularly infiltrated with collections of newly formed round and oval cells. The infiltration is found to be greatest in the papillary layer of the skin; in certain cases individual papillæ show the presence of the infiltration, while the immediately underlying cutis is nearly free. In consequence the papillæ are, as a rule, swollen and flattened, while the interpapillary processes of the epithelium show corresponding elongation. The cells composing the infiltration are round or oval in shape, and present the characters of the cells forming a new growth, rather than those of a granuloma due to the action of specific micro-organisms, or mechanical irritation.

"*Presence of Pigment.*—Scattered throughout the new cell-infiltration are seen cells considerably larger than their neighbours, and frequently presenting well-formed processes. The protoplasm of these cells is full of the characteristic dark brown granules of melanin. These pigment-containing cells are found in greatest numbers at the apices of the papillæ. In this situation these cells are not only more numerous, but larger than the similar cells scattered sparsely throughout the infiltrating cells. A few small pigment-containing cells are also seen at the periphery of infiltrated areas. The large pigment-containing cells at the apices of the papillæ do not occur in the layer of cells immediately underlying the rete malpighii, but lie several layers deeper than the basement membrane, well within the limits of the cutis vera.

"*Diagnosis.*—The specimen therefore presents the aspect of a congenitally pigmented patch of skin, and gives evidences of recent growth of new cells of connective tissue origin, some of them containing pigment, while the majority do not. In other words the specimen seems to be a pigmented mole (nævus) undergoing early sarcomatous changes."

As regards the suggestion in the last part of this report that the growth was in a congenital mole, I do not think that it can be upheld. The man knew of no mole, and assured us that the patch had been present only a few months. Nor had it, to the naked eye, any appearances suggestive of a mole. It was quite uniform in its surface and showed no disposition to ulcerate. I may add that

before the above report was sent to me, Dr. Galloway, into whose hands the specimen had in the first instance been placed, had very kindly written me an informal report, thinking that it might be of importance in the further treatment of the case, assuring me that the growth presented the characters of an infective sarcoma. We may therefore take it as established that the appearances presented to the microscope were not distinguishable from those of melanotic sarcoma. How far these appearances could be trusted in the direction of clinical diagnosis is another matter and more open to question. So far as I at present know, the man has remained during the two years which have elapsed without return.

Note on the effect of Brine Baths on the Urine—Purple-tinted spots on the backs of hands in connection with Gout.

Colonel S——, the subject of rheumatic gout, has recently, on my advice, visited Droitwich. His experience has been that whilst taking a twenty minutes brine bath every day, his urine was loaded with urates all the time. It is usually quite clear. He is a very temperate man, but inherits gout.

He has now, November 23, 1897, a very peculiar eruption of purple spots on the backs of both hands. Small discs, some polished; some confluent and rather rough.

I leave the above brief note just as it was written at the time. Nine months later Colonel S—— called on me again, this time to report the effect of mud baths which he had recently been trying. I was much interested in inquiring as to the condition of his hands. They were quite well. The spots had disappeared within a few months of my seeing him. As there had been no development of eruption elsewhere, I am not inclined to consider them as lichen planus, and having regard to their purple tint and peculiar features, am disposed to associate them with the patient's gout-history. I may add respecting the case that Colonel S——'s chief ailment consists in disorganisation by rheu-

matic gout of the right knee, with great thickening of the synovial membrane. He has been under my observation for this for more than ten years. He is in other respects in excellent health, florid, and moderately stout. His age is fifty-six. If we accept the diagnosis of gout as regards his eruption, the case proves that these purple-tinted papules are not always persistent or aggressive.

Inheritance of Gout—Liability in a young lady to a scar-leaving Eruption on backs of hands, neck, and trunk—Non-crystalline Tophi on the ears—Lymph-adenoma.

The following case is of much interest in reference to the connection of certain diseases of the skin with inheritance of gout. *Imprimis* let me say that both the mother and maternal grandmother of my patient had suffered from *bonâ fide* gout, having both of them had attacks in the great toe. Next, the patient herself, a lady of only thirty, had in both ears, exactly in the position where chalk-stones * are so often seen, little indolent irritable swellings just like tophi, excepting that they could not be proved to contain any concretions.

Miss R—— was a tall, thin lady of feeble circulation and liable to cold extremities, but who had never suffered much from chilblains. She did not consider that season or weather ever caused her eruption to be worse, and the date of her consulting me was in the summer of 1898 (August 12). In girlhood she had been considered delicate, and had always been encouraged to take beer and wine in moderation. At school, however, at the seaside, she improved and got, as she said, plump and well. Since then, that is since æt. 17, she had been thin and constantly liable to the eruption which I have to describe. At the age of fourteen a chain of glands enlarged in the right side of her neck, and it had never wholly disappeared. For three or four winters she had been taken to the Mediterranean for the winter in order to avoid the cold of England. She had never, however, been thought to be phthisical. Of one thing she

* See paper on "Tophi which are not Chalk-stones," ARCHIVES, Vol. VII., p. 146.

expressed herself as quite certain, that whenever she took steel in any form her eruption was worse. She thought that quinine also aggravated it, but about this she was less positive. If we add to this that at the age of fourteen she had an attack of typhus fever and an abscess near one knee after it, we may next proceed to describe the eruption.

Miss R——'s hands, on their backs and chiefly over the thumb, index and middle fingers, showed a pustular scar-leaving eruption. The scars were abundant but not deep, and they were quite sound. The little pustules began as minute erythematous spots, which ran a very chronic course, but finally produced a small quantity of pus in their centres. When the pus had escaped they would dry up and leave a white scar. The little and ring fingers were exempt from both spots and scars, but the others were almost covered with them. The eruption ended at the wrist, and there was none on the forearms. It was symmetrical on the two hands. Many similar pustules occurred on the neck and behind the ears, and there were some on the trunk and especially on the sides of the abdomen. Here white scars which had been left were far more numerous than the spots, but the latter were conspicuous, and in some places occurred in groups. The eruption on the trunk was not in the least restricted to the acne-positions, though some occurred on the shoulders. As regards the persistence of the eruption, I was told that it never got quite well, though it was often better and worse, and that it was not liable to sudden outbreaks. The symmetrical distribution on the hands and the exemption of two fingers suggested a nerve causation, and this was in part supported by the arrangement of the scars on the abdomen.

It may be well to speak of the lymph-adenoma complication in the above case separately, since it probably had no connection with the eruption. The right side of the neck had a long string of slightly enlarged glands, extending from the angle of the jaw to the clavicle. None of these glands were larger than small grapes, and they remained isolated the one from the other. They had been recognised

for fifteen years and had never shown any tendency to inflame or to grow. Recently, however, they had shown infective properties, and a cluster of much larger glands had developed in the armpit of the same. Their conditions were characteristically those of lymph-adenoma.

ON INFECTIVE DISEASES OF LYMPATHIC GLANDS.

(*Continued from page* 272.)

THREE CASES OF ACUTE LYMPHO-SARCOMATOUS DISEASE ENDING RAPIDLY IN DEATH.

CASE I.

CASE XXX.—*Syphilis without recognised chancre—Enlarged gland in neck—Acute Lympho-sarcoma in the second year—Death—Autopsy.*

Mr. B—— came under my care in the first instance on June 22, 1896. Part of his ailment was an enlarged and elongated gland in the right side of neck, over the carotid. It received pulsation in a most deceptive manner, and might have been suspected as an aneurism. He said that he had never in his life had syphilis, and that for some years he had never had intercourse. Before the gland enlarged his throat had been sore. In addition to this gland affection he was covered with a dusky erythematous (almost urticarious) eruption which did not itch in the least. He told me that two years ago I had prescribed for him for headaches, of which he had been almost wholly relieved.

I was much puzzled as to whether or not the eruption was syphilitic, and the state of his throat was also open to doubt. It seemed possible that he might have had a chancre of his lip. If so, however, it had healed without special treatment. At the time that the sore was present on his lip the glands in both sides of the neck were somewhat enlarged. The eruption was, however, more uniform in appearance than syphilitic rashes usually are. It may be added that he had pruritus ani, and that the skin around

the anus was white and thickened by scratching. I prescribed mercury.

On July 10 the eruption was less conspicuous, but still present. He had abrasions on his tongue, and filmy sores on tonsils. I wrote in my notes, "I think there can be no doubt that he has syphilis." There were some very hard glands in both groins, and some abrasions or mucous patches at the anus. He had balanitis, but there was no definite sore. In August, under the continued use of specifics (mercury and iodides), he was "almost well."

On Dec. 12 I wrote, "He has long been quite free from eruptions, but his tongue has relapsed, and is now covered with red patches. His tonsils still show films. There is not the slightest doubt as to syphilis."

More than a year later, on April 22, 1898, my note records, "He has continued free from symptoms with the exception of some relapses on the tongue."

On May 10 he was quite free from symptoms of syphilis, but complained that for three weeks past he had had much pain in the back. He said that this aching pain was on the increase, and that it was always present in the morning on waking.

He now looked ill, and he drew my attention to some enlarged glands in both groins. He was passing almost sleepless nights from the pain in the back, and his tongue was dry and furred. He looked so ill that I advised him to go home and keep his bed. I feared, from the symmetrical enlargement of the glands and the groin and the very severe pain in the back, that he had some malignant growth commencing in connection with the vertebræ. At my suggestion he placed himself under the care of my friend, Dr. F. M. Mackenzie, of Hans Place, near to whose house he had lodgings.

Dr. Mackenzie wrote me on May 15 that the condition of things was no better, that there was some elevation of temperature, and much pain in the lumbar and sacra regions and outer sides of thighs. He was now taking iodide of potassium and salicilate of soda.

A fortnight later, as there was no improvement, the

glands increasing in size, &c., and the patient's financial circumstances not good, I obtained his admission under the care of my son into the London Hospital. My diagnosis at this time was an acute form of lymph-adenoma. It should be noted that his mother and maternal grandmother had both died of cancer.

I did not see Mr. B—— after his admission into hospital, and I am indebted to my son for the facts which conclude my narrative.

After admission the pain in the back continued to be very severe, and there was increasing general weakness. The axillary, cervical, inguinal, and popliteal glands were all enlarged, some of them attaining the size of hen's eggs. Neither liver or spleen could be made out to be enlarged, though the former was tender on pressure. The tonsils were both enlarged, and sloughy in their centres. About June 6th a hard lump was noticed, the size of a walnut, attached to the right fifth rib in the mid-axillary line. Another firm swelling (evidently lympho-sarcomatous) subsequently formed over the second rib close to the sternum. Later on this invaded the sternum itself. Progressive weakness and loss of appetite, emaciation, sometimes delirium and coma, with almost constant elevation of temperature (100° to 101°) were the chief symptoms before death. He was given liquor arsenicalis in steadily increasing doses up to one drachm daily, with, as a rule, iodide of potassium. These drugs had a marked effect in checking the growth of the glands, which for a time actually diminished. The arsenic brought out an attack of herpes zoster, and caused some general pigmentation. The blood was very carefully examined by Dr. Bullock with quite negative results as regards the presence of micro-organisms. The white corpuscles were relatively increased, but not excessively so. The urine was always normal. The condition of the throat was a curious one; it and the tongue were always dry and the tonsils greatly swollen, though the latter diminished somewhat after some sloughs had come away from them. Death occurred on July 24th from exhaustion.

Post-mortem examination (by Dr. Schorstein):—*Heart*

and *lungs* normal. *Spleen* large and soft, weighed 9½ ozs., otherwise normal. *Liver* weighed 6½ lbs.; scattered throughout its substance were numerous round white secondary deposits. *Kidneys* also contained many secondary deposits, the largest ones measuring about an inch in diameter. *Lymphatic glands:* The abdominal, inguinal, mediastinal, axillary, and cervical glands were greatly enlarged, soft, greyish in colour, but with no caseation. In the anterior mediastinum they were matted together to form a mass at least five inches in diameter. This invaded the pericardium. The aorta was completely surrounded by growth, which everywhere had the character of lympho-sarcoma.

Although in this case, in the first instance—owing to the patient's positive statement that he had not had intercourse for two years, and the corroborative absence of traces of a primary sore—I felt some doubt as to whether his symptoms were really those of syphilis, yet in the end it quite vanished. I have little hesitation in believing that the primary sore was on his lip or in his mouth, and that the enlarged gland in the neck was due to it. Thus, then, we appear to have a case in which the adenitis of syphilis, in spite of specific treatment, passed on into lympho-sarcoma.

