by means of a process of evolution, of that which gives to an already existing organism that property by which it becomes infective. I have no reason for suspecting that the *infectious* inflammatory sore-throat of which I write ever leads up to true diphtheria. As to the suggestion that this throat-affection may possibly be of an erysipelatous character, I have not seen in any case erysipelas in any other part of the body of an affected person. I remember that in one family living in a most healthy locality, but drinking dirty water, the mother suffered from erysipelas of the scalp, and the father and several children exhibited this throat-affection. I cannot regard this affection, then, as of an erysipelatous character, although, adopting Dr. Thorne Thorne's theory, it might possibly derive its origin from that blood-disease and become infective. The tonsils are the primary seat of the local affection. The only points of difference between it and quinsy are, that it is communicable—that it is accompanied by a certain amount of anæmia and depression, and that the mortality from it is probably slightly greater. Mr. Arthur Clarke, a medical man of Stock, Essex, who was the first to direct my attention to the disease, calls it "spreading quinsy", and I think it could scarcely be better designated.

Sir John Rose Cormack suggests a very small blister on the arm or elsewhere as a sure test for distinguishing diphtheria from what he calls "simple membranous sore-throat". If the case be diphtheria, the blistered surface will become covered with a diphtheritic pellicle; if it be not diphtheria, no false membrane will appear. The public are too prone to speak of every throat-affection by the name of diphtheria; and I regret to find that many practising medical men, more especially those in the rural districts, are less particular than they should be in the diagnosis and nomenclature of throat-affections. As the disease does not often destroy life, the disinclination on the part of the public to submit to such an interference with individual liberty as will prevent its extension forms a difficulty in successfully dealing with it, which is almost insuperable in the present unenlightened state of opinion in the rural districts.

FRACTURE OF THE CLAVICLE, FOLLOWED BY MYELITIS, PARALYSIS, AND DEATH.

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FRACTURE of the clavicle from muscular action, and that in its turn followed by inflammation of the spinal cord, paralysis, and death, is of sufficient interest and rarity to the medical profession to induce me to publish the following case in the *BRITISH MEDICAL JOURNAL*.

Miss H., aged 49, single, was in fair health on July 17th; on which day she was carrying a stoup (kind of pail) of water up a flight of stairs. She had only lifted the stoup and ascended one or two steps, when something gave a loud crack and her arm became powerless. On visiting her immediately after the accident, I found that she had sustained a fracture of the left collar-bone, which was broken obliquely about its centre, giving rise to considerable displacement and swelling over the part. The fracture was very readily reduced, and the fragments were retained in position by suitable appliances. The elbow was fixed to the side, and the arm brought well upwards across the chest to the opposite shoulder, and retained there by a sling and other breast-sheet. The patient now expressed herself as feeling quite easy. During the next few days, she complained of pains in the left hand, both shoulders, and neck, which I attributed to rheumatism. Her pulse was normal; there was no heat of skin, at least not of any moment; her appetite was unimpaired; she was restless at nights.

On July 23rd, six days after the injury, in order to relieve the pain, I readjusted the appliances; and at the time observed that the integuments of the left side, down to and including the left breast and up the left side of the neck, were much discoloured, and the superficial veins seemed enlarged and very apparent over the site of the fracture and for some distance around it. I could, however, find no preternatural pulsation or fluctuation. The pulse was felt at the wrist, and the left hand was comfortably warm. Suspecting that, perhaps, this might be a case of fracture from a preternatural brittleness of bone, in a person of rheumatic or carcinomatous diathesis, I inquired particularly as to my patient's former health, and found it very satisfactory. She had never had any serious illness, and had no family history of cancer, rheumatism, or paralysis.

