charge now from the tube, and he could breathe for twenty minutes at a time easily with the tube corked up. (I expect he could have breathed for longer, but was nervous.) Ice was again ordered for external application, and four days after (February 28th) the external inflammation had subsided. Internally there was still swelling of the ventricular bands and the cushion of the epiglottis and ary-epiglottic folds, but no ulceration anywhere; the extremity of the vocal cords was quite normal in appearance.

On March 9th, the laryngeal opening was larger, and breathing tolerably easy. He walked about now for several hours with the tube corked up. At this visit I commenced to dilate the laryngeal opening, and passed a No. 7 œsophageal bougie (bent to shape) through it.

On March 13th, 16th, 20th, and 23rd I again dilated it with Mackenzie's three-pronged dilator, and on each occasion passed œsophageal bougies of increased size through the constriction with ease. After each operation he was able to breathe better and for longer with the tube corked up, and now (March 28th) he is able to dispense with the tracheotomy tube altogether. The general condition is excellent, and he has gained in weight. He may now be considered as cured. The tube is entirely removed, and the tracheal opening closed up within twenty-four hours. At the last visit he pointed out to me the cicatrix of an old scrofulous ulcer in the neck, which had been hidden by the beard, and which I had not seen before.

As to treatment, iodide of potassium was, of course, given, at first in doses of 5 grains, afterwards reaching 15 grains, three times a day. This was given without any reference to syphilis. The tracheotomy wound was always dressed with iodol gauze (except just at first, when iodoform was used), and washed with perchloride of mercury (1 in 1,000). Iodol was insufflated into the subglottic region through the tracheotomy tube, and headache was relieved with antipyrin.

A drawing of the condition of the larynx at the present time is here appended (Fig. 5); it was executed by Mr. P. S. Hutchinson

Fig. 5.

who also made the drawings of the larynx reproduced in Figs. 1 and 3. It is seen that the laryngeal aperture is now large enough to permit of easy respiration. All active inflammation has subsided. I quite expect that occasional dilatation will still have to be performed; but the patient may be said to have made a very successful recovery.

Perichondritis of the larynx may arise, as is well known, in the course of typhoid fever, tuberculosis, syphilis, and cancer; it has also been known to occur as a result of chronic laryngitis; to these must be added traumatism, both external and internal. Charles H. Knight, of New York, recently recorded a very interesting case of this kind, the cause of which was injury to the larynx by strangling during a quarrel. He also, in the same paper, recorded a case in which perichondritis followed from swallowing a plate of false teeth during an epileptic fit in a woman. The lodging of the teeth in the pharynx was succeeded by abscess of the posterior wall of the larynx. Perichondritis from decubitus, the pressure of an ossified cricoid cartilage against the vertebral column, has also been described by Gerhardt and Dittrich, and Mackenzie has seen it after cut throat.

The injudicious use of œsophageal bougies in the aged is referred to by Knight as an etiological factor, and there is no doubt that careless or prolonged use of the galvano-cautery to the larynx may give rise to it.

It seems desirable to correct the general opinion that perichondritis must necessarily be caused by syphilis or cancer. The case I have here recorded shows how it may arise out of chronic laryngitis, and the same catarrhal condition which leads to production of innocent neoplasms may also lead to perichondritis of the laryngeal cartilages.

A second case of extensive perichondritis of the larynx has occurred in my practice recently, arising out of chronic laryngitis, and in which there was no question of syphilis. In this case the cricoid cartilage was extensively affected, and formed a large abscess externally, on opening which a large quantity of sero-sanguineous fluid was poured out. The stenosis of the larynx was extreme, and tracheotomy had been performed many months before I saw the case by a surgeon at the Cape of Good Hope. As to prognosis, every case of perichondritis of the larynx, even when extensive, is not necessarily followed by fatal termination. Those due to syphilis, or of traumatic origin, frequently recover, and the case I have here first recorded in detail shows how perichondritis, arising out of chronic laryngitis, may also recover. What influences prognosis most is probably the extent of cartilage involved as well as the patient's general condition; and it is probably true, as all writers on the subject are agreed, that perichondritis of the cricoid cartilage progresses slowly but surely towards a fatal termination. Sufficiently accurate descriptions of the symptoms and laryngoscopic appearances of this disease are contained in many textbooks. I will merely remark that, in cases where there is a possibility of the presence of malignant disease, very little importance can be attached to the examination of the secretions.

A MODE OF OBTAINING VACCINE LYMPH WITHOUT PUNCTURING THE VESICLES.

By W. C. GRIGG, M.D.,
Physician to Queen Charlotte's Hospital.

THE present method of taking lymph for vaccination purposes is coupled with so many inconveniences, not to say dangers, that I feel sure medical men will gladly welcome any suggestion which will dispense with the necessity for puncturing the vesicles at the risk of obtaining a lymph contaminated with blood, or of favouring the occurrence of subsequent inflammation.