In the case which is to follow, the main facts are similar, but the patient did not live long enough for such extensive implication of the lymphatic system. In him the syphilis was more remote, it having appeared to be quite cured three years before the gland disease showed itself. The latter, as far as could be ascertained, began as a primary affection of the axillary glands. The patient was, at the time that this was discovered, apparently in robust health. I by no means wish to suggest that in either case the preceding syphilis was an important factor. It is, however, well known that in the secondary stage of syphilis the lymphatic glands are often somewhat enlarged for a time, and my supposition is that lymph-adenomatous processes usually originate in glands which have at some former period been inflamed.

Case II.

Case XXXI.—*Primary enlargement of Glands in both Armpits in a healthy man who had had Syphilis—Rapid progress, with acute local inflammation and high temperatures—Death—Autopsy.*

C—— R——'s case was in its early stage of interest as apparently an example of inflammatory enlargement of axillary glands without obvious exciting cause. I had treated him some years before for syphilis, but he had since enjoyed robust health, and there did not seem any ground for the supposition that syphilis had anything to do with his gland disease. He was a big, strong man, and considered himself in excellent health at the time that the gland enlargement began. He had been dancing in a dress-coat which was rather tight, and on undressing to go to bed found that there was a lump in his left armpit. There was no material pain, and he had at the time no sore on his hand or elsewhere. This was about three months before I saw him, and during the greater part of the interval he had, under the advice of his family surgeon, Dr. A. T——, of B——, who knew of his syphilis, been taking iodides and mercury. So far from these remedies having reduced the glands, the latter had steadily gained in size, and one had also appeared in the other armpit.

When C—— R—— was brought to me by his surgeon on March 3, 1898, he had in the left armpit a mass of adherent glands which filled it, but of which the separate glands, though matted together, could be identified. There was no evidence of suppuration, and no redness of the skin. His chief discomfort was caused by the desire to rest the elbow on something at a distance from the side so as to avoid pressure. At a hand's-breadth below the armpit there was an area of inflamed subcutaneous tissue and reddened skin where suppuration seemed threatened. This had been present only two or three weeks. In the other armpit there was a single enlarged gland as big as a walnut, and quite movable. There were no enlarged glands on the neck or

elsewhere, and I sought in vain for any source of irritation on his trunk and limbs.

There was no definite history of tuberculosis or of malignant growths in the family. At the time of this consultation I expressed a fear that the disease might prove acute lymph-adenoma, or possibly sarcoma. Large doses of arsenic were prescribed, and at the same time it was agreed to continue the mercury. I could find no reason to connect the disease with the previous syphilis. The inflammation of the cellular tissue on the side of the chest was such that I confidently expected that an abscess would form. As there was already gland disease in the other armpit, I did not think it a suitable case for excision. We agreed, at any rate, to defer the decision on this point.

A fortnight after this consultation, which took place at my house, I was asked to visit C—— R—— at his home in the country, and to come prepared to excise the tumours if it seemed advisable. I was told that the advance had been rapid, and that the general health was rapidly failing. I found C—— R—— in bed, and looking ill. He had lost flesh, and his complexion was slightly yellow. The arsenic, &c., had been laid aside, as it appeared to cause nausea. The temperatures had during the past week usually ranged at 102° in the evening. The gland mass in the left armpit had increased in size. That in the right armpit was much as it had been, and was still quite loose, but in the root of the neck above, where none had been discoverable on the previous occasion, several could now be felt. The inflamed patch on the left side of chest, which had seemed to threaten suppuration, had, under the application of an evaporating lotion, lost much of its congestion and œdema, and now presented a fine cake-like mass as large as the palm of an adult hand. It now seemed clear that the disease was of a sarcomatous character, and that no operative treatment could be advised. From the manner in which C—— R—— during conversation seemed to lose his breath, I could not help suspecting that some impediment to respiration existed in the chest. We could not, however, on auscultation, find any evidence of this, and C—— R—— himself assured me that

he was not conscious of any difficulty in breathing. He drew a deep breath, and assured me that he felt all right. Although his pulse was quick, and temperature somewhat high, he was in good spirits, and we had difficulty in persuading him that he ought to keep his bed. He insisted that he did not ail much, and thought that we were exaggerating.

I felt bound to say to his friends that I thought the disease beyond the reach of treatment, and that the patient would not live many months. This led to their subsequently desiring to have the advice of a younger and more energetic surgeon. About ten days after my visit C—— R—— was, under the advice of a very able man, brought up to London in order to have a serum-injection treatment tried. His temperatures continued high, usually ranging about 103°, and he sank a few days after his journey to town. Through the courtesy of the surgeon concerned, I have been informed that a post-mortem was made, and that no deposits were found in the internal organs. The left axilla and pectoral region were at the time of death occupied by a large, brawny swelling, hard in places and soft in others. The adjacent muscles were infiltrated. There were also enlarged glands in the other armpit. Microscopic examination pronounced the tumour to be a round-celled sarcoma.

A very noteworthy feature in the above case was the presence of the ordinary phenomena of local inflammation. The swelling on the side of the chest below the armpit which rapidly followed the enlargement of glands was probably over lymphatic trunks. It was attended by acute œdema, vivid redness, and all the indications of impending suppuration. After a week or two, however, these conditions passed away, and only a solid cake-like induration remained. In the case which I have next to relate an abscess, attended by suppuration which required an incision for its relief, preceded the formation of sarcomatous growths.

All cases illustrating the connection between inflammatory processes and those of maligant new growth are of great value. They tend to destroy the artificial distinctions which theoretic pathologists have sought to establish

between the two. The following are the notes which I took on June 1, 1898, the date of the only occasion on which I saw the patient.

Case III.

Case XXXII.—*Milk Abscess—Rapid development of Sarcomatous Growths in both Breasts, both Tonsils, and the Lymphatics of Armpits and Neck.*

Mrs. M—— is only 27 years of age. She is the mother of three, and was in her normal health at the time of her last confinement, on November 23, 1897. She tried for a fortnight to nurse her baby, and had a very large supply of milk. An abscess formed in the right breast, and her doctor made her give up nursing. She used the breast pump, and had great difficulty in getting rid of her milk. Three weeks after her confinement her surgeon opened the abscess and let out a moderate quantity of matter. The incision had healed in the course of a week, the drainage tube having been removed. Very soon after this she noticed a movable lump in the right breast.

Such was the history which Mrs. M—— and her sister detailed to me on June 1, 1898. It will be seen that little more than six months had elapsed since her confinement. During that interval an enormous sarcomatous growth had developed in the right breast, gland-masses had formed in both armpits and in both sides of the neck, and both tonsils had been excised for growths of a lympho-sarcomatous nature. Although this rapid formation of malignant growths might have been supposed, in one so young, to imply a strong hereditary tendency, yet the only fact which I could obtain in that direction was that the late Dr. Braxton Hicks had many years ago operated on her mother for an abdominal tumour. It was supposed to have been "hydatid," and her mother had recovered and was still living.

The bilateral development of the growths—both breasts and both tonsils—seemed to indicate conclusively that blood infection had occurred. It was not likely that [illegible]

had spread through lymphatics. In all probability the law of elective proclivity of similar organs had come into play, and cell elements, shed into the blood by the breast in which the abscess had occurred, had contaminated first the other breast and then the tonsils. That these separate foci of growth had all developed independently seems incredible. Having suggested this view as explanatory of the facts, I will now proceed to describe the latter in more detail.

The left breast (the one in which the abscess had occurred) was at the time of her visit to me of small size, and painless. As the patient had lost all her fat the gland itself was easily felt, and there could be no doubt that its lower half was peculiarly hardened. It had, however, shown no tendency to grow, and had it not been that a large gland-mass was present in the axilla, doubts might have been felt as to whether the induration was really malignant. It was quite quiet. The other breast was as big as a child's head, very heavy, pendulous, and quite loose from the chest wall. It was inflamed and reddened, and presented several separate places which looked exactly like acute abscesses just about to break. Doubts had indeed been expressed as to whether it were an instance of suppuration or of growth, and my own opinion at first sight was that a case of milk abscesses had been previously neglected. On finding, however, that there was no real fluctuation anywhere, and that there was a mass of hard glands in the armpit, I soon felt sure that it was an inflamed sarcomatous growth. Numerous large veins coursed over the margins of the mass, more especially towards the clavicle, and in the root of the neck there were many hard and large glands. The patient had much difficulty in speaking, and I was told that within the last month both her tonsils had been cut out by a specialist surgeon who had declined to have anything to do with her breast. I found the tonsils exactly alike, very large, so that they almost met across the throat, and presenting each a huge excavated ulcer covered with greyish secretion. These ulcers probably occupied the line of the incision which had passed through the growth. The tonsils could be easily felt externally, and on the left side there was a mass of enlarged

glands close to it. The glands in the right neck were low down, and had probably been infected from those in the armpit, but those in left were from the tonsil. All the enlarged glands in the four different positions in which they were found presented similar features. They were firm, but not of stony hardness, and showed but little tendency to adhere to each other or to the surrounding structures.

The case was obviously beyond the reach of treatment, and it did not appear likely that the patient would survive many weeks.

Death took place about ten days after her visit to me. Unfortunately there was no autopsy.

As regards the withering up of what I cannot but regard as the primary growth which was attended by abscess in the left breast, it may be remarked that shrinking of one tumour is not unfrequently observed when others are rapidly growing. This I have repeatedly seen when tumours in the lumbar glands have followed primary sarcoma of the testis. Under such circumstances the testis may shrink until the patient may forget that it was ever enlarged, and consult his surgeon for the abdominal tumour only.

It is of interest to note that in Case I., as in this, both tonsils were infected.

NOTES ON SYMPTOMS.

(*Continued from page* 260.)

The interpretation of subjective symptoms is often a matter of great difficulty and makes large demands on our patience. It must, however, be attempted if we wish to fill up the details of our clinical pictures.

Mr. R—— is liable to attacks which he calls "bilious," which leave him with deep transverse furrows across his nails. There is, therefore, no question as to their physical severity. The problem is, what is their real nature?

It is now about six weeks since his last, and the furrow which was the result has travelled forward on all his finger nails until it is only a quarter of an inch from their free edges. It is a very conspicuous one, single, accurately transverse, and the nail which has grown behind it is quite sound. It is the fifth or sixth time that he has experienced the attacks which leave this condition. I asked him to describe carefully the nature of the "attacks." This he *did* as well as he could. He said that his finger tips became numb and tingly, as if frostbitten, but were neither blue nor pale. They usually felt hot rather than cold. The condition would vary much during the day, coming and going, and was, when at its worst, attended by a great sense of muscular weakness so that he could not use his arms nor walk. Always there was great weakness if he made exertion. Thus on one occasion during his last attack he had tried to take a walk, thinking it might do him good, but after half a mile had been obliged to ask for a friend's arm. On another occasion a man on each side had been necessary. The feeling was that of stiffness in the muscles and inability to use them. Sometimes this loss of power and numbness had

come on him when playing at cards, and he had become unable to take up a card without assisting one hand with the other. The fingers became, he assured me, stiff as well as numb. He never experienced the sensation of "pins and needles" further than a slight tingling.

It is a defect in this narrative that no trained observer has ever noted the state of the pulse and the appearance of the digits during an attack. The explanation which would best fit the description is that of spasmodic arterial ischæmia. But then we have the patient's allegation that his fingers are neither blue nor pale. It is, however, scarcely possible to imagine any other condition capable of producing such definite arrest in the growth of the nails. It is to be observed that the condition must be one of considerable duration, the attacks usually lasting a whole day. The larger arteries must also be implicated, since the limb-muscles become weak. All the larger limb-vessels must also be simultaneously affected. Nothing in the least approaching the gangrene of Raynaud's malady has ever been observed, nor, as has been stated, are there any obvious indications of asphyxia.

No. XL.—*The liability to Cramp after sleep.*

ERRATUM.

By a printer's error, Case XL. (*Liability to Cramp after Sleep*) has been printed here in duplicate, having appeared previously as Case XXIX. on p. 132.

[illegible] it by the pain caused. Those liable to cramp in the calf must be very careful as to movements of their legs just after waking. When once the sleep state has passed off and the muscles are, so to speak, thoroughly awake, there is comparatively little risk of its coming on.

