quent examination showed extensive dead black tissue, extending from the neck into both mediastina, and along the pericardial and pleural membranes. Half the heart, and the upper half of each lung, were enveloped in a stratum of wholly gangrenous tissue nearly half-an-inch in thickness, the serous membrane remaining smooth and unbroken. A diagram (Fig. 3) will help to give clearness to my brief descriptions. In all the diagrams, the shaded portion suggests the area and direction of the dead cellular tissue.]

SCARLATINIFORM RASHES AND SCARLATINA.

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THE difficulty which attends the diagnosis of scarlatina-like rashes under certain conditions has received striking illustration in Mr. May's cases, the results of which he has recorded with such honourable candour in the JOURNAL of January 4th. The question whether such eruptions are scarlatinal or not most commonly arises in connection with children, and I not unfrequently find myself confronted by it in the wards of the hospital and elsewhere. But, although familiar enough with the problem, I know of no ready and infallible key to its solution. I have failed to discover any reliable sign by which the simple eruption may be instantly and certainly distinguished from the contagious exanthem which it simulates. It is sufficiently established, I think, on the one hand, that patients with open wounds from accident or operation are extremely susceptible to the poison of scarlatina; and, on the other, that a scarlet rash of simple non-contagious character also frequently occurs under similar circumstances. And it is this equality of antecedent probability which renders the right decision of the question so important, and at the same time so difficult.

That erythematous eruptions, closely resembling the rash set up by the poison of scarlet fever, are also produced by other agents, is undoubted. Such are the so-called medicinal rashes which occasionally follow the administration of belladonna, of copaiba, and of quinine. Similar general scarlet rashes have been observed by Dr. Handfield Jones in malarial disorders in children, and by myself in a very marked form in a severe case of tertian ague in a child, recorded in the JOURNAL of last year. But, further, I think there can be no doubt that a scarlatiniform eruption, which is not contagious and not followed by the sequelæ of scarlatina, does arise in various traumatic conditions independently of the scarlatinal poison. I have seen it more than once follow paracentesis thoracis for empyema, after various surgical operations, and in a case almost exactly parallel to the one related by Dr. Braxton Hicks. One of my own children received an injury to the thigh, which was followed by abscess. There was no external wound; but at the commencement of the suppurative process a general scarlet rash appeared. It could not be traced to infection; it did not infect others. The rash disappeared in twenty-four hours; it was not followed by desquamation or sequelæ. In such a case, as Dr. Braxton Hicks points out, the introduction of scarlatinal poison from without by inoculation is out of the question. The eruption must be due to the absorption of scarlatinal poison through the ordinary channels, or of septic or deleterious matter developed *in loco*, or otherwise a result of the traumatic pyrexia.

Now, although there are, I believe, no certain and absolute data by which this "surgical erythema", as I am in the habit of calling it, can be at once distinguished from true scarlatina in its slighter forms, yet there are one or two points to be noted in connection with it which afford some aid towards a correct diagnosis. Surgical erythema, as far as my observation goes, is constantly wanting in certain leading features of typical scarlatina.

1. There is no swelling of the tonsils, no enlargement of the glands, although the fauces may be reddened.

2. The tongue never presents the strawberry-appearance. It is furred, perhaps; but the coating has not the whitish or yellow tint seen in scarlatina.

3. The rash is often not universal, but confined to the body and the parts covered by clothes, the face being free. Sometimes it is in more or less distinct patches, with portions of comparatively clear skin between. It rarely lasts more than twenty-four hours, and is never, in my experience, followed by desquamation: it is not sufficiently intense, and its duration too short.

Now, these variations from the perfect scarlatinal type are, no doubt, met with in extremely mild cases of scarlatina. They merely narrow the issue by excluding *well-marked* scarlet fever. The decision between surgical erythema and the slighter forms of scarlet fever can only be arrived at by the additional evidence, by the history and symptoms. Not unfrequently a positive conclusion is impossible, and the only safe practice is to isolate such cases, at any rate for a time.