The method which I have adopted for some time past for the extraction of lymph from the pock has, so far as my present experience goes, a double advantage, namely, that the supply of lymph obtainable from each vesicle is greater and its efficiency is increased. Out of upwards of 200 infants vaccinated by me during the past few months, I have not as yet had one ill-developed pock nor a single failure of a punctured spot, although many of the cases were from vaccine obtained from very young infants. As a general rule, I only vaccinate in four places, principally on account of the young age of the infants I am called upon to vaccinate. Down to December 31st, 1886, I had vaccinated altogether 2,685 infants, of whom, with one exception, all were successful either at the first attempt or at the second. The unsuccessful case resisted four successive attempts to vaccinate, for which no explanation can be given. The mother had never had small-pox.

A complete failure in all four spots on a first vaccination was comparatively rare, and could, as a rule, be traced to a deficiency in the lymph, for it seldom or never occurred when the lymph was obtained from children of three months old and upwards. It generally happened when the lymph was drawn from an infant less than a fortnight old, at which age the quantity of lymph is very scanty and its efficacy below the normal. It is seldom possible to vaccinate successfully more than a dozen children from one such infant; and failure in one, two, or three spots is not uncommon.

I may remark incidentally that where one or more punctures had failed to take, revaccination of the infant with lymph obtained from its own successful pock generally ensured a satisfactory result, the primary pock or pocks remaining quiescent until the pocks which followed the second vaccination arrived at maturity, that is, at about the eighth day, when they all faded away together. In these cases it was impossible to say from appearances, by the eighth day, which were the primary and which the secondary pocks. In only one case did this method of re-auto-vaccination fail, and no better results were obtained when lymph from other sources was substituted for its own. I had therefore to be satisfied with the two successful primary pocks.

My system of obtaining lymph is as follows: I drop a small bead of pure glycerine upon the centre of each pock, and then gently rub the top of the vesicle with a smooth, blunt instrument (the round glass head of a shawl pin does excellently). After the lapse of two or three minutes the bead of glycerine will have

increased to nearly double its size, especially if the vesicle contain a good supply of lymph. If necessary, a second drop of glycerine may be applied after the first has been used, and even a third.

This plan avoids the risk of drawing blood, which at times it is not easy to escape doing when puncturing the vesicles. Moreover, not having to hold the infant's arm, there is no fear of capsizeing the child, the possibility of which adds to the difficulty of arm-to-arm vaccination where many children have to be vaccinated from one.

I should be glad to hear whether, in the hands of other practitioners, the same good results are obtainable. I have only given the method a four months' trial so far, which is perhaps hardly sufficient to authorise any definite conclusion.

CLINICAL MEMORANDA.

HÆMOPHILIA.

THE particulars of the following case are of interest from the very early age of the patient and the symmetrical arrangement of the phenomena.

M. S., aged 38, a primipara (married eighteen years), was on February 14th delivered of a male child after a natural and quick labour. The child was apparently healthy and strong, crying lustily. On the third day a small dark spot was observed on either side of the occiput; the day following the child had two black eyes, evidently due to extravasations of blood, the discolorations extending symmetrically above the eyebrows and on the malar bones. The eyeballs presented an unusually pearly appearance. Next morning the nurse observed a purple swelling on the external aspect of the left humerus, and in the evening the same was to be observed on the right side. The following night the umbilical cord began to bleed, which the nurse arrested temporarily by the local application of brandy and by retying. Hæmorrhage broke out, however, again on the proximal side of the ligature, and the child died from loss of blood before medical assistance could be obtained. DUNCAN R. MCARTHUR, M.D.

Sturminster Newton.

UNDER the above heading Mr. Eagle recorded a case in the JOURNAL of March 10th; and as a very similar case has just come under my notice, I think it worthy of record.

On March 8th I delivered Mrs. P., a countrywoman aged 25, of an apparently healthy male infant. The child was at the full term. It was somewhat jaundiced on March 10th, but better on March 11th. On March 12th the jaundice became more intense, and on March 13th two swellings appeared, one behind each axilla, evidently composed of extravasated blood. During the next two days other swellings appeared on the back, shoulders, front of chest, elbows, and knees. The cord separated on the morning of March 15th, and there was a continual oozing from the umbilicus till the child died at mid-day on March 16th. No treatment was of any avail.

Mrs. P. was delivered of a male infant six years ago at the eighth month. He survived his birth one month, and died much swollen and covered with lumps. Two years ago she aborted at the end of the third month, and lost much blood. I did not attend her on these occasions. Two of her brothers suffer much from epistaxis. GEORGE VINCENT, M.D., M.R.C.S.

Shouldham, Downham, Norfolk.