I was explaining the above to a patient who had suffered much from cramp, when he replied: "Yes, I have found that out for myself, and I am so determined to avoid bending

my legs soon after waking, that I always take care that the bed clothes are not tucked in, so that I can slide out of bed feet first to keep them straight."

No. XLI.—*Bug-bites mistaken for Syphilis.*

Patient. I had syphilis eight years ago, and I want to know if I may marry.

Consultant. How long have you been free from symptoms?

P. I still have some symptoms.

C. How were you treated?

P. I had two years' continuous treatment, and have been taking medicines on and off ever since.

C. Just tell me what you remember of your first symptoms. What did you have?

P. Oh, I was covered with blotches, and the doctor said it was syphilis.

C. That is enough; but had you not a sore on the penis —a chancre?

P. I do not remember having had any. It was only an eruption, but my penis is often a little sore, so it may have been.

C. You say that you had two years' continuous treatment?

P. Yes, I took mercury regularly for two years.

C. Were you quite free from symptoms when you left it off?

P. To tell the truth, I have never been long free from the eruption. It comes and goes, and I have some now.

C. Show me what you have.

He exhibits a group of florid dusky blotches, arranged irregularly (constellation-wise) on the side of his abdomen. In the centre of each is a minute puncture.

C. Why, those are nothing but bug-bites.

P. You don't say so! I am living at a very clean house, but I admit I have caught a bug occasionally.

At this stage I make him undress, and find him covered on limbs and trunk with blotches and papules and stains, in various stages, all clearly of the same nature. There are many on his legs and ankles, and some of these have

been scratched and made sore. The whole might easily have been mistaken for a syphilitic eruption, but in the middle of all the more recent spots a little puncture is visible.

C. Tell me, now, how does your eruption come out?

P. Oh, I find a new set of spots, now here, now there, when I get up in the mornings. They are red bumps, or sometimes little blisters, and they burn and itch.

C. How long does the burning last?

P. Two or three days, and then it goes away, but the spots persist for weeks and leave stains.

C. And is this eruption all that you have had? Have you really never had a chancre?

P. No. I have never had anything but what you have seen.

C. And you have been taking mercury for two years?

P. Yes, on and off; not quite regularly.

C. It has done your health good?

P. Yes, I think so, but it has never got rid of the eruption for long together.

No. XLII.—*Loss of ability to walk—Threatened Paraplegia, supposed to be syphilitic, but more probably sexual.*

In the case of Mr. B——, the symptom which had caused alarm had been temporary inability to walk. He was a man of 52, of heavy frame, who had suffered from syphilis (a mild and perhaps doubtful attack) just twenty years before he came to me. Eight years after the syphilis he had had inflammation of one eye, which was then attributed to it, and for which he had specific treatment. This attack had resulted in detachment of retina, sparkling synchesis, and loss of perception of light. The other eye had remained perfect, and with this exception nothing had occurred to him to remind him of the old taint. Five years before I saw him he had (at the age of 47) married. His wife was near his own age. Previous to marriage he

had been excessively indulgent with women, but since then much more moderate. He had always been a heavy smoker, and free in the use of stimulants.

The failure of power to walk had occurred on several different occasions recently. His wife had noticed that in sitting he would lean forwards, and that he always seemed to rise with difficulty. He had also complained of sense of weakness across his hips. One day (three months ago) after a drive he sat down in a chair at his club, and on attempting, after a short rest, to rise found that he could not walk. As he described it, he could move his legs freely, and could stand up if he remained still, but felt that he should certainly fall if he attempted to step forwards. He had at the same time a dull sense of weakness across his sacrum, but no sharp pain. On the occasion referred to he sat down again, moved his legs about, and after a while regained power sufficient, with assistance, to walk to a cab and to get home. For some days afterwards he walked badly; but gradually he recovered, until, a few weeks before I saw him, another very similar attack occurred. From *this* also he was recovering when he was brought to me. He still, however, walked slowly and awkwardly, and had some difficulty in rising from his chair and starting. I may here remind the reader that he was a big, strong-looking man, though pale. He had not had any bladder symptoms, and his knee reflexes were good—possibly a little excessive for his age.

On inquiry I learnt that he had had, some ten or fifteen years ago, an attack not wholly dissimilar from his recent ones, and had found himself unable for a time to use his lower limbs. He very readily accepted my suggestion that he had been very excessive in sexual intercourse, but denied that this had occurred of late. He had never had any severe pain in his back, but a disagreeable aching and sense of weakness.

Mr. B—— had been brought to me in the suspicion that his attacks, which seemed to threaten motor paraplegia, were in connection with his old syphilis. I did not incline to support this view. He had no other syphilitic lesions.

The attacks had been transitory and wholly without sensory complication. I was inclined rather to attribute them to sexual causes and loss of tone in the spinal cord. In minor degree, many persons after sexual exertion experience an aching weakness across the hips, with some sense of insecurity in walking. What had happened to Mr. B—— seemed only an exaggeration of such feelings. The transitory nature of the muscular failure seemed to favour the view that it depended upon loss of tone, and not on structural change. As regards sexual excesses, these were fully confessed to at former periods of life, and although denied of late they might still have been too much for the spinal cord of a man past middle life and which had previously suffered. As regards treatment, I had much confidence in advising that iodides should be avoided and tonics given. He was at the same time enjoined to give his spine rest.

No. XLIII.—*Pain in the tread of the foot incapacitating for walking—Arterial Occlusion probable.*

The symptom of which Mr. K—— complained was pain under the tread of his left foot, aggravated by walking. It had persisted for some months and had almost disabled him from his occupation. He was employed as an inspector in the Health Department of the City of London, and was, he said, often quite unable to walk or even to stand. The pain disappeared almost wholly in the recumbent posture. Several consultations had been had before I saw him, and neurotomy had been strongly advised.

At first Mr. K—— was inclined to locate his pain in one spot between the base of the great toe and the next, but on careful examination it appeared that there was no single tender spot, and that the aching extended across the whole foot at the level of metatarso-phalangeal joints. It involved also the toes themselves, to some extent. When both feet were uncovered and placed side by side, it was obvious that the toes of the affected foot were more dusky and redder than those of the other. This the patient had noticed, and he also said that they were colder. He had

varicose veins on both sides, but they were larger on the affected one. When he was in the recumbent position the difference in the dusky congestion of the affected foot was obvious. We now found that whilst the anterior and posterior tibials could be found very easily in the sound limb, they could not on the affected one. The femorals beat with equal force on the two sides. There was no very definite history of any sudden attack of arterial occlusion, but Mr. K—— remembered, when asked, that he had suffered from pain in his calf. There could be little doubt that the disabling pain complained of was arterial and not nervous in origin.

The patient was a man of about 46.

No. XLIV.—*Arcus Senilis as a Symptom.*

The premature formation of the arcus senilis does not appear, any more than the premature blanching of the hair, to be indicative of premature senility. "Grey early grey long" is a proverb which amounts at least to a negative assertion of this fact as the result of popular observation. I have just seen a gentleman, aged 64, in whom the arcus was in both eyes very conspicuous. He was in good health, and was not liable to headaches or other ailments. He told me that a surgeon had remarked upon his eyes when he was little more than thirty years of age. It was a family matter.

I have known two families in which several of the males acquired the arcus very early in life. Yet those who did so enjoyed good health and lived to fair ages.

No. XLV.—*On Cold Feet.*

Digestion always increases the liability, and attacks may come on during a meal or soon afterwards. If a meal causes cold feet, headache will usually follow. In many patients any little mental worry or excitement brings on an attack. Patients liable to frequently recurring coldness of the feet and hands sometimes say that nausea or even vomiting may be caused if the feet become very cold. I

think that the feet have more influence in this respect over the stomach than have the hands. The mere fact of the feet being cold (say from tight boots) will often cause headache. On the other hand, severe headaches, however caused, are usually attended by cold feet.

No. XLVI.—*Description of a Fall in Fainting.*

A man fell in a faint whilst standing in my room. He fell backwards softly on to his buttocks and then on to his back, and lastly his head went back. He did not strike his occiput at all hard. He looked lividly pale, but by no means absolutely blanched. Consciousness was entirely lost for only a minute or so.

No. XLVII.—*Extreme feebleness of the Radial pulse.*

Extreme feebleness of pulsation at the wrist, which in minor degress we often encounter in patients who are yet in tolerable health, was illustrated in the case of Miss M——. On two occasions, with an interval of several weeks, I was quite unable at first to detect any pulsation at all.

I examined the wrists very carefully in order to discover whether there were any abnormal distribution, but could not find any. Her hands were rather thin, and a very diminutive superficialis volæ could sometimes be detected. Even when this were felt I could not perceive the pulsation of the radial, which was of course more deeply placed. At length, by carefully flexing the wrist and placing the hand at rest on the table, I succeeded in feeling a very soft and feeble pulsation in both radials, better in the left than in the right.

This extreme feebleness of the peripheral circulation occurred in a young lady who was much out of tone, and consequently complained of cold extremities. On the second occasion of my examination of her, however, she had very much regained her health, and the hands were quite warm.

If any one should feel surprised that so small a vessel as

the superficialis volæ could be felt when the radial could not, it may be well to remind him that just after it is given off this little vessel becomes, as its name implies, very superficial. In elderly persons with enlarged arteries, its pulsations may easily be counted by the eye, whilst those of the radial itself are quite hidden.

CANCER AND THE CANCEROUS PROCESS.

Serpiginous Ulceration of the Palate in an Elderly Man—Cancer or Tuberculosis—Microscopic evidence of Epithelial Cancer—Repeated cauterisations and favourable progress during seven years.

Mr. P—— is a thin, rather delicate looking man. The following notes describe the condition in 1889, at which time he was 58 years of age.

"He has a patch over the right side of soft palate, extending from foot of uvula to pillar of fauces, and forwards to border of hard palate. It presents a level granulating surface and a slightly jagged edge with red margin—much like lupus. The border of the velum is notched by ulceration, but the peculiarities are that there is no deep ulceration nor any great thickening. It has a firm evenly thickened base.

"The question is between scrofula and cancer, The sore is perfectly clean, and looks more like lupus than cancer. I fear, however, that some glands in the neck are enlarged, and the age of the patient and the short duration points towards malignant disease.

"He thinks that it has not been there more than six weeks. He discovered it by accident when he had some tickling in his throat. He first showed it to Dr. England two weeks ago. Three years ago Dr. E. cut his uvula. There is no family history of cancer."

The above are the notes which I wrote at the date of my first consultation. On a second occasion, after a month's treatment with iodides and mercury, which had done no good, I excised some portions for microscopic examination, and the verdict was "epithelial cancer." Feeling, however, still some doubt, and not liking hastily to undertake an excision which would have to be very extensive, I advised him to allow me to use the actual cautery. On two occasions under chloroform I used Pacquelin's cautery as

freely as possible to the whole diseased surface. The result was a complete healing. The two cauterisations were done in February, 1890, with an interval of three weeks.

In August, 1893, Dr. England wrote to me that the parts had remained quite sound until May, 1892, when Mr. P—— contracted a sore throat, following on which was a return of the ulceration at one spot on the border of the scar. Dr. England again used the actual cautery, and with the result that the resulting scar remained well until the spring of 1893, when there was another recurrence, with tendency to spread on the left anterior pillar of the fauces. The cautery was used for the fourth time, and the sore again healed. At the date of Dr. England's letter, however, Mr. P—— was ill in bed with symptoms of disease in the stomach (sub-acute gastritis).

In September, 1896, Dr. England was again good enough, at my request, to report on our patient's condition. He wrote to me as follows:—

"I have looked up Mr. P——. He is a very busy man, and hard to find at home. He tells me that he has been very well for the most part, but he looks thinner. We must remember, however, that he is five years older that when you first saw him. He is now sixty-three. He suffers occasionally in winter from the cold and damp, when his throat becomes dry and painful, and he is hoarse. His disease, you will remember, was on his hard palate, extending on the right side to pillar of fauces, soft palate, and uvula. There is now a dark red patch, almost round, about a quarter of an inch in diameter, on right side of hard palate, about half an inch in front of velum. It feels to me to be quite smooth, and like a cicatrix, but he says it spreads occasionally when he is not very well, and feels to his tongue as though it were about the thickness of writing-paper above the surrounding mucous membrane."

