each division of the kingdom to one authority—in England, for example, to the University of London. Remodel the examination, abolish the present list of optional subjects, for it is founded on the erroneous notion that for the purposes of the medical student and practitioner dead and living languages can be the equivalents of each other, and that a subject from the natural sciences can be the equivalent of either, and no matter which. Either a subject is necessary, or it is not necessary; if necessary, include it; if not necessary, exclude it altogether, without vain compunctions or regret. The only inconvenience entailed by the necessity for a summary decision on the necessary subjects will be an inconvenience to the General Medical Council, who will once more have to make up its oscillating mind on the question of the inclusion or exclusion of Greek. The justification of the advocacy of Greek lies in the cardinal circumstance that it is *par excellence* the language of science. A very large proportion of technical terms, compound scientific words, and the descriptive names used in anatomy and physiology, medicine and surgery, are taken from the Greek. A knowledge of Greek is of immense assistance to the student in understanding and mastering these terms, and I cannot but believe that even on the score of economy of time in learning, and not afterwards forgetting, it would be for the advantage of the student if the Medical Council made Greek compulsory. Another reason for including Greek is that more than half the bad spelling which appears so prominently in the papers of candidates at the professional examinations is due to want of acquaintance with the Greek language. How would it be possible for any candidate well grounded in Greek to leave out the *g* in diaphragm or the *e* in pleura—to call symphysis “simpathis”, and “epiphysis”, epithesis?

The preliminary examination should be of a character sufficiently high to be accepted by the University of London as equivalent to the matriculation, and to open out to medical students the medical degrees of the University.

To the University of London, I should be glad to see entrusted the task of examining in physics, chemistry, botany, and zoology. A preliminary scientific examination—of course, less difficult than the preliminary scientific of the University of London (for it would be a serious mistake to make it too severe)—could be passed by students as soon after the preliminary in general education as they were ready for it. The advantages which would flow from the improvement of the preliminary by the inclusion of Greek, and from the institution of a preliminary scientific examination, would comprise an elevation of the typical forms of medical students, abolition of bad spelling, raising the standard of culture of medical men generally above that required from members of the legal profession and pharmaceutical chemists, lightening the medical curriculum and giving room for the introduction of neglected matters of great practical importance, concentration of the attention of the student at a medical school on the human body in health and in disease, and encouragement to those who desired to obtain the higher degrees and qualifications. For the purpose of securing to students facilities for studying the natural sciences, steps should be taken for the establishment, maintenance, and extension of provincial museums of a strictly educational character. Every important provincial town should possess a well-built, well-situated, well-furnished, well-arranged, well-lighted, well-dusted, well-catalogued, and well-ticked museum, and be provided with an educated curator, who could give demonstrations of specimens to classes or individuals paying for instruction. The Government of the country should be urged to undertake the work in connection with the Science and Art Department of the Committee of Council on Education. In London lectures on the scientific subjects should be delivered annually at a central institution by Professors appointed by the College of Surgeons, or the University of London. In the provinces, the need for professional instruction could be met by the extension of University teaching. During the time intervening between the preliminary and the preliminary scientific examination, students might advantageously reside with practitioners, especially such as were attached to provincial hospitals, and occupy leisure time in acquiring a knowledge of dispensing and book-keeping, and an interest in medicine and surgery, or else in demonstrating their own unsuitability for the profession, and withdrawing before their parents or guardians had paid the fees at a medical school.

