struck from the knee as a centre with a radius equal to the height ; from that joint to the ground, this curve compensates for the absence of an ankle-joint. The steel uprights, jointed at the knee, are then rivetted to this foot and to the sockets already prepared, to which straps are also to be secured ; hence results an artificial limb like that depicted below, which fits firmly, and adheres well to the stump, and with which patients walk very well indeed, with very little fatigue and without chafing. Its appearance may be much improved, however, by continuing the lower socket downward to the boot.

Fig. 2.

For amputation above the knee, with a tolerably long thigh-stump, some modification has to be introduced ; thus the hinge of the upright at the situation of that joint must be provided with a simple mechanism that fixes it in a straight position, and quite stiff during progression, and which, by an action of the hand, may be released, allowing the limb to bend, as the natural knee does, in sitting down.

A few words concerning weight and price are now necessary. The Beaufort leg is stated by General Maxwell to weigh about five pounds ; the limb as modified—namely, steel being substituted for wood uprights, weighs about four pounds. The price at which such a limb can be made is £3 3s. for amputation below, £3 13s. for amputation above the knee.¹ A pin or bucket leg costs from 25s. to 30s. Thus, in point of immediate outlay, the Beaufort leg is less advantageous than the sort of limb usually supplied ; but, in point of appearance, utility, and comfort, there really is no comparison between the two ; and indigent persons obtaining such pecuniary assistance as may be necessary, are able to follow their avocations with this leg in very considerable comfort, while to many a little better circumstanced, such a limb is procurable without undue strain on their resources.

¹ Mr. Schramm tells me that his calculation is the lowest possible, and that it is founded on the supposition of his having to make a large number. To make one limb, or only a few, at such price, would not pay him.

PRESENTATION.—Mr. W. J. Penny has been presented with a handsome clock, by the officers, students, and nurses of the Bristol General Hospital, as a token of their regard and high estimation of his labours, as house-surgeon, upon his retiring after three years' service.

A CASE OF DOUBLE, OR BILATERAL, HERPES ZOSTER.

By J. MAGEE FINNY, M.D. Univ. Dub., F.K.Q.C.P.I.,
Physician to Sir Patrick Dun's Hospital, Dublin.

THE following case, having recently occurred in the extern department of the hospital, is worthy of record, on account of the rarity of herpes zoster attacking both sides at the same time.

Mrs. D., aged 40, an otherwise healthy well-to-do woman, consulted me on September 29th, 1884, for what she feared was erysipelas of her neck and ear, and for a most severe headache, which had lasted for four days, and had deprived her of sleep. She stated that the headache was all over her head, but particularly on the right side, and that at the time of its first appearance she noticed a number of small red spots on the left side of her neck and shoulder, that these spots had a burning "sore" pain, that they had increased in size and number since the day before her visit, and that also her right ear was very sore, while a number of painful spots had broken out through her hair on the back of the scalp on the right side.

On inspection, the characteristic erythematous patches of herpes zoster, studded with vesicles of various sizes, were at once recognised ; and it was evident that both sides were simultaneously affected, although at a somewhat different level. On the left side, the erythematous patches were most numerous ; they followed the distribution of the descending sensory nerves of the cervical plexus, with the exception of the suprasternal division, and were limited to the upper part of the deltoid and pectoral muscles ; a large patch occupied the posterior superior triangle of the neck, and one or two small ones were over the sterno-mastoid. The eruption on this side would correspond to von Bärensprung's variety, *Z. cervico-subclavicularis*. On the right side, the ascending branches of the second and third cervical nerves were those engaged (*Nervus occipito-collaris*), and no patches were visible below the level of the thyroid body, though a large cluster occupied the anterior triangle of the neck as far forwards as that body, corresponding to the junction and cutaneous distribution of the superficialis colli and infra-maxillary branch of the facial nerve. Another patch was on the lower jaw, and a third was situated near the mastoid, over the origin of the plexus. The whole of the external ear was red and swollen, and thickly studded with very minute vesicles, the swelling extending a short way into the meatus auditorius. The scalp on the same side, and strictly limited to that side, as far forward as the mid-parietal region, was the seat of a number of scattered pimples and vesicles (the redness usual in herpes elsewhere being absent), and which followed closely the course of the greater and lesser occipital nerves.