In spite of the positive evidence given by the microscope, I am obliged to doubt whether the disease in this instance is really cancerous. My diagnosis in the first instance inclined rather to lupus than to cancer, and the progress of the case during nine years seems to favour that opinion. The use of the actual cautery on the soft palate is not very easy, and although I did it resolutely I could scarcely hope that it

would be efficient for the cure of epithelial cancer. The diagnosis must remain in some doubt. Meanwhile, however, whether tubercular or not, we may regard the success obtained by cauterisation with satisfaction. There has never been any aggressive gland disease, although in the first instance we thought that some enlargement could be detected.

TWO EXAMPLES OF SARCOMATOUS GROWTHS IN CONNECTION WITH THE VASTI MUSCLES.

CASE I.—*Sarcomatous growth in connection with the Vastus externus—Excision—Early recurrence and death.*

Mr. P——, aged 60, a saddler from Cawood, Yorkshire, consulted me in December, 1892. He was a thin, grey man, and was the subject of a large, smooth tumour in the outer part of the right thigh, which had been present for a year. It did not adhere to the bone, but appeared to be developed in the vastus externus. I advised excision, but did not urge the operation.

I subsequently learnt that he had the growth excised a week after I saw him, and that it very quickly recurred and grew to an enormous size, causing death six months later.

I am indebted to Dr. Hamilton, of Cawood, for this information.

CASE II.—*Sarcomatous growth in Vastus internus—Expansile pulsation in the later stage.*

I mention the above case at the present time because I have recently seen another somewhat similar one. In this also the patient is a man past middle age. The tumour was in the first instance clearly in the muscle, and could be moved with it. The diagnosis seemed to rest between gumma and sarcoma. Iodide of potassium was liberally tried, without any good result. The tumour has grown and become more fixed, and has also acquired a slight but definitely expansive pulsation.

Primary Melanotic Sarcoma of Skin.

I excised a little nodule of melanosis from the cheek of a girl of 17, on April 13, 1898. It had been growing for about five months, and had appeared in perfectly sound skin as a little, pin-head, black spot. It had increased rather rapidly, and was as big as a pea. Its section was homogeneous, and coal black, and measured a quarter of an inch across. It was well circumscribed, and there were no other nodules near it. No history of cancer in the family, but much gout.

Slow-growing Sarcoma of Glands.

The portrait here given is that of a woman now aged 50, for whom, sixteen years ago, I excised a fungating tumour on

the skin of the thigh, which had been of slow growth. The diagnosis by the microscope was that it was a spindle-celled

sarcoma, and we constantly anticipated that it would recur. A large elliptical portion of skin was taken. The scar has since remained quite sound, and the patient has enjoyed on the whole good health. At the time that I did the operation there were some enlarged glands in the right side of her neck. They were of inconsiderable size, and showed no tendency to inflame. No special treatment was, I believe, adopted. I did not see my patient again for many years. Recently, however, she has again consulted me, and has allowed me to have the photograph taken from which the woodcut has been executed. The gland mass has been slowly increasing in size during the whole intervening period, but without causing any material inconvenience. It now presents a smooth, rounded exterior without any indication of separate glands. And as there has been no infection of the other side or of the axillary glands, it may be assumed that it has grown either from a single gland or from a very small number. An interesting fact in its present condition is that it has lifted the large vessels upon its surface, and that the pulsations of the carotid artery are now easily visible immediately beneath the skin. A shallow furrow in which the vessel rests may indeed be traced in the photograph. At no time has there been any evidence of obstruction either of vein or artery.

Note on the position taken by the Carotid Artery in different tumours of the Neck—Sarcomatous growth in Glands.

The position finally assumed by the carotid artery when displaced by tumours in the neck is often of much help in diagnosis. If a lobe of the thyroid gland has caused the displacement, the artery will have been carried to the back of the neck, and may be found behind the posterior edge of the sterno-cleido muscle. If, on the other hand, the displacing growth has begun in the cervical glands, the artery will, if not embedded, probably be lifted forwards, and have become superficial in front. I had recourse to this condition as an aid to diagnosis in the case of a lady whom I saw with Mr. Butler at Guildford. In this instance the patient was

seventy-two years of age, and a swelling had been first observed in the right side of her neck towards the end of March, 1897. It was at first thought to be a thyroid tumour; by the end of May it had grown to the size of a Tangerine orange, but was quite painless. Iodide of potassium ointment was used, and it was thought that the tumour much diminished by its employment. Subsequently the growth extended from the jaw to the clavicle, pushed the larynx over, and so much impeded respiration that the patient was obliged to sleep in her chair. It was in this condition that I saw her, and the position of the carotid artery made me feel confident that the tumour had not grown from the thyroid.

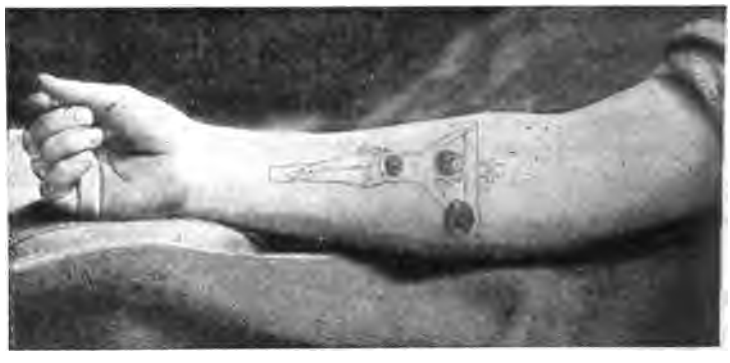
Death occurred a few weeks later. The autopsy showed a sarcoma which had infiltrated the muscles, but did not involve the thyroid gland. In this instance the veins over the growth were much distended in consequence of obstruction.

SYPHILIS A FORM OF YAWS.

Chancres assuming the type of Frambœsia.

One of the chief arguments urged by those who have hitherto held that Yaws and Syphilis are distinct diseases is that the primary sores and the secondary eruption of the former are peculiar. Their peculiarity consists in their presenting the Frambœsial type, that is, in being attended by the production of a granulation-mass, in form and general appearance resembling a fruit, such as a raspberry. In reply to this I have urged over and over again that in England the eruption of syphilis not unfrequently takes this form, and have adduced the fact that cases described in Scotland as "Frambœsia" and in Dublin as "Morula" were without any reasonable doubt nothing but syphilis. Remarkable and very definite examples of the Frambœsial type of syphilis have been cited, not only from my own practice, but from that of Professor Petrini, in each instance published with a portrait (see ARCHIVES, Vol. IX., p. 199). By a remarkable coincidence I am enabled this week to offer an illustration of the Frambœsial type of the primary sore. The other cases all illustrated the secondary eruption. The appended woodcut has been executed from a photograph sent to me a fortnight ago by Dr. Crossley Wright, of Halifax. It exhibits three Frambœsial chancres on the arm of a young man who had been tatooed by a man who was no doubt the subject of syphilis. Nothing has been ascertained as to the operator's condition, but there is no doubt that the sores here shown were true chancres, for they have been followed by a specific ısh. There were enlarged glands above the elbow and in the mpits. It is believed that another youth who was tattoed ; the same time has suffered in a similar manner, having no wer than six chancres. I feel sure that the formation of

frambœsial granulation-masses in connection with primary sores is not very uncommon in English practice where the chancre is erratic. The typical induration is seen for the most part on the penis only. We sometimes encounter it on other parts, as the finger, the lip, but on these latter parts the appearances presented by the chancres may vary within very wide limits. From this proneness to vary, very numerous errors in diagnosis result. The portraits of



vaccination-chancres, which I published many years ago, well exemplified this variety in local conditions in different persons from the same virus. In one at least the whole sore was covered and concealed by a granulation mass. It is time that these facts were fully and freely admitted, and when they are so there will remain but little upon which to base any argument against the identity of yaws with syphilis.

The Absence of Sore Throat in Yaws.

The asserted fact that the subjects of yaws seldom or never show any sores in the tonsils has been strongly urged as implying that yaws is distinct from syphilis. In the first place it may be doubted whether the rarity is so great as is alleged, and next it is an unquestionable fact that the English climate renders the throat much more liable to suffer than does that of the tropics. There may also—but on this point I have no information—be a di[redacted]ness

to tonsil affections in different races. As regards difference in climate, I have obtained many items of evidence. A lady, the wife of an Indian officer, described to me a severe attack of "blood poisoning" which she had passed through some years ago in India. Wishing to know whether she had syphilis, I asked as to eruption. "Oh, yes, I was covered with sores." "Had you a sore throat?" "I do not remember one, but then you know we never have sore throats in India. Before I went there I suffered much from them, and I have done so again since I returned, but during my ten years in India I never remember a sore throat."

Syphilis a form of Yaws.

In my last number I ventured to express, without any reserve whatever, my belief that in yaws we have the parent-form of syphilis. This amounts to saying that syphilis, as we know it in Europe, is tropical yaws modified by race and climate. If we accept the proposition that yaws has been long indigenous amongst native inhabitants of South America, it becomes not at all improbable that it was really imported into Europe in the sixteenth century. Three centuries of prevalence in European populations may easily have sufficed to give the disease such minor peculiarities as now seem to distinguish syphilis from yaws. Nor indeed is it by any means improbable that some of these supposed peculiarities may be due solely to difference in race. No good narratives of the course and symptoms of yaws when occurring to Europeans have as yet been recorded. It is much to be hoped that those who have opportunities will carefully avail themselves of them, and record their observations in full detail.

The hypothesis which I have suggested would well explain the occasional occurrence of frambœsial syphilis in Europe which has been recorded, not only in isolated instances such as those recently published by Petrini, of Galatz, and myself (ARCHIVES, Vol. VII., p. 357), but in minor epidemics such as those of sibbens, button scurvy, and morula. These are but instances of syphilis reverting to its original type.

A MYXŒDEMA NARRATIVE.

I HAVE just had a long conversation with an intelligent lady who has been for six years the subject of myxœdema. The disease was, she tells me, first recognised by Sir John Williams in 1892. There are, however, some facts as to her former history which it is of interest to record. She has through life had a dry skin. Not even dancing would ever cause the slightest tendency to perspiration. She has always been a chilly subject, loving the fire and the summer weather. She was always liable to have her lips easily become blue. Although a good walker, she could seldom get her feet warm even by walking, and her experience of a Turkish bath on several occasions was that it made her head hot and very uncomfortable, whilst the feet remained cold. On one occasion the bath made her faint, and after that she never tried them again.

Her own description of her myxœdemic symptoms is that she became yellow or creamy looking with habitually bluish lips. Next her features changed, and she got bags under the eyes and thick lips. She was unable to exert herself, and spoke thickly and slowly. It is possible that the thyroid extract was at first given in too large doses, for she says it made her very weak and caused her to lose all her hair. At the same time her features improved, and she felt lighter and better. After she had been for a time almost bald, her hair grew again almost as thick as ever.

A year or two later she had the symptoms of psoriasis on her knees and backs of forearms, but only small patches. For this she consulted a specialist who prescribed arsenic, and almost delined to recognise that arsenic, she thinks, did her health some harm as the psoriasis

As regards the use of the thyroid extract, although Miss S—— admits that it has done her good, and although she still has recourse to it occasionally if she has any tendency to relapse, she is not enthusiastic. She says that it often makes her feel weak and feverish, and, as she thinks, makes the psoriasis worse. It never produces the least moisture on the skin. She has of late suffered much from pain at the pit of the stomach.

Miss S—— is at present at the age of fifty-two, and seven or eight years since the myxœdema commenced; a comely lady, but with somewhat full and expressionless features. Her complexion is, as she says, "creamy" with patches of congestion on the cheeks. She says that she can walk well and long distances, and she enjoys her life. Her pulse is extremely soft and feeble, and she still, as she has done through life, suffers much from constipation.

I have thought the above narrative worth writing out because it carries the history of the case over a considerable period, and also because it records facts which may possibly prove useful as helping us to a full conception of the malady. The habitual constipation, the very feeble circulation, and the inability to perspire, with finally the addition of common psoriasis, are features which may have their bearing. Although myxœdema has been definitely associated with thyroid atrophy, it would be unwise to assume that in that fact its whole pathogeny is included. We must also keep our eyes open to discover, if we can, the meaning of the complications which may be associated with it. As regards treatment, although Miss S—— does not speak quite so gratefully of it as might have been expected, yet in spite of its drawbacks I have no doubt that it has been the means of restoring and preserving her health.

RHEUMATISM AND GOUT.

No. LXVII.—*Anchylosis of the Wrist.*

Mr. S.—— has his left wrist anchylosed, the hand in a dropped position. In this forearm he retains good pronation, &c. In the opposite limb, however, he has lost pronation, and the limb is almost fixed at right angles, the amount of flexion and extension being very limited.