Would not the most beneficial arrangement of the four years of professional study be into four periods, each of a year's duration, and each terminated with an examination after the manner of the arrangement but recently in force in the University of France? It is gratifying to know that the importance of examining students at the end of their first year has received substantive recognition in the General Medical Council. How many waste their first year from sheer idleness or dissipation, or from the force of evil example, or from the consciousness of abilities sufficient to enable them to master the necessary subjects in their second year, or from want of guidance, direction, and aim. An

examination at the end of the first year would be like the guiding star, and gently lead the student on. It would supply a needed stimulus which would save many from diverging from the track. Scarcely inferior in importance, as I endeavoured to prove some years ago at the Medical Teachers' Association, would be a practical examination in medicine, surgery, and midwifery at the end of the third year, the passage of which might entitle the successful candidate to a certificate of competency to act as an assistant to a registered practitioner. Would it not be well if medical students were obliged, as in the University of France, to show that they had attained the age of eighteen years before they were allowed to commence professional studies, or shall we still encourage the entrance into our medical schools of irresponsible babes and sucklings? Has it not sometimes occurred to you that the professional curriculum might advantageously commence in the summer, and that the first summer session might be occupied, *inter alia*, with a course of osteology, and a course of elementary human histology? If not, consider, I pray you, what a great point gained for the student would be a thorough knowledge of the bones, and a fair knowledge of the tissues before the beginning of the first winter session. No more shivering on the brink of dissection in October and November, for anatomy would already have been robbed of the passing strangeness and distastefulness which bewilder and impede the uninitiated freshman.

By the amalgamation of corporations for the purpose of examination, the expenditure of the Medical Council on visitations of examinations would be greatly lightened. Let the money thus saved be devoted to visitations of medical schools. A measure of this kind would probably induce that conjunction of metropolitan schools, that improvement in the quality and quantity of teaching, in the remuneration of teachers, and in the educational material provided in the schools, and that formation of a great medical faculty in connection with the University of London towards which advanced reformers are now straining their weary eyes in vain.

CASE OF EPISTAXIS COMPLICATED WITH AN EPILEPTIFORM SEIZURE.

By JOHN COCHRANE, L.R.C.P. & L.R.C.S.Ed., Edinburgh.

THE following case occurred in my practice lately; and as it presents some features worthy of attention, I wish to record it.

About nine o'clock on the evening of June 25th, I was requested to visit an elderly man who was bleeding from the nose, which could not be stopped by the usual household remedies—cold to the nape of the neck, etc. When I entered his bedroom, I found him sitting partially undressed, bending over a chamber-pot which was quite filled with bright blood, mixed with large clots. The blood was running profusely from the left nostril alone, and under the bed was another chamber-pot completely filled with clotted blood.

The man was in a composed state, and did not appear to be at all alarmed, but his face was beginning to become blanched. Being desirous of trying the effects of an injection through the nasal cavity of a solution of the perchloride of iron, I used it with a quantity of the tincture of the perchloride of iron, diluted sufficiently with water. As the blood still continued to flow in spite of repeated injections, I resolved at once not to further delay; but, cutting some lint in sufficiently long strips, I dipped one of them in a strong solution of the perchloride of iron, and insinuated it up the left nostril, and in a few minutes all traces of bleeding ceased. The patient expressed himself as feeling much better, and to me he appeared to be more comfortable; when, all of a sudden, he gave a short cry, and drooped his head. I noticed that his teeth were firmly fixed, and that his hands were clenched. He fell on the floor, and struggled like one in a convulsive fit. I laid him on his back, and managed to get his jaws open; and, after a few minutes had elapsed, consciousness gradually returned. He now rapidly recovered, and was able to sit up and converse with me. During the convulsive attack, he was perfectly insensible. His pulse before the attack was normal, and, during it, there was no material difference, with the exception that it became much quicker. The bleeding was completely stopped, and, to verify this, I removed the nasal plug. Previously to the introduction of the lint, I examined the throat, and saw the blood flowing into the mouth. On examining, again, after the fit, not a single drop could be seen.

Now, in regard to this case, it strikes me that the cause of the production of the epileptic symptoms was most probably the injection of the iron solution, which had in some manner been partially absorbed, as it is well known that fatal cases have occurred where *nævi* have been hypodermically injected with the perchloride of iron. That injection in this case did not check the bleeding, although I tried it

repeatedly, does not augur well for this procedure; and I am certain it caused considerable annoyance to the patient.