MULTIPLE SARCOMATA OF THE SKIN.

SARCOMA CUTIS is such a rare disease as to justify the recital of the following case. Koebner reports only two such cases (secondary), whilst Kaposi had only seen five cases of the idiopathic disease (*Hebra on Diseases of the Skin*, vol. iv); in the latter the affection always began in the soles of the feet, and was doubtless a general morbid affection from the very outset.

On October 8th, 1887, I was called to see E. D. G. E. T., a school-mistress, single, aged 32 years, fair complexion, red hair, extremely anæmic, temperature 101° F., pulse over 100 and weak. She was in bed, and could not change her position in the least owing to intense pain in the right hip; she stated that she had come two or three weeks before from near Leeds, where she had been ill and treated for sciatica for six weeks. On examination, I found a distinctly localised oval swelling, four or five inches in length and three inches in width, situated immediately over the upper and back part of the right ilium to which it was attached; the inner

border of the swelling, which was elastic and semi-fluctuating corresponded with the sacro-iliac synchondrosis; the superjacent skin was of its natural hue and consistence, and could be moved freely over the growth, the borders of which were distinctly definable. The growth itself was neither tender nor painful, and of six weeks' duration. There was a history and marks of scrofula in the patient. Was the growth a sarcoma or a chronic painless abscess? Neither a hypodermic needle nor a small trocar could obtain pus. This settled the diagnosis. There was no history of injury, except a fall on "the small of the back" two years before from a gig. On further examination, I found several nodules in the skin of the head, face, and neck, and a few on the body, some of which projected half an inch above the skin level. The nodules varied in size from a split-pea to a pigeon's egg. Some were evidently situated in the deeper layers of the skin itself, whilst the skin could be moved over others; they were mostly isolated, some were firm, others elastic and compressible; over some the skin was of its normal hue, over others white and glistening, whilst on other nodules it was bluish-black, giving the appearance of an enlarged vein. She stated that these nodules developed shortly after she became ill, and that some disappeared entirely, but I could find no cicatrix nor anything else to mark the site of a former nodule. There was no ascertainable evidence of disease in the lungs or liver; there was dysphagia, which was probably due to nodules in the submucosa of the gullet (as in one of Kaposi's cases, in which they also appeared in the lining of the stomach, intestines, and bronchi); the fauces were quite bloodless. Cough and dyspnoea were conspicuous by their absence. The nodules continued to increase in number up to her death, which took place from exhaustion on November 17th, three months and a-half from the commencement of the illness, when no less than sixty or seventy were present on the head, neck, and trunk, the limbs, unlike all Kaposi's cases, being exempt. There was some remission in the sciatic pain before death, but the iliac growth was unaltered. There was no ulceration or gangrene of any of the nodules. The lymphatics were unaffected.

The rapidity with which the nodules developed after the first noticed growth seems to favour the view that the whole of the tumours were due to a primary disease of the blood, and were not the result of secondary infection. I regret not to have been able to obtain a nodule for microscopic examination after death, owing to the great distance (ten miles over moorland) from the patient's house and my other engagements at the time.

Stanhope.

WILLIAM ROBINSON, M.S. and M.D.

THERAPEUTIC MEMORANDA.

PEPPERMINT WATER IN PRURITUS PUDENDI.

EVERY practitioner will have had under his care cases of this troublesome affection, which have been proof against all treatment, especially in the neural forms, where the cause of the pruritus, which is, of course, only a *symptom*, is more difficult to remove. No excuse, therefore, is needed to mention a local remedy which will, if the skin be unbroken, either cure the patient, or afford relief whilst the source of the irritation is being treated.

The agent here alluded to is peppermint water, used as a lotion. The B. P. preparation of aq. menth. pip. answers well, but is bulky for carrying about, and is incapable of concentration unless rendered alkaline. This is best done by borax, as being in itself soothing and antiseptic. Patients can easily make their own lotion, as required for use, by putting a teaspoonful of borax into a pint bottle of hot water, and adding to it five drops of ol. menth. pip., and shaking well, the parts affected to be freely bathed with a soft sponge.

If no cracks or sores are present, this lotion will remove the itching, but if there be eczema, etc., or rawness from scratching, it is inapplicable, olive oil, with five grains of iodoform to the ounce, being then more useful. The greatest and most permanent relief is afforded in the neural form, especially in the reflex pruritus which often accompanies pregnancy, and which then may take the place of reflex sickness or vomiting. It is also very useful in the pruritus which occurs in the climacteric, or in elderly women, in whom it may be only part of a general pruritus, and also in those cases of women of all ages, where the urine simultaneously becomes of very low specific gravity, without any evidence of having a gouty or granular kidney as a remote cause.

In pruritus due to pediculi, ascarides, an irritable urethral car-