These conditions are attributed to a three months' attack of gonorrhœal rheumatism. He was three months in bed, the elbow and wrist were the only joints affected. He had got wet through whilst suffering from gonorrhœa.

He has had gonorrhœa several times (five or six) since the one which caused the rheumatism, and no rheumatism has complicated them. An uncle suffered much from gout. His father died young. He has himself been threatened in his great toe joint and thumb.

No. LXVIII.—*Spondylitis Deformans in a Cat.*

At page 350 of Vol. VIII. I recorded a remarkable case, with woodcut illustrations, of multiple arthritis deformans in a cat. Not only were many of the large joints severely affected, and the characteristic conditions produced, but the joints of the spinal column were also extensively involved. Since the publication of my case I have found almost its exact counterpart, so far as the spinal column is concerned, recorded long ago in *Le Progrès Médical.*

Dr. Brison, who records the case, speaks of it as an example of multiple exostoses, hyper-ostoses and synostoses of the vertebral column, and distinctly states that the bones of the limbs were almost wholly free. It would therefore

appear to have been a close analogue of what we know as spondylitis deformans in the human subject. In the latter affection, although it is unquestionably a form of rheumatic gout, it is not uncommon for the joints of the limbs to escape. In the cat in question the only osteophytic growths on the limbs were two small ones near to the trochanters. The ribs, on the contrary, as is usual in osteitis deformans, presented many osteophytes. The author speaks as if the malady were well known in France, and says that it leads to death by marasmus after the duration of several months, or it may be of several years. He describes it as reducing the poor animal to a state of rigidity, in which, taken up by the head, it could be lifted without bending, and says that it merits the name of "chat barre de fer." He did not know the exact age of his patient; thought that it was at least in its fourth year.

In my own case, although the osteophytes were numerous and large, and must have been sufficient to greatly diminish the flexibility of the spine, there was no true anchylosis. In Dr. Brison's case the synostosis was, however, quite complete in a great many of the joints, more especially in the cervical region. From the fourth to the tenth vertebræ inclusive no distinction whatever could be observed between the bodies of the vertebræ as seen from before. Dr. Brison inclines to attribute it to a form of periostitis of indeterminate nature, "a chronic and special form of inflammatory action."

It may be well to remark that this affection, so closely similar to spondylitis deformans in man, would appear to be quite distinct from the ossification of the anterior common ligament of the spine, which is not uncommon in horses and asses. In the latter affection, specimens of which are to be found in all our museums, a riband of dense bone passes down in front of the vertebral bodies and unites them. But there are no true synostoses, nor any development of osteophytes.

DISEASES OF THE EYE.

No. XXXIII.—*Fleshy Cyclitis in connection with Gout.*

A very marked example of chronic cyclitis was brought under my notice in the case of Miss B——, aged 23, who was sent to me by Dr. Hewer. There was a dusky, fleshy thickening of the whole sclero-corneal region. It was especially conspicuous upon the upper parts, and although it had begun on the right eye it was now nearly symmetrical. Quite recently it had extended somewhat upon the cornea. The present attack had commenced about six months ago, after an attack of mumps. The history of the patient and her family very definitely connected it, as usual, with inherited gout and its frequent concomitant, feeble circulation.

Miss B——'s mother was rheumatic, and one of her uncles had suffered from gout. She herself had in childhood suffered severely from chilblains, but the liability had decreased since she grew up. She had once had an attack of very severe pain in one hip-joint. The pain suddenly moved from the hip to the neck, and she was kept in bed by the attack for some days. She had frequently had flying pains in her ankles and other joints, and had sometimes had her eyes inflamed, "as if pins were pricking into them." One of her brothers was liable to what was called "neuralgia in the eyes."

Many of the facts above mentioned may, I think, be taken as evidences of inherited gout, and the condition of cyclitis was exactly similar to what I have seen in other cases with parallel history and like concomitants. I strongly recommended a prolonged change of climate.

The date at which the above notes were taken was September 23, 1885.

No. XXXIV.—*Optic Neuritis in one eye only—Question as to Syphilis.*

A case which I have just seen raises an important question as to the symptomatic significance of neuritis of the optic disc in one eye only. I did not myself see the patient during the neuritis stage, but the diagnosis had been made by a very competent ophthalmic surgeon. When I saw the case the disc of the affected eye was rather paler than that of the other, and at its lower border the choroidal rim was very definitely notched. Beyond these there were no changes. The disc was bright and clear and free from all trace of effusion, and its vessels were almost of normal size. The patient was a young man of twenty-six, apparently in excellent health, who had had gonorrhœa, but in whom there was no proof of syphilis. At the time of the optic neuritis he had no head symptom, excepting a little headache, and he had had none since. The recovery had taken place under specifics. Optic neuritis, affecting one eye only, and resulting in complete recovery, is, in my experience, very rare. It is difficult to imagine, under the circumstances described, any cause other than syphilis which could have caused it.

No. XXXV.—*An instance of very extensive Choroiditis Disseminata in Inherited Syphilis.*

On Friday, June 3rd, a very interesting example of extensive disseminata choroiditis in connection with inherited syphilis was brought to me. The patient, a lady of 27, could just manage to read one word at a time with her remaining eye. Her choroid in this eye was disorganised all round the yellow spot, but the latter still remained sound. There were very large irregular areas of denudation in the central parts of the fundus, and at the circumference deposits of pigment after the retinitis pigmentosa pattern. This was her only available eye; with the other she had barely perception of light, and it was not possible, owing to the state of the cornea and media, to inspect the fundus.

This was the most extensive example of choroidal denudation which I have ever seen in connection with inherited syphilis. I have seen its parallel in the acquired syphilis more than once. In one of these latter the patient, who was a schoolmaster, retained for many years the use of his yellow spot region, all around being denuded.

In the present instance there could be no reasonable doubt that the patient was hereditarily syphilitic. Apart from the state of her corneæ her physiognomy was characteristic, and there was a history of severe keratitis in early life. Her teeth were not marked. It appeared that she had had relapses of choroidal symptoms several times during the last ten years. Quite recently opacities in the vitreous and posterior polar cataract had made their appearance. Thus there was reason to fear that the conditions may prove slowly aggressive, and that she may in the end lose all useful sight. This event is, in my experience, very rare in connection with inherited taint. She had good health in other respects.

No. XXXVI.—*Choroiditis simulating Retinitis Pigmentosa with central denudation and divergence of Globe in connection with Inherited Syphilis.*

Another instance of the loss of an eye for all practical purposes in connection with inherited syphilis has recently been under my observation in the person of a youth named C. F——. This patient offers the most extreme condition of syphilitic malformations [illegible] teeth which I have ever seen. His physiognomy is also [illegible] haracteristic an[illegible]story is clear. He has, how[illegible]rived at the a[illegible]nty without having ever su[illegible]n keratitis. [illegible]ye enjoys almost perfect vi[illegible] the right d[illegible] is so defective that he only [illegible] to count [illegible] ophthalmoscope shows the [illegible]e brillia[illegible] ther[illegible]erous pigmen[illegible]e retina p[illegible] retinitis p[illegible]nd a il[illegible] denudatio[illegible] di s[illegible] proof that [illegible] t[illegible] somewha[illegible]

DISEASES OF THE NERVOUS SYSTEM.

No. CII.—*Paralysis Agitans in a man who had had Syphilis, but probably hereditary.*

Captain H—— (seagoing) was under my treatment twenty-six years ago for tertiary syphilis, and I have seen him occasionally since. He is now 65 years of age and in splendid health. He still follows his vocation as sea-captain, and might be taken for 50. The ailment which brings him to me to-day (July 16, 1898) is paralysis agitans in his right arm. He thinks it is quite recent, but I convince him, by reference to my notes, that he came for precisely the same symptom four years ago. He still writes a good hand. His mother had the same affection, and it became aggravated in her later years. I do not think that there is any reason to attribute the affection in the son to his long past syphilis. No doubt it is inherited. He has had no indications of syphilis for more than twenty years, and has a healthy, grown-up family.

Captain H—— is the subject of rheumatic gout in his terminal joints, and also of Dupuytren's induration of the palmar fascia. He tells me that many seagoing men have their fingers contracted into the palm. He had thought that it was an affection peculiar to seamen.

No. CIII.—*Hæmorrhagic Apoplexy—Absolute right Hemiplegia without any impairment of consciousness or memory—Diaphragmatic Respiration—No bladder symptoms.*

The case of Mrs. F—— interested me much, possibly ause I do not often see patients suffering from apoplexy. s lady was absolutely hemiplegic in her left limbs, l neither move them nor feel in them, yet she retained ct consciousness, good memory, and could converse

well. I certainly never saw any approach to such a condition after injury to the head, nor anything so well marked after either hæmorrhagic apoplexy or embolism. There seemed good reason to think that the case was one of hæmorrhage, and it no doubt involved central parts.

Mrs. F—— was a stout lady, aged 52, a total abstainer who had enjoyed good health until her present illness. She had had two "seizures" during the five weeks just before I saw her. She was of course confined to her bed. She told me, as regards her first attack, that it occurred soon after her return from the seaside, at a time when she was feeling unusually well. She was in her kitchen talking to a friend, when she suddenly felt "pins and needles" in her left foot. She mentioned it to those with her, and it soon involved her arm and she sank down on her knees and buttocks. Consciousness was not in the least impaired. She was assisted to bed, and the hemiplegia soon became complete as regards both right limbs and partial in the right side of face also. Her buttocks showed much bruising from her fall. At the end of a month she was much better, could move the limbs, and had regained clearness of enunciation, when, without any fresh attack having been noticed, her symptoms were found to be greatly aggravated and the paralysis of the limbs was again complete.

It was about the fifth day after this relapse that I saw her. She lay on her back in bed perfectly conscious, and, as I have said, able to converse though speaking indistinctly. Her face was slightly drawn to the right side. Her breathing was almost wholly diaphragmatic and very shallow. Her left upper and lower extremities were quite helpless. She could not move them in the least, nor could she feel the touch of the finger. When hairs were pulled on her leg she thought sometimes that she could feel a little, but it seemed uncertain. There had been, I was assured, no trouble with the bowels or bladder. She knew when she wanted to pass water, and there had been no dribbling, nor had the catheter been needed.

Death took place about a week after my visit, but unfortunately there was no autopsy. It is as an example of

complete double function (motion and sensation) hemiplegia with retention of perfect consciousness, that I think the case worthy of mention.

No. CIV.—*Insidious symptoms of general Nerve Disorder in the beginning of the second year of Syphilis.*

A young gentleman (Mr. M——, æt. 23) was brought on account of a rather peculiar form of syphilitic psoriasis which affected his elbows. It was a year and a month since his chancre, and he had been treated all the time with mercury, but with many interruptions and never efficiently. He was not considered to be ill, and one question was whether he might suitably leave England for India and engage in tea-planting. I found, however, on making a routine examination that he had some very ominous symptoms. He could see perfectly, but both discs were unquestionably swollen and their margins blurred. He was somewhat deaf, more especially in the right ear, and had during the last week, when exposed to noise, several times complained that he could not hear conversation. His right pupil was dilated and he had had squint and diplopia. His shins were still bruised by football kicks. He had no knee jerk on either side. Although he looked well and reported himself as perfectly so, yet it came out on inquiry that complaint had of late been made as to his temper. He had just been rejected at an examination, a result which he attributed to the fact that he had of late not been able to read long without feeling his head uncomfortable. I thought his manner hesitating and slow, but was assured that it was customary to him. He denied any headache, and said he ate and slept well. It came out, however, that a few weeks ago he had experienced a sudden attack of numbness in the right limbs. It began in his right foot and then passed upwards to his trunk, arm, and face. It lasted, he thought, twenty minutes and then wholly disappeared.

In the left eye, the pupil of which was moderately dilated, there was no loss of accommodation and no defect, so far

as I could ascertain, of any muscle. There was not, and had not been, any ptosis, and I was assured that the squint (now quite gone) had been convergent. Thus there was no reason to think that the third nerve was affected. Th eruption on the elbows, which was the only extant evidence of the recent syphilis, was very peculiar. It was exactly in the positions which non-specific psoriasis usually affects, and it showed white scale-crusts like the latter. It was, however, serpiginous, and was speading in irregular crescents like a lupus. There was a single spot on the front of one knee. With these exceptions all traces of syphilis had disappeared from the skin and mucous membranes.

