doing all in as short a time as possible, that he "might get a few minutes' smoke" at the ladder-foot before his next journey up. More than once, too, he has foolishly tried with how heavy a weight he could climb, and has been "brought to" before getting to the top. Then his master also vends beer, and again the patient's physical power has been called in to deliver eighteen-gallon casks at five o'clock in the morning: a supplement to his other labour which brought with it the added danger of an unlimited allowance of beer. This has been his employment for many years; but for six or seven years, and more particularly for the last two or three, he has noticed that his breath was apt to fail him a little occasionally. After climbing the ladder, he felt a want of breath sometimes; he "used to get a touch of it now and again when he got to the top", and had to rest his hod for a few minutes before depositing his load. Sometimes he has been taken with giddiness on reaching the scaffold; he thought little of it, and used "to take hold of something and hold it till his head got right, telling his mates what was the matter". Again, when getting to the bottom of the ladder, he became liable to feel a lightness in his head, and to lose his eyesight for a few minutes, as if he were "going to take a fit". The trouble would pass away in five or six minutes, and he would mount again. That he put much strain upon his muscles, was evidenced by their aching at night. He took no note of these warnings, but continued his work, and prides himself on never having lost a single day.

After making fifty-nine hours last week (five of them overtime), he went to bed on Saturday considering himself in good health, but at four in the morning was suddenly awakened by a severe attack of what proved to be cardiac dyspnoea, for which he was admitted into the Birmingham General Hospital on the following day (June 14th). Several paroxysms of considerable severity have followed. He presents a very loud regurgitant aortic *bruit*, with almost complete loss of the aortic second sound. He has, besides, a systolic *bruit* at the apex. The apex of the heart beats in the mammary line.

The patient has only once had some rheumatic pain in his hip, which did not disable him. Twenty years ago, he had some venereal affection two or three times; and at present his legs present several cicatrices of a very regular circular or oval shape, and much enlargement of the upper half of one tibia.

A CASE OF AMAUROSIS FUGAX.

By CHARLES EDWARD GLASCOTT, M.D.,
Surgeon to the Royal Eye Hospital, Manchester.

THE following case derives much of its interest from the circumstance that we have here a man in perfect health, and engaged in his daily avocation, suddenly plunged into the most utter darkness, and gradually restored to perfect vision in the course of a fortnight. This occurred without the slightest morbid change observable in the eyes, and was not referable to any known cause; nor was it possible to suggest the cause of the blindness.

Thomas C., a miner, aged 24, was brought to me suffering from sudden blindness. The previous history fails to throw any light upon the etiology of the case. There was no kidney or heart-mischief, no evidence of syphilis, no history of fits, giddiness, or other nervous symptom. He never had had any disease, but a fit of colic four years ago, and had worked as a collier for the last fourteen years without losing a day's work from sickness; and the only accident he ever had was a small scalp-wound on the occiput eighteen months ago. He had been a teetotaler for five years, and only smoked one ounce of tobacco per week.

I first saw him on January 27th, 1877. He stated his case as follows. On going to work at 6 A.M. that morning, his sight was perfectly good, and he worked at getting coal till 8.30, when he noticed suddenly that he was in darkness, and called out to his mate that his lamp had gone out, referring to his Davy lamp which hung at a distance of four feet. He was told that it was burning brightly; but this he refused to believe until the lamp was handed to him, and he found it to be hot; he was then brought to the pit-mouth, but he could not tell when he reached the daylight.

