be desired. For twelve months afterwards, he kept in good health, but at that time had a return of the sciatica from exposure to cold and wet. This, however, proved very amenable to medical treatment, and he is now in perfect health.

This poor man's sufferings were very severe, and his testimony was unequivocal as to the great relief resulting from the operation.

CASE III.—Janet L., a spinster, aged 28, was operated on by my hospital colleague Dr. Stirling, eighteen months ago, for a first attack of sciatica. The nerve was exposed in the region recommended by Nussbaum. There was a perfect cessation of all the old symptoms for twelve months afterwards. About this time, she was exposed to cold and damp, and the sciatica returned in full force. She was at once readmitted to the infirmary, to have the operation repeated. There were well marked symptoms of an acute sciatica; and besides, it was found that she was suffering from ovarian irritation, metritis, and endometritis. Having at this time charge of the female wards, and knowing the benefit which had accrued from the previous operation, I proceeded at once to repeat it. The nerve was exposed in the middle third of the thigh and easily found, although the depth, owing to her corpulent condition, was considerable. It did not present at the seat of operation any abnormal appearance, neither did I feel any adhesions giving way when it was freely stretched. Relief did not come so speedily here as in the two cases just recorded, the conditions being more complex, but in a fortnight the sciatic pain was all but gone. After appropriate treatment for her uterine malady, she was dismissed cured, at least of her sciatica.

Seven months have now elapsed, but I have heard of no return of her old disorder, and one day lately I saw her walking without any difficulty.

CASE IV.—J. M., aged 27, healthy and muscular, a wood-carter, and much exposed to wet and cold by his occupation, was admitted to the Perth Infirmary in September 1878, suffering from an attack of sciatica. After he had been under medical treatment for some time without getting any benefit, the nerve was cut down upon and stretched by my colleague Dr. Stirling, under whose care he remained for about a month. At this time, he was placed under my charge, Dr. Stirling having taken his holiday; and as there was still considerable sciatica, I repeated the operation, breaking up recent adhesions between the nerve and its sheath at the seat of the first operation. The immediate results here were somewhat disappointing, the pain subsiding but slowly. For the last six months, however, he has had perfect health, and, although much exposed during the last severe winter, has been able to continue his laborious employment without any return of his former symptoms.

CASE V.—J. C., aged 46, labourer, was admitted to the infirmary March 24th, 1879. For fourteen months, he complained of pain extending from the back of the hip down the back of the left leg to the ankle, of a gnawing character, and greatly aggravated by walking or movement, also pain extending from the groin down the fore part of the thigh. On account of this, he had often been compelled to abandon his work for a time. On examination of the limb, there was considerable wasting, the difference in the circumference of the two at the middle of the thigh being two inches. There was also diminished power in the left leg, the muscles of which were atrophied.

On March 31st, the sciatic nerve was stretched, the incision being made in the middle of the thigh. After this, the old pain in the back of the limb disappeared, and, although the patient had pain for a time at the seat of operation, he never had a return of his sciatica. After the operation, the sensation in the left foot was all but gone; power was much diminished; he could not raise his leg from the bed. The faradaic current was applied daily to the muscles of the leg, and the metallic brush to the skin of the foot. In a short time, sensation had returned to the foot, and he was able to raise his leg and flex it freely.

He left the infirmary on May 31st, in the following condition. He had no sciatic pain, but complained of a burning pain in the foot, extending to a little above the ankle. Power of motion in the leg and foot was diminished, but there was no pain on walking; the pain in the anterior crural region was gone.

REMARKS.—It will be observed that the sciatica, although of long standing in this case, was cured by the nerve-stretching; and I have no doubt that the anæsthesia and diminished power would have been entirely removed by a continued application of the faradaic electricity, had our patient not left prematurely of his own accord.

AN inquest has been held at Middleton on the body of a child, two months old, which had died after a dose of laudanum administered by its mother because it was "very cross". The coroner remarked that these cases betrayed such an amount of carelessness that he thought it right to submit the facts to the public prosecutor. The inquest was adjourned.

A CLINICAL NOTE ON PHLEGMASIA DOLENS.