I was obliged to give an opinion that Mr. M—— was in danger of a very serious attack on his nervous system, and he ought at once to be put under the full influence of mercury and should on no account go from home.

No. CV.—*Diplopia, Deafness, Facial Paralysis, and other nerve symptoms in the secondary stage of Syphilis—Recovery—Periostitis of Sternum seven years later.*

I treated Captain P—— eight or nine years ago for a very ominous attack of nerve symptoms in an early stage of syphilis, and have, I believe, published his case. He had diplopia, deafness, facial paralysis, and other symptoms. I ordered him into a Home, kept him in bed, and pushed mercury rapidly to salivation. He recovered completely, but with absolute and permanent deafness in the left ear. He has since served in India and other places, and has enjoyed good health.

After an interval of seven years I have just seen him again. He is now in good health, but has during the last month suffered much from pain in his sternum. There is no definite node, but the pain has been worse at night and with decided tenderness, so that no doubt periostitis is present.

P.S.—Rapid and complete relief by the iodide of potassium subsequently confirmed the diagnosis.

SYPHILIS.

No. LXXXIV.—*Yaws in Benin.*

A gentleman who had lived in Benin, and who knew yaws, told me that the native children take the disease, and that their parents wish them to have it and get it over young. This is precisely parallel to the statement from the the Fiji Islands. In Benin the native name for yaws is "effier."

No. LXXXV.—*Three infections of Syphilis at intervals of thirteen and seven years—Lupoid eruption after the second.*

In the following there appears to be good evidence of three infections of syphilis. The only doubt attaches to the third, in which the indurated chancre has not as yet been followed by secondary symptoms. This, however, may probably be due to the fact that he has had mercury in anticipation. After the first and second, definite secondaries followed. His recovery from each of these would appear to have been complete, for he had entire immunity from symptoms until the next infection. The lupoid eruption which occurred in the second year of the second attack was a very peculiar one (see memorandum below). It is, I think, not unusual for the manifestations resulting from a

second infection to receive some modifications from the former one.

AGE.	DATE.	DETAILS.
40	1878	Syphilis: complete. Went to Aix la Chapelle.
41	1879	Under mercurial treatment.
42	1880	Quite well.
43	1881	
44	1882	
45	1883	
46	1884	
47	1885	
48	1886	
49	1887	
50	1888	
51	1889	
52	1890	
53	1891	A second infection of syphilis. I prescribed mercury.
54	1892	After a short course he left off treatment.
55	1893	Came to me for syphilitic lupus Oct. 18, and again Dec. 12.
56	1894	Second visit; all the spots gone (Sept. 12).
57	1895	Well.
58	1896	Well.
59	1897	Well.
60	1898	He comes to me in June with an intra-urethral ulcer. Eruption on legs.

Additional Memoranda.

His last gonorrhœa began two or three days after exposure, and was "virulent," with very severe pain.

It was not till three months later that it was found that there was a chancre in the urethra. The meatus was then incised.

The lupoid eruption for which Mr. W—— was under my care in October, 1893, was somewhat peculiar. It had been coming out for six months, and consisted of groups on inner borders of buttocks and outer side of left hip. There were a few on one forearm. Each group consisted of separate indurations deeply placed in the substance of the skin. None were *ulcerated*, but in retrogression scars were left. He had then been a year without medicine. Six months' treatment with mercury and iodides completely cleared his skin, and no relapse occurred.

No. LXXXVI.—*the progress Chancres when ... is not ...*

Dr. Z——, a yo... ...ician, off... ...ry interesting illustration of the b... ...of indura... ...res when not treated by mercury. ... the s... ...his reflected pra... ...close ... ...an... ...a distance f... ...r tha... ...nct... ...He had

contracted them in Africa from a native woman, and the first of them had made its appearance exactly one month after the date of intercourse. The first was in the roll of the reflected prepuce, close to the corona. It preceded the others only but two or three days, and the remaining six came almost simultaneously. At first, on account of the multiplicity of the sores, he hoped that it was only herpes, but as they persisted, became indurated and ulcerated more freely, he touched them all with nitric acid. When the effects of the acid had passed off he applied iodoform, but still took no medicine. Finally he had fever and an abundant eruption came out.

Dr. Z—— came to me a few days after the appearance of his eruption, two months after the contagion and one after the recognition of the sores. He was freely covered on chest and abdomen by a characteristic erythematous and papular eruption. He had had much aching in his bones, and he thought some sore throat. I could, however, find no trace of sores in his tonsils, His seven chancres had all healed under the influence of iodoform, and were all in the well-known parchment condition. Any one of them might have been recognised without risk of error as an indurated chancre, although none were of large size or much thickness.

No. LXXXVII.—*A healthy family after Vaccination-Syphilis.*

Mr. W——, jun., was one of those whose cases are narrated in my first Report on Syphilis from Vaccination, 1874. He suffered rather severely, and his arm-chancre recurred several years later. He married in 1878, seven years after his syphilis. In 1885 he brought his eldest child, who looked quite healthy. He then had three living and healthy children, and had lost none. He was himself in good health.

I mention this case because some authors hold that erratic or non-venereal chancres are productive of more severe syphilis than others.

No. LXXXVIII.—*Reputed transmission of Syphilis seven years after the primary disease in the father—Fallacies.*

I have so often expressed the opinion that syphilis is very rarely transmitted to offspring when several years have been allowed to elapse before marriage, that it becomes a duty to record any facts which may seem to be an exception. One such is the following. I treated a gentleman from Cornwall on account of periostitis affecting his os calcis, and at the same time excised one of his eyes which had been lost. I sent him to the seaside, and he took specifics for several months, with the result that he entirely regained his health. This was in 1881; and in 1888, with my full permission, he married. The attack of syphilis to which we referred his periostitis was twelve years back from the date of his marriage, but he had had another sore, without constitutional symptoms, seven years later.

It was in June, 1876, that I first saw him for the node on the os calcis, and in October, 1881, he was under the treatment of another surgeon on account of another chancre. This second chancre led to nothing, and at the time of his marriage he appeared to be in excellent health. He married in April of 1888, and in December of the same year his wife was delivered of a seven months' child, which subsequently suffered, as I was assured by a very competent man, from symptoms of syphilis which were unmistakable. His wife also after her confinement had an eruption of an erythematous character on her chest and body which was believed to be specific. I did not myself see either the child or its mother.

If the above facts can be trusted, it will be seen that a man who had himself had no symptoms of a secondary or tertiary class for thirteen years, and in whom seven years had elapsed since a primary sore of doubtful character, was the father of a syphilitic child which caused contamination to its mother. But we must glance at the fallacies. Although my patient assured me most positively that he

had had no primary symptoms since the date mentioned, he yet admitted having been exposed to risk, and we well know that infection sometimes takes place without the primary symptoms being observed. The case is in my experience so entirely exceptional, that I feel much more inclined to suspect that fresh syphilis had in some way been contracted shortly before marriage than to take the view which the patient wished me to entertain. The credibility or otherwise of such evidence depends much upon the frequency with which it is offered to us, and I may repeat that my experience has afforded extremely few narratives in the least parallel to the above.

This case is of further interest as an example of the permanent cure of a very troublesome node. The os calcis was very much thickened when Mr. P—— first came under my care, and his treatment gave us a great deal of trouble. It was of two years' standing, and he had already taken specifics for a considerable time. It entirely prevented his walking or wearing a boot. The treatment which succeeded was a long course of large doses of iodide of potassium during residence at the seaside. What is somewhat remarkable in connection with bone syphilis, after it once got well there was never any tendency to relapse.

No. LXXXIX.—*Recurred Chancre or New Infection —A question of Diagnosis.*

Captain A——'s case is, in reference to the theory of recurred chancres, a very peculiar one.

In 1888 he had a soft sore, which he treated himself by local applications only, which healed in a fortnight and was not followed by secondaries. It left, however, a definite scar.

In January, 1896, he had gonorrhœa, or more probably a urethral chancre, and at the same time a large sore on one finger which was no doubt a chancre. Six months after the beginning of these (in July), he was sent to me covered with psoriasis-lupoid eruption of a very severe character. Under mercury this quite disappeared, and in six months

he was well but covered with deeply pigmented stains. He now left off specifics, and he remained quite free from symptoms and in good health until December 1, 1897.

On December 1, 1897, he came to me again with a very definite induration of considerable size, with rounded elevated borders and a depressed centre. It was in the corona, and, as he positively assured me, exactly in the site of the "soft sore" which had occurred nine years ago. The scar of the more recent sore on his finger remained quite sound and quiet. Captain A—— admitted having exposed himself to risk just about a month previous to this consultation, and said that the sore had followed about two weeks after this occurrence.

I feel almost certain that this new chancre ought not to considered as a gumma, but rather as the result of a new contagion modified by the fact that he had recently been under treatment for syphilis. If it were independent of the recent exposure to risk and of spontaneous formation (*i.e.*, an indurated gumma), then it seems more probable that the process would have affected the site of the sore on the finger or that near the meatus, both of which were true chancres, whilst the scar in the corona was left by a sore of short duration which was not followed by secondaries. Its relation to the scar is probably simply that the latter was a vulnerable part and thus favoured the absorption of virus.

No. XC. — *Remarkable persistence of Secondary Symptoms.*

In the case of Mr. A——, the secondary phenomena of syphilis were somewhat peculiar and remarkable for their persistence. This gentleman was 39 years of age when he for the first time contracted chancres. They were, as is but too common, diagnosed as being "soft," and no treatment was resorted to until he was covered with eruption. When he came to me, in probably the third month from date of contagion, he was literally covered with erythematous blotches, which in some parts threatened to become papular, and the roll of the reflected prepuce, from the frœnum on one side to

the same point in the other, was involved in induration. He had no sore throat. Mercury was, of course, at once prescribed. A slight ptyalism occurred at the end of a fortnight, and at the end of a month the induration had gone, and to a large extent the eruption also. Two months later, however, although he had not wholly left off mercury, the eruption showed a tendency to return. The mercury was increased and regularity in taking it was insisted upon. In spite of this, however, the eruption persisted, and a month later still his back was still covered with large erythematous patches and rings, and there were many also on his limbs. The eruption was at this stage very peculiar. It consisted of erythematous patches, some oval, some round, and some irregular, all of which enclosed a pale, almost white centre. Most of them were from the size of a shilling to that of a halfpenny, and none showed the slightest tendency to become pustular or even papular, and from all the congestive redness was discharged completely by pressure. There was no eruption on the face and but little on the front of the body, but the back was covered. It will be seen that the patient had now taken mercury for four months. He was well in health, and from first to last had had no sore throat. His chancres had quite gone, and showed no tendency to relapse. It should be added that he had formerly suffered from malaria.

It would seem certain that the mercury had kept the disease in a condition of three-parts cure. Probably we had not given quite enough.

When I last saw this patient (Oct. 29) he was returning to his home abroad, and was almost, but not quite, free from eruption.

No. XCI.—*Gumma of one Mammary Gland in a man after Syphilis and during treatment—Complete but very gradual disappearance—A family history.*

It was ten years after the first syphilis, whilst under mercurial treatment for a second chancre, and when the

latter was disappearing satisfactorily, that the mammary gland enlarged. It became of considerable size and very hard. It was evenly rounded, and the nipple was fixed. It caused no pain. This enlargement persisted, with but little change, for six weeks. Meanwhile the chancre had become parchment-like, but no secondary symptoms had shown themselves. After this, under the steady continuance of mercury, the induration of the gland slowly diminished, and in the following June no trace of it remained. Not long after this he married (against my advice). Two years later I saw him again for sore throat of a specific nature, and ascertained that he had had no relapse in the breast, and nothing further of the nature of tertiary symptoms. His wife had remained well and had borne him two children, one of whom had died of inanition, aged one month, whilst the other, aged two, was in good health. Early in 1893 he had a fresh sore, but no secondaries followed.

From this date till his marriage, twenty months later, he continued the use of mercury. He married against my advice. His wife remained quite well, but their first child died, æt. one month, of "inanition." He himself remained quite well until 1898, when he had sore throat. Ulceration above soft palate in right side. It is now better under mercury and quinine. A smoker.

