this subject, as I am not aware that anyone else had previously made similar observations. The production of special paralysis in consequence of localised lesions is a further development of the subject, as shown by Jackson and Ferrier.

Although I am arguing in favour of direct shocks to the nervous system, be they physical or moral, as instrumental in the production of paralysis of various kinds, I am quite open to the conviction that these conditions may be perpetuated by purely mental operations, and may also be removed by methods which act solely on the mind. As a good example of this, I may here allude to the termination of a case of hemi-anæsthesia, published in the JOURNAL, by Mr. Horrocks, House-Physician of Guy's Hospital, a few months ago. This girl, having passed through the whole ordeal of metallotherapia as well as the orthodox treatment by galvanism and medicines, remained perfectly incorrigible, and left the hospital just as she entered. The punctiform appearance of her anæsthetic arm showed how perseveringly she had been "worked at", to use my clerk's expression. A few weeks ago, her mother requested me to take her in again, which I did, and I then determined to practise a totally different plan; viz., to leave her alone. I ordered her nothing, and systematically passed by her bed, as if her case were not worth the trouble of discussing whilst there were so many sick people about her. In fact, I neglected her with a purpose, when one day I found her sitting at the side of the bed, which she had hitherto kept, and she told me that she could walk a little, and had some feeling in her right side. I then encouraged her; said that she would now make rapid progress. This she did, and soon left the hospital perfectly recovered. It, therefore, certainly seemed that the treatment by a "masterly inactivity" had been more successful than all the orthodox and novel methods practised on the first occasion. This is simply the experience which every medical man must have had in all kinds of hysterical disorders, where treatment is often as positively bad as neglect is as positively good.

In looking upon a woman's nervous system, I often picture to myself an instrument something like a differential thermometer, having a glass globe full of air and a number of pipes leading from it containing fluid, which are constantly influenced by the pressure within. I see the fluid in the pipes unceasingly oscillating or passing up and down under the slightest influence on the bulb, and, in like manner, I see in my imagination a nervous fluid continually in motion, or may be in undulation, through the whole of the nerves of the body. I witness then, as in the girl I mentioned who received a shock to her brain, all undulation cease; in another, cease on one side of the body only. The fright or blow may stop the current, and the limb is for all purposes dead; or it may have an opposite effect and throw it into a state of jactitation. If these slight causes will so derange the nervous apparatus, it is not surprising that equally slight causes will set it in order again. The nerve-force seems to be constantly ebbing and flowing under the influence of the most trivial impulses. A fall on a medicine-bottle deprives a girl of movement and feeling on one side, as well as of these of her special senses, and a sovereign tied on her leg will bring them all back again. I am often reminded of a remarkable watch belonging to a schoolfellow in my younger days, and which, in modern phraseology, was in a state of unstable equilibrium. The mere taking it from his pocket or looking at it would often arrest its movement, when a slight knock would send it on again. The works had never been good, or, being out of repair, the slightest jar would stop their action; and, what seemed remarkable, another blow would again start them into movement. So in these women, with their unstable nerves: a violent shock paralyses them, and another shock, be it galvanic or of a cry of alarm, will set them again in action. But not only a sudden effort of the will will set right the machinery, but the application of metals to the limbs or a trephine to the head.

I can, therefore, understand how a strong effort of the will will rouse the dormant powers; that is how the healthy hemisphere can send a stimulus to the inactive one; but this fact does not cover all the forms of cure which we see, nor does it afford an explanation of the production of the first symptoms. I do not see how a mere negation of the will can deprive a person of common sensation and the use of all her senses. As I before said, until the nature of nerve-force is better known, the explanation cannot be forthcoming.

OLD Yarmouth ale, like the bloaters, seems to be naturally provocative of thirst; since a sample analysed by Mr. Piessé of the Strand is said to have contained 126 grains of salt per gallon, which was considered, however, to be "naturally present in the water" with which true Yarmouth ale is brewed. It would be curious to know what would be the ultimate thirst of the ingenuous native who slakes the drought resulting from a feast of bloaters with draughts of "true Yarmouth ale".