By FANCOURT BARNES, M.D., M.R.C.P.,

Physician to the British Lying-in Hospital; Assistant-Physician to the Royal Maternity Charity of London.

PHLEGMASIA dolens has always been a subject of great interest to the obstetrician, opinion varying as to the share which phlebitis or lymphadenitis has in its production. As thrombosis or plugging of the iliac and femoral veins has been so frequently met with in parturient women, an easy solution of the occurrence is found in the supposition of an inflammation extending from the internal surface of the uterus along the uterine sinuses to the iliac veins. If, however, a similar thrombosis or phlebitis can be found in other parts of the body, the above explanation is insufficient, and some other cause must be conceived, having its seat in a general morbid or unnatural condition of the blood. The case would then be somewhat analogous to that not unfrequently met with in other conditions than those of the puerperal state; I allude to that plugging of the veins, or phlebitis, which may simultaneously affect several parts of the body. In gouty subjects this is not uncommon; and, under other quite unknown conditions, a plugging of the veins in the legs or arms may frequently be seen. Sometimes, indeed, an obstruction of the veins may be found in all the four limbs at the same time. In connection with this rare condition, I have thought the following case of sufficient interest to justify its being placed on record. The fact that in it one arm as well as both legs were attacked, supports clinically the theory that the plugging of the veins does not depend alone on a continuous inflammation proceeding from the uterus, but that the blood in its entirety has undergone a morbid change.

On March 31st, 1879, I was summoned by Miss Thompson, midwife to the British Lying-in Hospital, to see a young woman, primipara, aged 24, who had been safely delivered on March 25th of a living female child, after a natural labour of twelve hours. She was single, and had had some mental worry. The lying-in went on smoothly during the first three days, and on the fourth day the milk came on freely. She then became slightly feverish. On the 29th, she had not slept, and was in an excitable state. She took a dislike to, and complained of, the nurse. She had several attacks of syncope. On the 31st, I saw her, and found the abdomen swollen and tender to the touch. Pulse 120; temperature 103° Fahr. There was clearly some pelvic peritonitis. She was ordered quinine and opium pills, three grains of quinine, one-half grain of opium, twice daily. On April 1st, she seemed to be somewhat better, and remained about the same until April 5th, by which time the lochia had nearly ceased. On the 12th, symptoms of puerperal mania appeared. She passed urine into the bed. On examining the chest, loud bronchitic *râles* were heard over both lungs. The child had been suckled for the first four days, but had been sent away on account of her weakness. The quinine was increased to ten-grain doses, when she became deaf. The abdomen was not enlarged, but there was tenderness over the right iliac region. Temperature 103° Fahr.; pulse 111. There was a purulent thick discharge from the vagina, occasionally tinged with blood. The uterus was, therefore, washed out twice a-day with a 1 in 40 carbolic solution. On the 23rd, the left leg began to swell. Her maniacal symptoms had diminished. On the 28th, the right leg began to swell; and on the 30th, the left arm was swollen and white, like the legs. There was also some stiffness in the right arm, but it did not swell. On May 1st, both legs and the left arm were white, oedematous, and swollen. They were all three enveloped in cotton-wool. The general symptoms were worse; respiration 40; pulse 130; temperature 102° Fahr. She had slight rigors during the last three days. She took her food well; beef-tea, milk, brandy, port, champagne, and grapes. The bowels acted regularly. Since the left leg began to swell, she had several attacks of lividity. On May 4th, the pulse was 140; temperature 103° Fahr.; respiration 48; tongue dry and peeled; sordes round the mouth. The arm and leg still remained swollen, and continued to until her death. She was quite sensible, and only complained of thirst, continually asking for tea. She remained in this condition until May 10th, when she died at 1.30 A.M. It was impossible to obtain a *post mortem* examination.

In the causation of the site of the coagulation, mechanical causes seem to have some influence. It is almost invariably in the upper part of the limbs and at the base of the skull that thromboses originate; for example, in the femoral veins in the legs, the axillary veins in the arms, and the sinuses of the dura mater in the skull. The reason of this, according to Lancereaux (*Traité d'Anatomie Pathologique*, tome premier) is, that these vessels are situated exactly on a level where the walls of the veins are no longer supported by neighbouring structures, and, consequently, where the force of thoracic aspiration tends to

diminish and disappear. It is at these points that there is always a tendency to stasis of the blood-current in the venous system, and it is natural that at these points the coagulation should occur.