YEAR.	AGE.	DETAILS.
1884	25	Treated for syphilis, by Mr. Lee, by mercurial baths.
1885	26	Mercurial baths. Sore throats troublesome.
1886	27	I saw him for first time for his throat.
1887	28	Mercurial treatment.
1888	29	Quite well.
1889	30	
1890	31	
1891	32	
1892	33	
1893	34	A new and very hard chancre in March. Breast enlarged.
1894	35	Married in October.
1895	36	First child died, æt. one month, "inanition."
1896	37	Excellent health, but liable to herpes in penis and herpetic sore throats. Second child, born in 1896, healthy.
1897	38	
1898	39	Comes to me with sore throat. In good general health.

DISEASES OF THE SKIN.

No. CII.—*An exceptional form of Pruriginous Eruption in a young child—(Varicella-prurigo?).*

On June 14, 1898, Dr. Fortescue Fox brought me a patient in whose case the diagnosis was very difficult. Those who are fond of names which have no real meaning might have insisted that it was a form of "prurigo," whilst those who desire that their name should imply some knowledge either of cause or natural alliance, might have wavered amongst a number. It might be the result of flea-bites; a variety of psoriasis; a lupus vulgaris multiplex in an early stage; a sequel of varicella, *i.e.*, a varicella prurigo, or a hybrid between any two of these.

The patient was a well-grown girl of four years of age, of gouty family. Her eruption was confined to the limbs and face. The trunk was absolutely free. Thus the buttocks, as well as the upper parts of thighs, were covered with spots, but there were none on the loins and upper sacral region, the favourite site of pruriginous lichen caused by fleas. The absolute exemption of the trunk seemed indeed to be conclusive against the idea of any insect causation. The character of the eruption varied much in different parts. Both cheeks were covered with spots, papules, and discs, some of them more or less abraded, and all congested and looking not unlike the very earliest stage of lupus. On the arms and fore-arms the spots were more sparingly located, but much of the same character. Many were slightly scaly, like psoriasis guttata, and in a few glossy indurations had formed like keloid. On the buttocks and thighs the features of the eruption were much the same as on the arms, but the

spots were more abundant and less indurated. On the legs the spots were plentiful and more inflamed. Irregular indurations had been formed by their coalescence, and the subcutaneous cellular tissue was involved. Some thin crusts were present, but ulceration, although threatened, had not actually occurred.

The history of the case gave us but little help. The eruption in the first instance came out when the child was on a visit in August, 1897. It was at first considered to be chicken-pox, but it then affected the limbs only, and was not severe. After a duration of three months it vanished, and during the four winter months the child was quite free. The next attack occurred in the following April, and again when the child was visiting, but not at the same place. She had been observed for some days to be out of temper and tone, and then the eruption developed in successive crops, and the cheeks were for the first time attacked. The eruption on this second occasion was far more severe than on the first, but it was not attended by any failure of health. After it had been out a month, however, albumen was discovered in the urine. The child was kept to bed, and purgatives used, and this disappeared in the course of a week. The irritation of the eruption had not been more than moderate, and the child had kept her health, and slept fairly well throughout. There was a history that in infancy she had some vesicular eruption on the wrists and ankles, but it had soon passed away. Vaccination had been performed at the usual age, and without any ill consequences. When I saw the child there was nowhere any indication of vesication, nor any spots which showed much erythema as if of recent formation. I was told, however, that fresh spots did appear from time to time, and that sometimes there were distinct vesicles. The eruption had never before assumed such proportions as at the date of my consultation.

I presented this patient at one of my Demonstrations at Park Crescent, and directed attention to the fact that the eruption was almost exactly symmetrical and confined to the limbs and cheeks. This, I remarked, was conclusive as evidence against its being due to bites of any insect. A

number of portraits illustrating cases of prurigo after varicella and vaccination were placed by the side of our naked patient, and the similarity was acknowledged to be obvious. Taking into account the fact that in its first outbreak the eruption was thought to be chicken-pox, I ventured to say that I thought the diagnosis of varicella-prurigo more probable than any other.

No. CIII.—*Tebb's Eruption (Keratolysis Exfoliativus of Sangster).*

Dr. Sangster has published in the Journal of Dermatology an interesting example of congenital exfoliation of the epidermis, and accompanied it with an engraving from a photograph. My chief concern with it at present is to ask whether it has any relation on the one hand to congenital pemphigus, or on the other to the eruption of which the Tebb family were the subjects. Dr. Sangster's patient was a man of twenty-four, and was one of ten children, of whom four others were living and free from disease. His affection was noticed in the third week after his birth, and began on the forehead. By the end of the third year it had become, as it remained ever afterwards, almost universal, the palms and soles being the only parts exempt. The epidermis could in some parts be peeled off in large flakes, the surface becoming afterwards of a brilliant red, but without exudation. No bullæ had ever appeared. Perspiration was usually free, more especially in the palms and soles. The case might have been considered one of aggravated ichthyosis of the exfoliative type; there was, however, no family prevalence. As showing some alliance to the Tebb cases, Dr. Sangster records that the patient was liable to attacks three or four times a year, in which the exfoliation became much aggravated. There was, as in the Tebb cases, great irritation, and, as in them, the appendages of the skin were not affected. I cannot but think that the case is very closely parallel to that of the Tebbs, and if so, further support is afforded to Dr. Sangster's conclusion that the disease was in the main

non-inflammatory, and due to a congenital imperfection in the development of the skin. In the Tebb family a brother and sister were alike its subjects. Dr. Sangster names the condition keratolysis exfoliativus. In the Tebb cases the congenital peculiarity appeared to be a liability to urticarious irritation in association with keratolysis. Urticaria as a rule is not followed by exfoliation. I have referred to this subject at page 363 of Vol. VIII.

No. CIV.—*On Common Warts.*

A wart may be defined as an overgrown papilla which ha protruded through the level surface of the epidermis, takin with it only a very thin investment from the horny laye In many instances two or more adjacent papillæ are i volved, and coalesce to form the wart. In what is call the foliated wart the papilla has budded out in vario directions more or less dichotomously, and a branche cockscomb-like growth is the result. When there is mu foliation there is almost always a constricted base. dilated arteriole always enters the stem of a wart. Althou warts often, or indeed usually, occur in crops, they ne become diffuse—that is, the papillæ adjacent to them rem quite quiet, and are not involved in the process. In spe lating as to the cause of warts, we have therefore to what it is which gives to certain individual papillæ a t dency to grow beyond their due relations to the struct of which they form a part. In reply to this question may say that it seems certain that youthfulness of tiss favours their occurrence, but not extreme youth, for t are seen frequently in children, but hardly ever in infants

CV.—*Eruptions following Varicella.*

The following letter from the mother of a patient explain itself:—

"Two and a half years ago Charlie had chicken-pox, which seeme affect his skin to an unusual degree, and it was quickly followe

pemphigus, which he suffered from in an acute degree for some months in spite of Dr. C——'s treatment, and it is only since early last summer that he has ceased to have any spots or gatherings. For a long time the least blow or scratch would always cause a kind of gathering with a great deal of discharge, and all the time he has off and on had this kind of eczema. He has almost constantly taken the tonic with a small dose of arsenic in it, and it has done him much good, but not cured him.

The subject of the above narrative was brought to me in February, 1888. He was five years old, and was the subject of a most troublesome pruriginous eczema. I prescribed a tar wash and it suited admirably. In a few months he was well.

No. CVI.—*Falling of the Hair after Influenza (?) and in association with a Lichenoid Eruption on the Body.*

A young woman, aged 27, who had formerly had an unusually good head of hair, was sent to me because she was losing it. Her hair had unquestionably become very thin, and in parts, vertex and sides of temples, almost bald. The hairs which remained were gathered into tufts of two, three, or four together. There was a certain amount of adherent dirty and sticky scurf in some parts and here and there in little patches, and the skin of the scalp looked coarse. Her hairs were strong and very long. I inquired as to her nails, and she told me that she had had (in October) an illness, during which the nails and finger-ends became blue. It was called influenza; she felt very weak and was in bed a week. During this illness she had "red patches of the arms, neck, &c., which kept moving about." They did not itch, but burned. The falling of her hair occurred chiefly after this illness, and sometimes she would lose an ounce and a half or even two ounces a day. These weights are explained in part by the great length of her hair. Asked as to whether she had any skin disease now, she said she had a patch between her shoulders, and showed me one the size of the palm of the hand, over which were rough lichen spots and numerous tufts of dilated capillaries (like a nævus).

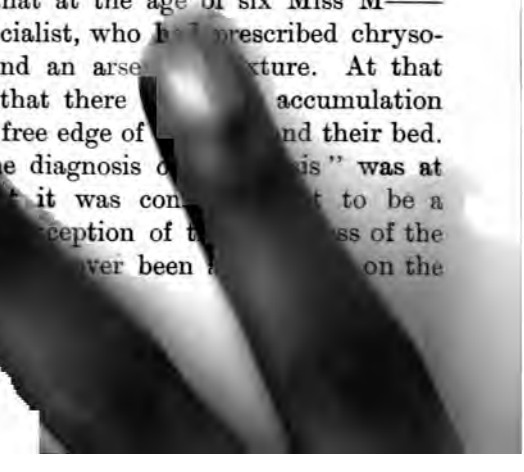
She is a tall, rather thin young woman, of rather fair complexion and feeble circulation; often pale, with dusky lips.

I pulled out many hairs. Their bulbs looked thin. None brought away the root sheath.

No. CVII.—*Disease of the Nails and Fingers beginning in Childhood—Family history of Skin Disease—A modified form of Psoriasis.*

Miss M——, aged 16, a florid girl in excellent health, was brought to me by her mother, March 17, 1898. I was told that some years ago I had treated one of her aunts (maternal) for similar disease.

The condition was that of dry and cracked finger-ends, with pin-pricked finger-nails and dry cracks across the flexures of her finger-joints. The nails were also somewhat undermined. They were much disfigured. The fold between thumb and forefinger was dry and cracked, and she had formerly had some ill-defined dry scaly patches extending from this fold towards the palm. The palm itself was soft and healthy. There was no xerodermic condition of the skin generally, and she was accustomed to perspire readily. On the tips of both elbows and on the fronts of both knees were dry scaly patches, but they were ill-defined and by no means presented the conditions of characteristic psoriasis. Of the nails the thumbs were the worst, and the little and ring fingers were almost wholly exempt. Toe-nails reported free. She has had sebaceous tumours of the scalp since the age of six. I was told that at the age of six Miss M—— had been taken to a specialist, who h[illegible]prescribed chrysophanic acid ointment and an arse[illegible]xture. At that time her mother [illegible]ated that there [illegible] accumulation of dry dust b[illegible]he free edge of [illegible]nd their bed. It was belie[illegible]he diagnosis [illegible]is" was at that time su[illegible] it was con[illegible]t to be a definite form[illegible]ception of t[illegible]ss of the el[illegible]ver been [illegible] on the li[illegible]



The family history was of much interest, and well illustrates the doctrines of transmutation in transmission. A brother of the patient had from infancy suffered for a long time and very severely from eczema. Of this he was now well, but with a dry skin and such liability to asthma that he was obliged to live at the seaside. A sister had a "dry skin," but no definite disease. On her father's side there was a history of eczema. The following are notes of the state of skin in a maternal aunt, who, as already stated, had been formerly under my care:—

No. CVIII.—*Notes of case of Pruriginous Eczema on a Xerodermic Skin (Patient, the Aunt of the preceding one).*

May 24, 1895. Mrs. A——, aged 45, consulted me on account of a pruriginous eczema on a xerodermic skin. She stated that she had troublesome eczema as an infant, and did not get well of it until, at the age of ten, she was sent to the Askern baths (sulphur). She was liable, on taking exercise, to burning heat in the skin, without perspiration. She had taken much arsenic and had become liable to numbness of her fingers, which often caused her to drop things. She believed that her family was gouty, and one of her grandmothers had, she knew, suffered from an eruption. I advised the disuse of arsenic, and prescribed local measures only. I heard subsequently that she was much better.

No. CIX.—*Symmetrical Pigmented Areas on sides of cheeks, temples, and hands—A form of Morphœa (?).*

In the following case an eruption of brown or blackish
vithout perceptible induration or thickening, seemed
substituted for the more ordinary conditions of
ea. The type of morphœa was that in which there
herpetiform bands, but in which symmetrical ill-
areas are affected (Mr. Denner's type).

Mrs. C—— dated all her ailments from a shock from a gas explosion in June, 1895. In June of the following year she had a miscarriage, after which "an irritable eruption" appeared on her hands and face. She had previously suffered from urticaria on her legs. The eruption soon assumed the condition of brown stains, and for these she was sent to me on January 10th, 1898.