When the patient was seen a few days subsequently, the majority of the bullæ had been arrested or had aborted, some few had become confluent and turbid, and those in the scalp were larger, and most distinctly bullous. The patient's general health had been fairly restored, as she was able to sleep, and the headache and the burning stinging pain in the affected parts had greatly abated. No new spots had appeared, but on the right side, above the clavicle, where the skin was free from all rash, very considerable soreness was complained of.

The treatment consisted of quinine and iron, in combination with sulphate of magnesia, and the local application of flexible collodion to the neck, and weak carbolic ointment to the scalp. The patient soon recovered.

REMARKS.—The foregoing illustrates at once the characteristic features of regular herpes zoster and certain unusual peculiarities. To the first belong (a) the sudden occurrence of the eruption, (b) its course along the cutaneous distribution of the sensory nerves, (c) the neuralgic phenomena which preceded and accompanied its appearance, and (d) the acute course of the complaint. To the latter may be referred (1) the occurrence of herpes of the scalp, and (2) the coexistence of the disease at different sides of the neck.

Herpes zoster, or, as I consider it might be termed, with a nearer approach to an accurate nomenclature, *neurotic herpes*, may be found in almost any part of the body. It has, however, its predilections for certain parts, if one may be permitted so to speak of a disease. The most favourite sites are in the course of the intercostal nerves and the lumbo-sacral plexus ; next in order come the brachial plexus, the descending branches of the cervical, and the frontal or facial branches of the fifth nerve. Among the most rare, are the occipital nerve and the nerves of the forearms and legs.

The chief interest of the foregoing case is, however, centred in the fact that the herpes attacked both sides at the same time. This is one of the rarest manifestations of a not uncommon affection ; and, indeed, in many of the most recent text-books, the possibility of

zoster being bilateral, instead of on one side only, is not even mentioned. "Unilateral herpes" is the name by which it is sometimes known; and the recognition of the almost invariable rule of its attacking but one side of the trunk, extremities, or face, is of great diagnostic value in contrasting it with catarrhal or simple herpes, which attacks one or both sides indifferently. In the comparatively few instances on record of bilateral herpes zoster, the eruption, as in the above case, is not on exactly the same level; but the cutaneous nerves attacked on one side are on a higher or lower level than those on the other side.

A CONVENIENT OPHTHALMOSCOPE FOR STUDENTS AND PRACTITIONERS.

By ARTHUR H. BENSON, F.R.C.S.I.,

Ophthalmic and Aural Surgeon to the City of Dublin Hospital.

THE instrument of which the accompanying woodcut gives a fair idea, was designed to meet the requirements of the students attending St. Mark's Ophthalmic Hospital, Dublin. As it possesses, I think, some novelty of design, and is a more useful and efficient instrument than any of the cheaper ones at present in use elsewhere, I venture to draw attention to it.

A student's ophthalmoscope, as also an ophthalmoscope for all general purposes, should possess, as far as possible, the following qualities.

1. *Portability.*—It should be light and compact, so as to allow it to be always carried without inconvenience.

2. *Simplicity.*—It should be as free as possible from complicated mechanism, and should not consist of separable parts liable to be lost or mislaid.

3. *Cheapness.*—It should be so cheap that no medical man should be without one.

4. *Efficiency.*—By this I mean that it should be sufficiently perfect to fulfil all the ordinary requirements of an ophthalmoscopic examination, both of the fundus and of the refraction of the eye.

Since the method of testing refraction by retinoscopy has so completely taken the place of the erect image method, the elaborate and expensive series of lenses incorporated in the so-called "refraction" ophthalmoscopes (Wecker's, Landolt's, Fox's, Nettleship's, etc.) have

become almost useless; and although the specialist may still wish to possess one of these beautiful pieces of mechanism, he will find that the instrument I am about to describe will fulfil the necessities of ninety-nine per cent. of his cases.

My ophthalmoscope consists of a plane and a concave mirror of the same size and curvature as those in Landolt's. The glass in both mirrors is perforated, the hole in the plane mirror being made somewhat larger than that in the concave one. The frame is made of black horn, cut into much the shape of the old fashion double eyeglasses, with a joint in the centre to permit its folding up. Behind the concave mirror is a clip for holding the lenses (as in Liebreich's), for direct examination in cases of ametropia.