The case just described points clearly to some general blood-poisoning, and the occurrence of thrombosis in the axillary veins in cancer, gout, and phthisis, can all be explained on this supposition. It has been pointed out by Murchison that one of the most troublesome sequelæ of typhoid fever is phlegmasia dolens, and in the left leg. All these clinical facts, together with the case which I have just related, point to a blood-poison as the cause of the thrombosis; the site of the coagulation being determined, as Lancereaux states, by purely hydrostatic influences. In no other way, does it seem to me, can the fact of this patient having the same phenomena in an arm as well as in both legs be explained.

THE DIAGNOSIS OF RÖTHELN.

By JAMES ROBINSON, M.D., Dunscar, Bolton.

So much uncertainty seems to prevail as to the correct position of rötheln in relation to the other exanthemata—whether it is a disease admitting scientifically correct diagnosis, or merely a modification of either measles or scarlatina, or a combination of the two—that I am induced, without further apology, to record the results of my own observations during two rather extensive epidemics of the disease recently prevalent in my locality. In its initial stages, progress, and decline, rötheln presents such distinctive characters, distinguishing it from both measles and scarlatina, that it is rather a matter for surprise that there should be such ambiguity and doubt as to its proper position in nosological medicine. That the various symptoms constituting the disease have been observed and noted by physicians, for a considerable number of years, there is not the slightest doubt; but they have been regarded by most, even at the present time, as special anomalies in the course of either measles or scarlatina, the presence or absence of certain prominent symptoms relegating it to a position under the head of one of them. In the last edition of Aitken's *Practice of Medicine* will be found the most correct description I have seen; but this differs in many essential points from my own observations of the disease. Niemeyer classes it under the head of roseola febrilis, and describes it as a modification of measles and scarlatina, naming it rubeola morbillosa or rubeola scarlatinosa, just as the skin or throat symptoms are most prominent; whilst it finds no place at all in the *Nomenclature of Diseases* issued by the Royal College of Physicians. A superficial observer, attracted by some prominent symptoms of measles or scarlatina, might diagnose it as one or the other; yet a more careful investigation would discover many minor and major differences in its course and termination, placing it without the category of either. The majority of my cases occurred in children, the greater portion of whom had had an attack of measles at some time previously, and many of them scarlatina. I saw the disease in three adults, all of whom had measles in childhood and one of them scarlatina. Rötheln, in its general character, presents various degrees in severity, just as in the allied diseases scarlatina and measles.

In the simple form, the rash is well out, the sore-throat is slight, and the irritation of the bronchial mucous membrane is moderate, with slight coryza and sneezing.

In the severe form, the catarrhal symptoms are still very perceptible, but the brunt of the attack is borne by the throat.

There is also an intermediate variety, in which the general symptoms are severe, and the influence of the poison is exerted equally upon the skin and on the mucous membranes. The period of incubation seems to vary, generally being about six or seven days, at the end of which time symptoms of a slight cold make their appearance, speedily followed by a considerable and sudden rise in temperature; hoarse cough and sore-throat, accompanied by watering of the eyes, headache in adults, or a convulsion in children, sickness, and sometimes severe vomiting. On the second day of the fever, the rash makes its appearance, usually first on the neck and chest, afterwards the trunk, face, and extremities, in patches of varying size, which soon coalesce and form larger ones, less crescentic in form and of a brighter colour than in measles, attended by considerable itching, and perceptibly raised above the level of the surrounding skin. It begins to fade on the following day, its complete subsidence being rarely prolonged beyond the third or fourth day, with slight desquamation of the cuticle, which in mild cases is almost imperceptible.