After getting the patient to bed, I carefully examined his heart; but, with the exception of a soft blowing murmur at the mitral area, due apparently to the loss of blood, there was nothing abnormal. This murmur disappeared after a few days' rest; and now my patient is up, and to all appearance has made a good recovery. For a long period before this attack of epistaxis, he had been much troubled with a heaviness in the head; but, beyond this symptom, he enjoyed pretty good health.

I must not omit to mention that I at once, on seeing the man, administered a dose of thirty minims of the liquid extract of ergot, and left some doses to be given during the night if there were any appearance of bleeding; but as there was no recurrence, although the plug was not left in the nostril, the drug was not again administered.

CLINICAL MEMORANDA.

IS PSORIASIS PALMARIS ALWAYS A SYPHILIDE?

I HAVE read with interest the views that have been expressed on this subject; and, though I cannot go the length of agreeing entirely with Dr. Spender that "there is no such thing as psoriasis palmaris except as a syphilide", yet I would say from my own experience that a non-specific dry scaly disease limited solely to the palms and soles is remarkably rare. In support of my view, I would quote Hebra, who says: "The palms of the hands and the soles of the feet are, however, peculiar in being very rarely the seat of a non-syphilitic psoriasis; whereas they are well known to be very subject to a syphilitic affection which (from the special anatomical structure of these parts) presents characters supposed to resemble those of psoriasis, and which is, therefore, called the psoriasis palmaris syphilitica." The difficulty, often impossibility, of tracing a true syphilitic history in these cases is well known, and therefore the absence of such history does not of itself prove the disease to be non-syphilitic. Further, I would point out that the majority of cases get well under antisyphilitic treatment.

I remember seeing a case in which a middle-aged man had a deeply fissured dry condition of one thumb and a part of the palm. There was no disease elsewhere. He denied having had syphilis, and there was no evidence that his statement was untrue. Various remedies, both internal and local, were tried with little or no benefit; but under mercury a marked improvement took place. This case seemed at first sight to be common eczema; it was unsymmetrical, and looked as if it had been produced by local causes. Nevertheless, it improved under specific treatment.

My own view is, that a very large proportion of the cases of palmar psoriasis are syphilitic in origin; but I grant, as I have already said, that there may be some that are not syphilitic; and the question arises, Are they eczema or psoriasis? If there be no sign of either disease on other parts of the body, I hold it is impossible to make a differential diagnosis; but suppose, for the sake of argument, that, from some peculiarity in the shape of the eruption, or from the colour of the scales, or from some other symptom, we were able to decide between psoriasis and eczema, what advantage would be gained? The object of an accurate diagnosis is to aid us in our treatment; and if, in this instance, the treatment be the same in both diseases, why should there be any dispute about the name?

The first point, therefore, in all cases, is to form a correct opinion as to whether the disease be syphilitic or non-syphilitic; and for the latter variety I would urge the retention of the present name of psoriasis palmaris.

MALCOLM MORRIS,

Joint Lecturer on Skin-Diseases in St. Mary's Hospital Medical School.

FATAL HÆMOPTYSIS IN A CHILD.

THE discussion at present going on in the JOURNAL with regard to the expectoration of blood by infants recalls to my mind a case, of which I made short notes at the time, of distinct phthisis pulmonalis at a very early period of life, terminating by sudden and copious hæmoptysis. The child, a boy aged one year and two months, was the son of extremely scrofulous parents and had been ailing from birth. I saw him ten days before his death in 1877, and he was then completely emaciated, with constant cough and expectoration, which was occasionally ejected from his mouth—an unusual occurrence in infants. On auscultating the chest, cavernous respiration with gurgling was heard at the apices of both lungs. With the usual antistrumous remedies, he appeared to improve; but suddenly one morning, during a fit of coughing, he expectorated about a pint of blood, and died immediately. I did not

make a *post mortem* examination; nor, indeed, do I think it would have proved much more than was clearly evident. The case itself is interesting as one of phthisis pulmonalis at a very early age, and from the peculiarly uncommon manner of death.