The parts affected were the cheeks near to the ears and the temples. The nose and whole front of face were normal. Mainly the changes were those of pigmentation only, but I thought that the affected area was slightly thinned and somewhat rigid. She had often been told that her face needed washing. On the backs of her hands were numerous brown spots which looked like lichen, but were quite imperceptible to the touch. The regions involved were quite symmetrical. Opinions might have differed as to whether or not they were slightly indurated. I thought that they were. Mrs. C—— said that the spots on the backs of her hands had been usually red rather than brown.

Mrs. C—— was liable to a sensation of violent throbbing in her head with noises in her ears. She had also much pain in the small of the back and a bearing down in the iliac fossæ. She was also subject once or twice a month to violent headaches, attended sometimes by slight epileptoid attacks, followed by collapse. After these she would regain consciousness but slowly. She had also very cold feet, and according to her own expression, "everything went to her head." She did not consider that she was losing flesh or strength. Her eyes were white and watery. She told me that she could not take either quinine or arsenic.

MISCELLANEOUS.

No. CCCXXI.—*Is Cystinuria a "family disease" or an "heritable disease"?*

A distinguished writer on the urine states that "a curious circumstance in the history of cystinuria is its tendency to run in families." He then proceeds to cite as evidence that Dr. Marcet observed it in two brothers, that both Lenoir and Civiale had operated on two brothers, and that Peel relates the case of two sisters who voided cystinous urine. But clearly not one of these four cases illustrates more than "family prevalence" in the technical sense. To "run in families" should mean to descend from parent to offspring, but here we have nothing of the kind proved. Nor am I aware that inheritance has ever been observed in the case of cystinuria.

No. CCCXXII.—*Family Prevalence in relation to Inheritance.*

Family prevalence, as distinguished from inheritance, is certainly a remarkable phenomenon. It would imply that conditions so produced are due to some peculiarity resulting from that particular couple, and not from either parent singly. The close similarity often observed in twins, both as regards features and morbid tendencies, is an example of the same kind of influence. In animals which bring forth many at a brood we find no difficulty in conceiving that one litter may differ from others bred of the same parents. An instance in which of a litter of rabbits nearly all had congenital cataract once occurred under my own observation.

Probably it will be found on careful investigation that this difference between inherited and family prevalence, upon which Adams insisted so strongly, is not, after all, of universal prevalence. Some degree of inherited tendency may probably be found in most instances of family prevalence. In the case of retinitis pigmentosa and deaf-mutism this is not infrequent. Still, however, the main fact remains unquestioned that it is quite possible for several brothers and sisters to show some very peculiar form of proclivity which cannot be traced in any progenitor.

No. CCCXXIII.—*On Vibrissæ (Nasal and Aural) as indications of race and family descent.*

Amongst personal peculiarities which may go to the recognition of family inheritance are the development of hairs in the nostrils and in the external ear. In the nostrils these hairs have been named Vibrissæ, but I am not aware that those occurring in the ears have received any special name. Some persons have the orifices of the nostrils completely protected from the entrance of dust by the development of these hairs. They grow, I think, more usually from the projecting fold of skin on the inner side which covers the columna, but some may often be found just within the outer margin as well. In the ear, the large tuft of hair often springs from the inner side of the tragus, and crossing the orifice, they completely protect it from intruding objects and to some extent from cold air. Those who have abundant vibrissæ very commonly, I believe, have these tragal tufts of hair also. A Scotchman of my acquaintance, a thin, spare man, has both his nostrils and his ears quite occluded by these growths of hair.*

Perhaps we might suitably speak of the hairs in the ear as aural vibrissæ. Careful observation might perhaps

* Quain, describing the vibrissæ, says, "Within the margin of the nostrils there are several short, stiff, and slightly curved hairs which grow from the inner surface of the alæ and septum nasi, up to the point at which the skin is continuous with the mucous membrane lining the cavity of the nose." Respecting the ear, he says simply that the tragus is frequently covered with hairs.

enable us to make some use of the presence or absence of these hairs as indicative of race. In all probability they belong chiefly to those races and to those individuals in whom the growth of the beard, whiskers, and moustache is also abundant. They occur chiefly, if not exclusively, in men. Whether they are in any relation to the general tendency to hirsute development in the individual I am unable to say, but should think it probable that they are rather local peculiarities incident to certain families belonging to hirsute races. As indications of family relationship no doubt they have their value and are worthy of study. Sometimes the regions affected by them become the seats of sycosis, and the removal of the hairs is then necessary. Under all other circumstances their presence is rather to be regarded as an advantage to their possessor.

No. CCCXXIV.—*Persistent Pellicular Conjunctivitis with lupus-like thickening of Mucous Membrane —Death from Croup.*

The patient to whom the following note refers was a little girl of six years old. I saw her only once. She had the mucous membrane of her upper eyelid much thickened and partially everted. The thickened surface was covered by a thick coherent membrane, and bled when the membrane was detached. The condition, I was told, had been present several years, and had resisted all treatment. She was the niece of a physician who brought her to me, and who had previously obtained much highly skilled advice. I thought that the disease was a combination of lupus of mucous membrane with pellicular formation, and advised the free use of the actual cautery. The appended letter gives all the further details with which I am acquainted. It would appear that the child had a remarkable proclivity to pellicular (diphtheritic) formations.

"DEAR MR. HUTCHINSON,—On the 8th of July last, you were good enough to look at my niece, who had been suffering for the last five years more from an extraordinary affection of the eyelid. This you were

inclined to think was a form of lupus, but said that you had never seen a similar case.

"As to the result of treatment, no kind of cauterisation, Paquelin or other, had the slightest result, the false membrane forming again almost immediately.

"I regret to say that the child died after two days' illness—the cause, 'Croup and Bronchitis.' The remarkable fact about this is that less than a year ago she had been subjected to a six-weeks course of injection with Diphtheria Antitoxin in St. Thomas' Hospital, into which she had been admitted in order that that treatment might be thoroughly carried out. You may perhaps remember that she was an exceptionally well-developed child for her age.

"I promised to let you know the further progress of the case, so tell you all I know; but I have not seen her myself since the day you examined her. Believe me very faithfully yours,

"P. B. M."

No. CCCXXV.—*Influence of Race and Diet in Leprosy and Tuberculosis in Japan.*

The following extract is from the pen of a Japanese physician and contains some important facts. I take it from one of the reprints, &c., which Dr. Albert Ashmead sends us from time to time across the Atlantic:

"Among the classes backward in development, leprosy still preserves its sway. In Japan, the population may be divided into three classes. In the rich, noble class, almost pure Indonesian blood, inbreeding of four families for 1200 years, leprosy is very rare. In the great middle class it is more frequent. Among the outcasts, the Eta, the negroid element, it is rampant.

"In the first class tuberculosis makes numerous victims, more than in either of the other classes; in the second class syphilis is the prevailing scourge, and has been so for 1300 years; the third, as before said, is a prey to leprosy.

"These three different bacilli seem to have picked out their ground during 1300 years in which the closely-hemmed-in and isolated empire has been preyed upon by them.

"By changing the environment congenial to the microbe one can change his characteristics. A change in the conditions of the lower class of Japan to the higher plane would probably produce a corresponding change [redacted]

"Two factors are necessary for the prevention of leprosy: obstacles to inoculation, that is isolation, and improvement of the human class preferred by the bacillus.

"The Ainos of Japan, who have been always isolated from the Japanese, have never contracted leprosy (yet they are the greatest salt eaters in the world). This might be considered as an isolation of the healthy. It is our desire to have the whole human race isolated in the Aino manner.

"We do not know, of course, whether the Ainos have ever been inoculated. One individual would have acted as a nucleus for the disease. It is very probable that in the course of twenty centuries one or more Ainos were inoculated. However well isolated they were, although shunned by the Japanese as dogs because of their hairiness, as the country was after all a leper centre, some individuals were contaminated. Some poor Aino must have at some time joined the company of some outcasts in the Eta villages. The inoculation is certainly very probable; and the absence of the disease among the Ainos is certain. We assume, therefore, that the Aino has immunity, or that the bacillus does not prosper in Aino flesh. Now, here is a curious remark: 'There has always been a suspicion that fish diet has something to do with leprosy. Now the leprous Japanese eats a great deal of fish, and no meat; while the Aino feeds on bear meat, and is not very fond of fish; he is, in fact, a nomad, consequently a hunter.'"

No. CCCXXVI.—*Salt-fish in Iceland.*

"Of Iceland to wryte is little nede
Save of stock fische."

These were the opening lines of a chapter in a geographical work of the sixteenth century.

No. CCCXXVII.—*General Pruritus from Fish.*

"I become quite itchy if I eat salmon." This was an expression used by a patient, and supports an opinion which

was long ago forced on my mind that fish is often a cause of general pruritus, even in persons who do not develope actual urticaria.

No. CCCXXVIII.—*Nimia Diligentia.*

It is an interesting illustration of the fact that to cease to do evil is often the first step in medical improvement, that one of the chief claims to the gratitude of posterity which the biographers of Petit put forward is that he succeeded in persuading surgeons that it was not necessary to cut the frœnum linguæ of infants.

No. CCCXXIX.—*Consultation Practice in the last Century.*

It is recorded quaintly of Dr. Thomas Willis, when in practice at Oxford, that "He pursued his profession *and kept Abingdon Market*" (Hutchinson, Vol. II., p. 481).

No. CCCXXX.—*Distinction between a Stroke and a Fit.*

The popular distinction between a stroke and a fit was well illustrated by a hemiplegic patient who asserted, "I never had a fit; I never lost my senses; I only had a stroke."

No. CCCXXXI.—*Doctor and Patient.*

Consultant: Who are you under?

Patient: Well, you see I go once a week to Dr. Brown, but whether I am under him or he is under me, I never can quite tell. I believe he would admit that I have had more experience of my complaint than he has.

No. CCCXXXII.—*Death of Van der Linden from Pneumonia.*

Dr. Van der Linden, of Leyden, 1604–1664, died after a short illness in March, 1664. Guy Paton, of Paris, who

was his friend and correspondent, thus mentions his death in one of his letters: "Van der Linden died at Leyden, aged 53 years, of a fever and defluxion on the lungs, after having taken antimony and without being blooded. What a pity it is that a man who wrote so many books, and was so well skilled in Latin and Greek, should die of a fever and suffocating catarrh without being blooded." The illness was probably catarrhal pneumonia.

No. CCCXXXIII.—*Death of Sir Thomas Browne from Abdominal Obstruction.*

Sir Thomas Browne (Religio Medici) died after a week's illness from "colic, with much suffering." He may have had an impacted gall-stone, or possibly a stricture and blocked bowel. He was aged seventy-seven.

No. CCCXXXIV.—*Cause of Napoleon's Death.*

Napoleon Bonaparte died at the age of 52 of cancer of the stomach, May, 1821. His father had died at the age of 38 of the same. Napoleon was the son of a very young mother. His mother was possibly not sixteen when he was born, and certainly not twenty.

Cancer is, I believe, more common in the children of aged parents than of young ones. We must, however, here bear in mind the inheritance, and also the depressing and annoying conditions under which Napoleon's last years were passed. There can be little doubt that mental depression disposes the tissues to cancerous changes.

No. CCCXXXV.—*Coleridge at the London Hospital.*

Guy's Hospital has long made its boast of Keats, but it is perhaps not so well known that Coleridge was at times an amateur dresser at the London. The following is from his autobiographical memoranda: "About this time my brother Luke, or "the Doctor," so called from his infancy because,

being the seventh son, he had from his infancy been dedicated to the medical profession, came to town to walk the London Hospital under the care of Sir William Blizard. Mr. Saumarez, brother of the Admiral Lord Saumarez, was his intimate friend. Every Saturday I could make or obtain leave, to the London Hospital trudged I. O the bliss if I was permitted to hold the plasters, or to attend the dressings. Thirty years afterwards Mr. Saumarez retained the liveliest recollections of the extraordinary, enthusiastic blue-coat boy, and was exceedingly affected in identifying me with that boy. I became wild to be apprenticed to a surgeon. English, Latin, yea, Greek books of medicine read I incessantly. Blanchard's Latin Medical Dictionary I had nearly learnt by heart. Briefly, it was a wild dream, which gradually blending with, gradually gave way to a rage *for* metaphysics" (p. 22).

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