I saw him that afternoon, and found that, with his right eye, there was no perception of light from an argand burner, an inch and a quarter in diameter, at the distance of one foot; with the left eye, he had the very faintest perception of light. The pupils were only moderately dilated; so I instilled some atropia, and made a careful examination of the whole fundus with the ophthalmoscope. The media were clear, the retinal vessels normal in calibre; the disc rose-pink, and retina transparent; the region of the yellow spot was slightly more defined than in the normal eye; and the fovea centralis was a little redder

in the right than the left eye. Next morning, the quantitative perception of light had gone from the left eye, leaving him totally without perception of light. Both my colleagues kindly examined the eyes independently, and corroborated my observations as to the apparent healthiness of the fundus. On the 29th, I ordered one drachm of unguentum hydrargyri fortius to be well rubbed into each arm, and a couple of drachms to be worn in the axillæ, spread on lint. The patient remained in the same condition until February 5th, when he first complained of a metallic taste in his mouth. Next day, his gums were distinctly spongy, and he said he could see the other beds in the ward indistinctly. On the 8th, he was allowed to get up, and could see well enough to find his way about the hospital. Daily ophthalmoscopic examination found the appearance of his fundus unchanged. At his own request, on February 10th, he was discharged, and at once resumed his work; his vision at that date was the same with both eyes—viz., $V = 1\frac{3}{4} c + 24 = 1\frac{3}{4}$. The field of vision in each eye was perfectly normal.

I need hardly say that the use of mercurial inunction in this case was purely empirical; and though we have the coincidence of symptoms of mercurialism and commencing restoration of vision, I do not consider that the cure was due to mercury. Somewhat similar cases of transient amaurosis have been treated by means of strychnia and blood-letting, and with an equally happy effect. I have waited for two years and a half (seeing the patient at intervals during that time), hoping that some circumstance might arise which would point to the cause of the affection; but the eyes at present, as they always have done, present a perfectly normal appearance to the ophthalmoscope, and have a refraction of $+ \frac{1}{4}$. Should any of my ophthalmic *confrères* have observed a similar case, I would be much obliged for any suggestion as to the cause of the amaurosis and its rapid recovery.

CEREBRAL MENINGITIS: SUDDEN DEATH FROM CARDIAC THROMBOSIS.

By H. E. SPENCER, L.R.C.P.Ed.,
Resident Medical Officer to York Dispensary.

ON the morning of June 11th, I visited an anæmic, but well-grown and previously healthy girl, aged 15. She sought relief on account of an inflamed ankle, which she believed had been "twisted" by a slip ten days previously. I found the girl rather feverish and inclined to be sick; her foot and the lower third of the leg were hot and cedematous; but, as no symptom of any gravity was noticed, I did not very minutely examine the general state. The suspicion of a septic element in the case did occur to me, as the girl had been for two months acting as occasional nurse to another of my patients—a woman in whose legs some cellulitis had been set up. The next afternoon, an urgent summons to the case was sent during my absence; but, on visiting the case at the end of my rounds, I was much astonished to find that the patient was lying dead on the sofa, having expired about 4.30 P.M.

The friends stated that, during the preceding evening, the girl had begun to wander in her talk, and had continued more or less delirious during the night. In the morning, however, she was calmer, and persuaded her friends to let her be dressed and brought downstairs. The delirium came on, with intervals, during the day; and about half-past four, without previous dyspnoea or other warning, she "fainted", and in a few minutes was dead. There had been constant vomiting for about twenty hours. [The girl, who had the appearance of being eighteen or nineteen years of age, had menstruated regularly for eighteen months, the last time a fortnight before.]

Necropsy, twenty-four hours after death.—The body was well-nourished and muscular; rigor mortis was not well-marked; the lungs were normal; the heart was muscular and of normal size; the right auricle contained a firm fibrinous clot, evidently *ante mortem*, which sent a prolongation through a patent foramen ovale into the left auricle. [There had been no cyanosis.] The left auricle contained a large recent coagulum, which extended through the mitral orifice. The right ventricle was empty; the valves were healthy. The spleen was remarkably pale; the liver was also pale. The pia mater was everywhere hyperæmic; there were patches of lymph on its upper surface. The larger veins were markedly opaline. The convolutions were flattened; the adjacent sides of the Sylvian and other fissures were adherent. The brain generally was injected, except at the base; the ventricles were empty. No embola were found in the vessels. I was assisted in the examination by my colleague Mr. J. O. Horden.

I regret that the history is in so many respects incomplete; but, so far as an opinion can be based on the facts, it would appear that the cause of death was cardiac thrombosis, determined by the general anæmia.