A CLINICAL LECTURE

ON

IDIOPATHIC GANGRENOUS CELLULITIS AROUND THE RECTUM.

By FURNEAUX JORDAN, F.R.C.S.,

Surgeon to the Queen's Hospital; Professor of Surgery in Queen's College, Birmingham; Consulting Surgeon to the Women's and the West Bromwich Hospitals.

I SHOW you here a rather notable case. It is the least grave example of idiopathic cellulitis in the vicinity of the rectum I have seen. It is the first I have seen in a hospital, such cases occurring, as a rule, in the well-to-do; but our patient is a commercial traveller, so situated that hospital accommodation is a necessity to him. The more marked features of his case are those which are found in a class of cases of which I have seen a few remarkable illustrations in the private practices of my medical friends.

This man is of immense size, tall, stout, and weighing above twenty stones. He is excitable and active, and has been worried of late with reverses. He eats largely and drinks deeply. He has been much exposed to cold and wet, and, after more than usual exposure, he came in with a big swelling on the left side of the anus, extending outwards to the tuberosity, forwards to and across the perinæum, and backwards to the sacrum; it was pale, hard, and painful. Fever and extreme prostration were present. Iodine liniment was freely applied in large patches to the neighbouring skin. Incisions were also made into the swelling, and revealed most strikingly a large black mass of dead tissue, without any suppuration. There have been slight relapses, but in each relapse the black masses have become smaller. There has been no suppuration, and death has been confined to cellular tissue.

This typical but mild case (mild, I believe, from early and active counterirritation) suggests several topics for brief comment. The disease is essentially idiopathic. A kind of creeping cellulitis, not attended with much swelling, in rare cases, follows operations on the pelvic structures. In this, and in other cases which I shall briefly cite, there have been no operation and no injury.

The few cases I have seen have been in big, heavy, middle-aged men; in men of continual activity and excitable temperament, always working or travelling, or eating or drinking; in men who combined two bad habits—eating much and drinking much; in men sufficiently well-to-do to indulge at will, and who firmly believed that excess of work needed excess of victuals and liquor; in men who were indifferent to weather, and had been notably exposed to cold and wet. All the cases I have seen occurred in cold weather, and I believe they are more frequent with us in the exposed high table-land of mid-England. It is not probable that all the favouring conditions, which have been combined with singular uniformity in my cases, will always be found together. Some causes may be powerful, others feeble, others absent. Probably, idiopathic cellulitis occurs in men, chiefly because men combine the several conditions which lead to it. Freely drinking women rarely eat excessively. It is a matter of wonder, not confined to the public, that "drinkers" should live so long, seeing that they frequently take little solid food. In truth, they live so long because they eat so little. Singularly little food supports the adult. Take much food, and at the same time check metamorphosis with copious alcohol, and you lay a train for very certain pathological explosions. One of these explosions, and a dangerous one, is cellulitis around the rectum. The pale, hard, slightly lobed, extremely prominent swelling projecting between the big buttocks of a big man is not easy to describe. It may begin anywhere in the vicinity of the rectum—around the tube or near the surface; if it begin deeply, it quickly comes to the surface; if it begin under the skin, it soon extends deeply. Its deep position is sometimes known by the effects of pressure, as on the sacral plexus. In a somewhat similar disease—cellulitis of the neck—I have known paralysis of one arm appear a day or two before the dense collar in front of the neck.

The progress of the disease is very rapid. The skin over the swelling, if not cut by the surgeon, quickly melts away, and discloses a mass of dead, black, foetid tissue, but, as a rule, no suppuration. The slough comes away rather slowly; a cavity, usually of extreme size, is left, which closes tardily, and leaves, curiously, no fistula, as does the ischio-rectal abscess.