R. W. FOSS, M.D., Stockton-on-Tees.

THERAPEUTIC MEMORANDA.

CHLORIDE OF BARIUM IN ANEURISM.

I HAVE treated a case of abdominal aneurism, at the unpromising age of sixty-three, with one-fifth to two-fifth grain doses of chloride of barium, with great success; after failure of five months' rigid adherence to absolute rest and Tufnell's diet. The case was seen by several professionals besides myself, who all coincided in the diagnosis, and the reliability of the improvement has been verified by two of them. The chloride of barium, having affinity to the heart and blood-vessels, promises to be a great remedy in these diseases, and especially in aneurisms.

I hope that those who have frequent opportunities of treating aneurisms will give this important drug a careful trial.

JOHN FLINT, M.D., Scarborough.

SODIUM-SALICYLATE IN CHRONIC RHEUMATISM.

THERE are few better established facts in the history of therapeutics than the success in acute rheumatism of treatment by the salicylates. Very little evidence, however, has been given of its effect in the chronic forms. A few observers, after a short trial, declared it useless; and few voices have been heard in its defence.

In a paper read before the British Medical Association in 1877, I gave short notes of about thirty cases so treated. I have now accounts of 57 more, all well-marked cases of chronic articular rheumatism treated during the two past years as out-patients at the Leeds Infirmary. Making the usual allowance for the imperfection of out-patient notes, I find that, out of the whole number of cases in which the drug was given, viz., 103, 16 did not return after the first visit. Next, out of the 87 of whom notes have been taken, 61 (70 per cent.) derived some benefit from the drug, which was in most cases sodium-salicylate in doses of fifteen to thirty grains three times a day. The remaining 26 felt no improvement, and in four cases some sickness was noted. In comparatively few of the cases was the relief given as speedy as that afforded in the acute disease; but, considering the generally unsatisfactory nature of the treatment of chronic rheumatism by drugs, I think we may say that sodium-salicylate deserves a further trial.

ERNEST H. JACOB, M.B. (late Resident Physician to Leeds Infirmary), Leeds.

THE TREATMENT OF ECZEMA OF THE HAND.

WITHIN the limited compass of a therapeutic memorandum, it is impossible to discuss a subject more than in a very superficial way; but I am much obliged to several correspondents for noticing my paper, and for their interesting remarks. I am glad that Dr. Liveing distinctly reaffirms what would seem a natural postulate in skin-pathology; but the high authority of Dr. McCall Anderson deserves all respect. Let us turn, however, to Plate XVII of the New Sydenham Society's *Atlas of Skin-diseases*, and we shall find a very bad disease of the palm of the hand, labelled *psoriasis diffusa*; the figure is rather a fearful one, but represents pretty closely the condition of the hands in the patient whose case I related in my former paper. Does it need much argument to prove that *psoriasis diffusa* is a misnomer, and that the therapeutic use of arsenic and tar for such a hand (at least in the early stage of treatment) would be a bad and exasperating practice? Eczema is much more likely to attack the extensor side of a limb than psoriasis is to come on the flexor side; thus it is almost part of the "common learning" of skin-diseases that prurigo on the outside of the leg may be complicated with eczema, but honest non-syphilitic psoriasis of the centre of the palm is one of the rarest events, if it exist at all.

The present point is, however, therapeutic, not pathological. A few days ago, I received a letter from a surgeon-major in the Army Medical Department, stationed about a thousand miles from England, telling me that he had had "so-called psoriasis of the palms and soles for nearly ten years, scaly and fissured. No remedy suggested by distinguished specialists has been of any use". My correspondent then enumerates the "remedies already tried": viz., (1) mercury internally and externally; (2) *liquor carbonis detergens*; (3) *oleum Rusci*; (4) vulcanised India-rubber gloves; (5) carbolic acid; (6) iodine; (7) camphor; (8) gas-tar; (9) palm-oil and glycerine; (10) sulphurous acid; (11) solution of potash; (12) hypophosphite of soda; (13) Turkish baths;