In this connection, the pallid spleen and liver must be considered. The relation of the imperfect auricular septum to this event suggests another topic for reflection. I do not see any adequate cause for the meningitis, all the recognised ones being apparently excluded. The question of septicæmia seems to be an open one.

CLINICAL MEMORANDA.

PSORIASIS PALMARIS.

I CAN corroborate, from my own experience, the statement made in the JOURNAL of June 7th by Dr. McCall Anderson, that there are three affections of the palms and soles which closely resemble each other, viz., eczema rimosum, simple psoriasis palmaris, and the so-called syphilitic psoriasis palmaris, and that, therefore, no absolute statement can be made, as Dr. Spender suggests, that "there is no such thing as psoriasis palmaris except as a syphilide", although everyone will agree that simple psoriasis of the palm is exceptional. With regard to the syphilitic affection, there is one diagnostic point that has not been alluded to in the JOURNAL which is often a help in doubtful cases; and that is, that the syphilide almost invariably begins in the centre of the palm, while the two diseases which so closely resemble it do not as a rule. Even here, however, no absolute statement can be made. I have a patient at the present time attending the skin department of University College Hospital, with well marked simple psoriasis affecting the trunk and usual situations; and, since he has been under treatment, a thickened, scaly condition appeared on the ball of the thumb close to the centre of the palm, which has yielded to a strong application of cantharides. The patient is a robust, healthy-looking young man, without the least evidence of syphilis, and there were no patches of psoriasis on other parts of the hand. Two years ago, a man was attending the skin department with an eruption upon the palms of the hands, consisting of circular well-defined patches about one-third of an inch in diameter, covered with fine silvery scales. There were one or two on the sides and back of the fingers, but none elsewhere. Similar spots on other parts of the body would have been unhesitatingly pronounced to be psoriasis, and the eruption was not at all like its syphilitic namesake. He had had several previous attacks, always on the hands, strenuously denied syphilis, about which he had had previous inquiries, and the eruption was cured by treatment suitable for simple psoriasis.

H. RADCLIFFE CROCKER, M.D.

In reference to Drs. Spender's, Living's, and McCall Anderson's very instructive papers on psoriasis palmaris, I may state that I am in the habit of recognising five distinct diseases that are wont to occur on the palm or sole without other parts being necessarily simultaneously involved, and which may present a not very dissimilar appearance—namely, eczema, psoriasis, syphilis, lichen ruber, and erythematous lupus. I have frequently met with psoriasis in this situation as part of the general non-syphilitic disease, often in gouty subjects, and with no coexisting eczema. There is also a form of palmar psoriasis to which the late Mr. Nayler first called my attention, and which, for the sake of distinction, he was in the habit of designating "non-specific palmar psoriasis". In these cases, the skin of the whole palmar surface of the hand, fingers, and thumb is red, thickened, and hard, and the natural furrows of the skin occupied by small white scales, so that the whole surface is mapped out with fine white lines. No cracks nor fissures are present, and the part is always dry and harsh, and generally hot and irritable. The condition may exist with or without psoriasis in other situations, and nearly always occurs in women. I lately saw a typical case. A girl, a teacher in a school, was admitted at the Hospital for Diseases of the Skin with psoriasis of the nails of both hands, and a few patches of the same complaint on the arms, the palmar aspects of whose hands were affected as described. The eruption in all parts had always been dry and scaly, and had existed two years. A rash which, by the patient's description, was probably psoriasis, had shown itself at intervals in other parts from an early age. There was no history of syphilis. Though in lichen ruber it is unusual to find the eruption only on the palms of the hands, I have seen it fade and disappear in other parts, while some evidences of it have remained on the palms.

WYNDHAM COTTLE, M.B., F.R.C.S., Savile Row.

In hospital practice, I see numerous cases of all three varieties—namely, eczema palmaris, psoriasis palmaris, and syphilitic psoriasis. The differential diagnosis seems to me most easily made by the following characteristics.