When using the instrument, one mirror is held in the hand, whilst the other is in front of the eye; thus the necessity for a handle is obviated, and the unpleasant and disturbing reflections experienced in using Nettleship's reversible mirror are avoided. The ophthalmoscope, when folded, measures only two inches and a quarter in length, and an inch and a quarter in breadth, and weighs (without the lenses) less than half an ounce. It is fitted into a small soft leather case, which also contains pockets for the four small lenses, and for one

large convex lens two inches in diameter; the latter, for use in the inverted method, etc., will perhaps be more conveniently kept separate, as the case will then lie quite flat in the waistcoat- or watch-pocket, taking up no more room than an ordinary *pince-nez*. My custom is to carry the large lens in a chamois bag. The lens has a hole in its periphery, through which a loop of string is passed; this enables me to hang it, when not in use, on my wrist, or on a button of my coat, instead of laying it down where it is liable to be scratched and mislaid. This is especially convenient in working in the out-patient department.

The advantages which I claim for this ophthalmoscope are its "portability," its "simplicity," its "cheapness" (about 5s. 6d.; large lens, 2s. 6d.), and its "efficiency." I need not here restate the advantages of the plane mirror in retinoscopy, which have already been laid down by my friend and colleague Mr. Story (*Ophthalmic Review*, August 1883), and are now accepted; nor need I say how incomparably better, for all purposes, is the large inverting lens, than the small ones sold with Liebreich's instrument. The ophthalmoscope is so light that, even if it falls, it is unlikely to be injured; and, when folded, both the glass surfaces are protected, so that the soft leather case keeps it in safety. It was made for me by Mr. George Prescott, of 9, Merrion Row, Dublin.

THE TREATMENT OF VASCULAR HYPERTROPHY OF THE NOSE.

Read in the Section of Medicine at the Fifty-Second Annual Meeting of the British Medical Association.

By J. HERBERT STOWERS, M.D.,

Physician to Department for Skin Diseases, North-West-London Hospital.

OCCASIONALLY, allied to acne rosacea, we meet with instances more or less severe of hypertrophy of the nose. Apart from cutaneous disorder, cases occur in which simple passive congestion of the organ exists, attended with troublesome subjective symptoms, as tenderness, throbbing, irritability, etc.

I am not aware that any special treatment has been advocated for the above, neither do I know that in any published treatise vascular hypertrophy of the nose is fully dealt with.

Chronic passive congestion leads to connective tissue increase, and to the production of lasting deformity; indeed, examples of such must be familiar to all. I do not contend that cases of long standing can always be cured by the method I propose, especially when the apex is pendulous, or bulbous, but in acute rosaceous acne, simple passive congestion with enlargement, or fibro-cellular hypertrophy, I would commend with much favour the adoption of the plan described by the title "multiple punctiform scarification."

Hebra, years since, suggested that for the more effectual treatment of erythematous lupus, a bundle of scalpels should be tied together, to enable many, more or less deep, punctures to be made perpendicularly to the surface in the skin by one movement of the hand.

At the instigation of Dr. Sangster, physician to the skin-department of the Charing Cross Hospital, a convenient instrument has been devised whereby the necessary number of minute double-edged steel blades can be included in one handle. Such an instrument I am enabled to show you at this time.

The intense congestion of the skin in rosaceous acne I had often permanently relieved by local depletion, but it was not until I was familiar with this instrument that I learnt the lasting benefit resulting from frequent blood-letting in this and more aggravated states. After the congested organ has been thoroughly fomented with water, as hot as it can be borne for several minutes, it should be held, and somewhat compressed, between the left thumb and finger of the operator, and then rapidly punctured with the instrument (two or more blades of which are "guarded" to prevent too deep insertion), perpendicularly to the surface, from base to apex. The compression considerably reduces the pain attendant upon the procedure.

It must necessarily be at the discretion of the practitioner in what cases, and how often, this plan should be adopted and repeated.

Although the number of punctures must vary with the severity of the case, the narration of three cases under my care, permanently benefited, will, I hope, be useful and instructive. These were respectively under treatment seven months, seven months, and five months, and the corresponding number of punctures in each case were 15,750, 11,150, and 52,200. The average number of punctures tolerated at one sitting will, of course, also vary with the sensitiveness of the part and the endurance of the patient. I have found by experience that from 500 to 3,000 is about the average, for, necessarily, the process is