NOTES OF A CASE OF HÆMATURIA.

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HÆMATURIA, or bleeding from the urinary passages, in the male may proceed from the kidneys, bladder, or some other portion of the tract.

The causes of hæmorrhage from the kidney, speaking generally, are wounds, contusions, and other injuries of the organ, intense hyperæmia, and the hæmorrhagic diathesis. The presence of calculi in the pelvis of the kidney is one of the most common causes of injury of the organ. As an example of nephritic hæmaturia dependent upon calculus, the following typical case may be recounted.

A. B., aged 36, groom, married, living at Gateshead, was admitted into the Newcastle-upon-Tyne Infirmary under my care December 8th, 1877. He stated that for two months he had been passing bloody urine, and that he had been under medical treatment for six weeks, and that at times the urine had become less coloured, but had never been free from blood. He had suffered seven years ago in the same way, when he had been under the care of the late Dr. Charlton, who informed him that he was suffering from stone in the kidney.

The present attack had occurred after a long ride on a restive horse. He expressed himself as feeling very weak, and was much disconcerted at the continuation of the condition, fearing that he would bleed to death. His mucous membranes were very pale, and his pulse was 84 and very feeble. He complained greatly of pain in the left lumbar region, which pain passed forwards and down the front part of the thigh, and also into the scrotum and left testicle. This pain was paroxysmal, and at times very excruciating. The urine was bloody, but without clots, the blood being uniformly diffused; when viewed by reflected light, it was a dirty red, but by transmitted light a pure red. After standing for some time, a slightly flocculent brownish sediment precipitated. Upon microscopical examination of the sediment, very few epithelial cells were seen, but numerous blood-corpuscles, some well preserved, others somewhat altered, were displayed, also blood-casts of the uriniferous tubules. No cells having the appearance of malignancy were recognised. The specific gravity was 1010, and the reaction was faintly acid. He was carefully interrogated respecting the passing of the urine, and he answered that it had never stopped; that in colour it had always been alike throughout the act of micturition, and that which was passed early was just the same as that voided at the end of the stream.

The diagnosis arrived at was that the blood was from the left kidney, and dependent upon a calculus situated in the pelvis.

He was prescribed ten grains of gallic acid every four hours.

December 12th. The urine was now of an amber colour; and, when examined under the microscope, very few blood-corpuscles were recognisable.

December 15th. The urine was perfectly clear, of a bright amber colour, and free from albumen; and, when examined by the microscope, no blood-corpuscles were seen.

He was prescribed two grains of sulphate of quinine, fifteen minims of tincture of perchloride of iron in an ounce of water three times each day.

December 20th. By his own desire, he left the hospital to return to his own home.

REMARKS.—The diagnosis of renal hæmorrhage was founded on the presence of the symptoms of renal nephralgia and the absence of symptoms referable to the bladder, the non-existence of clots, the uniform colouration of the urine, and the microscopical appearances of the urine.

From the history of the case, and from the bleeding recurring upon any violent exertion, it was inferred that the hæmorrhage was dependent upon the presence of a calculus in the pelvis of the kidney. For hæmorrhage that is dependent upon the presence of a tumour, especially cancer, is usually very profuse and persistent, while the bleeding which accompanies inflammation of the kidney and the infectious diseases, or which results from venous obstruction or scorbutus, is not often very severe.

Concerning the treatment; as there was danger of exhaustion from the attacks of profuse and persistent hæmorrhage, styptics were indicated. Gallic acid in full doses was, therefore, administered, and soon its beneficial influence was manifested. This acid was selected on account of its power of entering the circulation as such, and being eliminated through the kidneys as such, and thus being direct in its action upon the bleeding point. Subsequently, the sulphate of quinine and the perchloride of iron were given with the object of renovating the blood, which had become deteriorated in a marked manner.