From this time to the beginning of the fourth week, she went on satisfactorily, and, at the fourth week, I found the fracture had united. The bandages, with the exception of the sling, were removed, and the patient went to Edinburgh and Portobello for change of air. She expressed herself as "quite able for the journey", although she was weak

in general health and anæmic. The swelling over the site of the fracture was becoming less, and the yellow discoloration was passing away. During the first week or two after removal, she felt that the change of air was doing her good, and she walked out for about an hour each day.

On August 31st, she journeyed by tramway-car to the seaside, a distance of three miles, where she took a little exercise on the shore, and returned in the same manner. On the way home, she experienced great pain in the shoulders, and the same night she was very restless and sleepless. On the following day, she complained of the pain in the shoulders; feeling of tightness round the body; prickling through the body, especially in the fingers, which latter she described as feeling stiff and ironlike. Her face was flushed; the bowels were confined; the skin was perspiring. These symptoms continued with greater or less severity until September 6th, when both upper extremities became paralysed, although she still had the use of the lower part of the body. On September 7th, the paralysis extended to the lower extremities, and also to the neck, as evidenced by the inability to walk and stiffness of the neck. When she lay on her bed she could draw up the legs a little, but could not turn her head to either side—nor, indeed, was she able to turn herself upon her side. The skin was perspiring freely; her face was flushed; tactile sensibility was diminished, but the other special senses were quite normal; the extremities were warm; respiration was natural. She stated that she "felt as if she were going to fly at times".

On September 10th, the lower extremities and the bladder became quite powerless, and the catheter required to be used for the next two days to empty the bladder. On September 11th, the patient slept a good deal. She gradually grew worse towards the night; the breathing became laboured; and she died in a semiconscious state on September 12th.

In conclusion, I may mention that the very general nature of the observations as to the pulse, respiration, and temperature in this case is due to no neglect on my part; but is attributable to the fact of the patient having passed into the hands of other medical men after September 1st. These gentlemen gave her every care and the best of treatment, and doubtless observed many things which my imperfect opportunities prevented me from doing. Still, the few facts which I have mentioned should tend to confirm the diagnosis. In the absence of a *post mortem* examination, it may reasonably be conjectured that this was a case of inflammation of the lower cervical portion of the spinal cord, and probably due to the concussion at the time of the accident to the clavicle, and kept up by the irritation at the site of the fracture. At the same time, it was possibly a case of cancerous disease of the clavicle resulting in fracture, and that in turn causing extension of the same disease to the spinal column.

CLINICAL MEMORANDA.

EXCESSIVE SECRETION FROM THE NOSE.

THE case of watery fluid dropping from the nostril read by Sir James Paget at the last meeting of the Clinical Society reminds me of a case of disease of the fifth cranial nerve which was some years ago under my care, and which is published in the *Medico-Chirurgical Transactions* for 1869, vol. lii, page 28. In that case, there was, in addition to many other symptoms consequent upon the withdrawal of nervous force from the sphere of the trifacial, an incessant flow of fluid from both nostrils, which, on running down to the lips, made the skin very sore, and caused the moustache to fall out. In consequence of the incessant maceration which went on, the middle portion of the upper lip appeared quite white, like a scar from burning or from the application of sulphuric acid.

The same excessive secretion took place in the mouth, and the patient was, therefore, obliged to keep a pocket-handkerchief almost constantly applied to his nose and lips, in order to catch the stream of liquid. A handkerchief would become saturated with liquid in a short time. The lips appeared covered with froth, such as we see it in a patient who has just come out of an epileptic attack. Both corners of the mouth were very sore, being macerated by the constant flow. This liquid was slightly alkaline.

If we read Sir James Paget's case by the light of the one just alluded to, in which the cause of the flow was manifest, the pathology of it ceases to be so obscure as it was pronounced to be by our eminent *confrère*. The nasal mucous membrane receives its nervous supply chiefly from the ophthalmic branch of the trifacial nerve and from the sphenopalatine ganglion, the secretion from the mucous membrane being caused by the sympathetic and regulated and inhibited by the fibres of the fifth