The gravest feature in the progress of these cases is the great tendency to relapse or extension, or both. Cellulitis, closely followed by

gangrene, may suddenly extend in possibly fatal, and always dangerous, directions. Here are diagrams of cases which I have seen, in conjunction with medical friends, to several of whom I am much indebted

Fig. 1.

for notes and suggestions. They are merely suggestive, but they save many words.

One diagram (Fig. 1) is based on the case of a huge man, a brick-layer's foreman, who ate a pound of meat thrice daily, and drank spirits at a similar rate. In a drunken fit, he sat the whole of a cold November night on a doorstep. A swelling so large in a man so big I had never seen. After a few days' illness, with extreme prostration and high temperature, peritonitis set in, and he quickly sank. An incision (persistently refused for some days) showed an enormous mass of black gangrenous tissue, stretching into the pelvis beyond the reach of the finger. There was no suppuration. His family adviser—himself an able hospital surgeon—in a note about the case, uses the just expression, "dangerous cellulitis".

In another case, where the build, habits, and exposure were such as I have described, the family adviser told me that the rectal cellulitis was preceded by pains in the limbs, vague in locality, but so severe that the man's shouts could be heard in the street. Here the skin, no knife being used, rapidly disappeared, disclosing a large black gangrenous mass. While this was slowly coming away, sharp bladder symptoms set in—cystitis, more or less retention, and the formation of a large abscess near the neck of the bladder, which burst into the urethra. For some time, pus and mucus appeared in large quantities in ammoniacal urine. The convalescence was extremely tedious, but ultimately, under the skilful guidance of his family physician, the parts healed and left no fistula.

Yet another example, in a large manufacturer, an ex-mayor, the leader of his political party in a Worcestershire town, where political feeling runs high; who kept "a good table", and who was "never at rest". After a formidable cellulitis in the vicinity of the rectum, especially between the rectum and the sacrum, he appeared to be slowly recovering, when suddenly, with a return of high temperature and prostration, a crepitating swelling was found under the left larger gluteal muscles; when this was opened, my finger readily passed to the ischio-rectal opening in one direction, and the capsule of the hip-joint in another. Beginning at the lower part of the rectum, the cellulitis, during a relapse, ran upwards inside the pelvis, but fortunately turned at a right angle through the sacro-sciatic opening, and came outside the pelvis again in the gluteal region. (Fig. 2.) Several grave incidents occurred in the progress of this case,* upon which I cannot now dwell.

* These cases will be given more at length in another edition of my *Surgical Inquiries*.

One of these was alarming hæmorrhage from the seat of the cellulitis through previously-made openings, which the family adviser ingeniously checked by using a Barnes' dilator in the rectum. Another was the

Fig. 2.

appearance of a pleuropneumonia of most threatening aspect, but which, happily, kept within circumscribed limits. Recovery followed by very slow steps. Many medical friends and advisers, including an eminent Birmingham physician, were in attendance, and doubtless all helped to save a life which for some time trembled in the balance.

[ADDENDUM. An ailment at which I have already hinted as being very similar to the one of which we are speaking, is cellulitis of the neck. Here, also, in men, chiefly in adults who have transgressed in matters of eating and drinking, and who have been exposed to marked cold, a dense collar of inflamed cellular tissue forms at the front of the neck, associated with extreme prostration, fever, and copious frothy expectoration. It is extremely fatal. A case lately came under my care, in which exposure to a biting wind for many hours (in a cart, and with scant clothing) sufficed to produce cellulitis of the neck in a youth of sixteen. As there was marked dyspnoea, I made an incision down to

Fig. 3.

the trachea, when I came upon a cavity extending downwards between the trachea and sternum, containing stinking shreds of tissue, with a few drops of black, bubbling fluid. For a couple of days, he seemed much better, but then came a relapse, and he quickly sank. A subse-

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.

By W. B. CHEADLE, M.D., F.R.C.P.,

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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.

By G. H. PHILIPSON, M.A., M.D. Cantab., F.R.C.P. Lond.,

Professor of Medicine in the University of Durham; Senior Physician to the Newcastle-upon-Tyne Infirmary; etc.

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.