Syphilitic palmar psoriasis may be diagnosed: 1. By its certain

syphilitic constitutional history; 2. By the circumscribed appearance usually assumed in this eruption; 3. By the minute pearly glistening nature of the epidermic scales over a bright circus on the face; 4. By its obstinate duration unless specifically treated.

Psoriasis palmaris simplex is distinguished: 1. By its non-specific history; 2. By its more diffuse characters and non-symmetrical appearance; 3. By the split nature of the surrounding epidermis, and general desquamation of the skin; 4. By being usually referred to some habitual mechanical or chemical irritation, as in the case of barmen and others.

Eczema palmare is distinguished: 1. By its superficial desquamation, often accompanied by moisture, a distinctive sign of eczema; 2. By its almost invariable occurrence with gouty or rheumatic diathesis; 3. By its being amenable to treatment for the above-named affections, chiefly alkaline, and its non-influence by specific treatment.

One case nearly identical with that quoted by Dr. Anderson more especially occurs to me. A clergyman consulted me last year. He had been suffering for some years with a squamous affection of the palms of the hands. I prescribed the different preparations of mercury and tar, but with little or no avail. Vaseline and acetate of lead were most beneficial, as I have found in all these gouty skin-eruptions, combined with suitable constitutional treatment and dieting, without the use of stimulants, especially beer and alcoholic liquors, a poison to most skin-affections. He is now visiting the alkaline springs of Switzerland, from which, he informs me, he is getting much benefit.

JAMES STARTIN, Surgeon to St. John's Hospital for Skin-Diseases; Savile Row.

OTORRHOEA AND LIFE-ASSURANCE.

A PAPER by me was published in the JOURNAL, in 1876, on otorrhœa in relation to life-assurance, suggesting the importance of inserting some question touching pre-existing ear-disease in the examination forms. At the time, I received various communications from medical men on the subject; and since then, several patients have been sent to me, owing to the refusal on the part of different offices to accept them as good lives. I venture, therefore, to mention a form of question which has recently been adopted by the Western Counties and London Office, with which I am connected: "Have you ever been subject to headache, giddiness, epileptic or other fits, deafness, or long-continued discharge from either ear?" Since 1876, I have had under my personal notice three cases of persistent otorrhœa, and am cognisant of another, all of which terminated fatally. The first two occurred in hospital, and both the patients remained unconscious for a protracted period, suggesting, if any local guide had been afforded, the advisability of using the trephine. The third was a distressing case, as, from the young lady's previous health and spirits, her friends little anticipated her sudden and painful death. She had been under my care from time to time, but, whilst residing in the country, she was suddenly seized with severe headache, which was at first considered to be neuralgia, but it rapidly became almost unbearable; her mother wrote to me, describing her symptoms, and wishing to know if she should be brought to town. I fortunately telegraphed that a journey would be most dangerous, and wrote to her medical man, suggesting the possible advisability of making an incision over the mastoid process. I received, however, very shortly afterwards, a letter from him, stating that she had become suddenly unconscious, and, to his great distress, died in a few hours. I shall be obliged if any of the readers of the JOURNAL, connected with life-offices which may have adopted any form of aural question, will communicate the nature of the query either through the JOURNAL or to me.

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A DELICATE SPECTROSCOPIC TEST FOR BLOOD IN URINE.

MOST people think that it is only necessary to examine urine containing blood before the slit of the chemical spectroscope, or in a cell beneath the micro-spectroscope, in order to get the absorption-bands of hæmoglobin. But, in some cases, something more is required, as an examination of a specimen some days ago taught me. It was the urine of a case of acute desquamative nephritis; slightly brownish in colour, turbid, and acid in reaction; no blood-corpuscles were to be found on microscopic examination. When it was put in test-tubes of increasing sizes before the slit of the spectroscope, no absorption-bands appeared; it was then filtered; the filtrate, which was of the colour of golden sherry, gave only the band of urobilin.*

* I have described this band, as well as the others mentioned here, in the *Dublin Journal of Medical Science* of June 1877.