The temperature, at first very high, often reaching 103° or 104°, falls with the subsidence of the rash, unless the throat-symptoms, always present, predominate, when it continues high until the termination. The pulse may be 120 or 130, or even more frequent, declining suddenly with the temperature. There is sneezing, and the eyes are suffused,

but severe coryza is absent; hoarse and troublesome cough, with sometimes severe bronchial catarrh, is also present.

In mild forms of the disease, it most resembles an attack of measles, with sore-throat of varying intensity and swelling of the cervical glands. In the more severe types, it is most like scarlatina anginosa, with the rash and catarrhal symptoms of measles. I have not observed any suppurative of the cervical glands, albuminuria, or dropsy, even when the scarlatinal symptoms seem to be in the ascendant. The most frequent complications seem to be bronchitis and pneumonia. The mortality, in my experience, is low, and death occurs most frequently, from chest complications. The essential points in the differential diagnosis of rötheln from measles are in the presence of the throat and gland symptoms, and the early period at which the rash makes its appearance; and from scarlatina, in the presence of the catarrhal symptoms, the character of the rash, the manner in which desquamation of the cuticle takes place, and the complete absence of the sequelæ common in scarlatina. The strongest evidence of its non-identity with those two diseases, separate or combined, is that it is not protective against an attack of either, nor *vice versa*; and this fact alone goes far towards establishing its claim to be classed as a specific and separate disease, possessing well-marked and distinctive diagnostic features from any other of the exanthemata.

SURGICAL MEMORANDA.

ANTISEPTIC DRESSINGS IN MILITARY SURGERY.

THE JOURNAL of February 28th has just reached me, containing an inquiry from Surgeon-Major MacNamara respecting the best substitute for Lister's antiseptic treatment for wounds. I may mention that carbolic-oiled lint (one in forty) was generally used at the primary dressing of wounds received at the battle of Ulundi. Carbolicised tow and also tenax were applied to some of the injuries; but they were oftener employed to form pads, cushions, or swaths for the wound, outside the lint-dressing, to absorb discharges. This treatment was attended by the best results. The hygienic conditions affecting the wounded were certainly good; the air was pure, the climate cold; there was no malaria or ground emanations; the patients being well fed and in good spirits, and the camp moving daily.

It is doubtful whether Listerism proper could ever be practised at the first line of assistance in any engagement. There would not be the time sufficient to apply the special exactness required for this method. Even at Ulundi, the last of the wounded were obliged to be hurriedly treated, as the division was waiting for the "dressing" to be finished to move on to the king's kraal. I think, however, that a simple antiseptic treatment, consisting of carbolic oil or lint, is sufficient dressing at the outset for all ordinary gunshot wounds.

Dr. MacNamara, of course, is aware that Lister's method is not applicable to every kind of gunshot wound. It would not be indicated, for instance, as the treatment for penetrating or perforating wounds—cases where the injury done by the ball in transit would presumably lead to a disintegration of the interior structures in the channel of injury, and to consequent purulent discharge. The apertures would heal under this mode of treatment, and be followed by extensive sinuses within.

The aqueous solution of carbolic acid, which he advocates, might probably be better than the oil for open grooved or superficial flesh-wounds, whether incidental to injury or disease, in hospital or in the field; but, for penetrating gunshot wounds, with purulent discharge, I have found the carbolic oil or lint more effective in softening the tissues at the aperture—thus facilitating the egress of pus, and creating or keeping alive, at the same time, the natural vitality of the part.

Surgeon-Major Fraser, who treated the wounded after Sekukuni's engagement, informs me that he also employed, with the best results, the carbolic oil treatment in his cases.

I think that tenax is more efficacious as a deodorant and absorbent than carbolicised tow, although the latter is softer and more comfortable as a direct application to painful wounds.

In the JOURNAL for March 27th, Dr. Snow describes the "antiseptic marine lint" (which I have not seen) as being "more oily, more tenacious, and more thoroughly saturated with tarry principles" than tenax. But as these superadd a stronger odour and rougher existence, so to speak, being precisely the qualities which render tenax preferable to carbolicised tow for direct application to the slough of a wound, it follows, if tenax be inferior to the marine lint in these desirable qualities, that the latter would be as preferable to the former as the former undoubtedly is to carbolicised tow for direct application to suppurating wounds.

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