The rarity of affections of the crura cerebri makes it desirable that every case should be recorded. The diagnosis of crural hæmorrhage seems to depend mainly upon the presence of paralysis of the third nerve on the side of the lesion with partial or complete paralysis of motion, and sensation of the limbs and face on the opposite side. Such were the conditions in Dr. Weber's case, the best recorded case of the kind, given in his Remarks on hæmorrhage into the crura, in the *Medico-Chirurgical Transactions* for 1863.

The symptoms would naturally be modified by the part of the crus affected. In Weber's case, it was the crust of the left crus which was the seat of the hæmorrhage; there was paralysis of the third nerve on the left side, and the paralysis of the limbs and face on the right side was complete as to motion, partial as to sensation. In the above case, the hæmorrhage was into the tegmentum of both crura, extending on the right side down to the locus niger, the paralysis of motion, as was to be expected, was partial, amounting to double ptosis, and slight loss of power in the left limbs and face; the acuteness of sensation of the left side was somewhat diminished. The case shows that, in crural hæmorrhage, the levator palpebræ may be paralysed, while the other muscles supplied by the third nerve may be unaffected.

ACUTE RHEUMATISM WITH ENDOCARDITIS; PARTURITION: RECOVERY.

By J. EDWARD SQUIRE, M.D. LOND., M.R.C.P.,

Physician to St. George's and St. James's Dispensary, and Assistant-Physician to the North London Hospital for Diseases of the Chest.

R. F., aged 32, married, came under my care in July, 1883, with pain in the joints. She was a dark-haired woman, and was about eight and a half months pregnant with her first child.

On my first visit she was lying propped up in bed, in evident pain, having been ill three days. Her condition was then as follows. The right wrist was red and swollen, and contained fluid. She could not move the left arm for pain, and could not bear the hand touched; the second and third metacarpophalangeal joints were red and swollen with fluid. Both knees and both ankles were swollen, and fluctuation could be made out in all. The temperature was 103° Fahr. at 4 P.M., the pulse 140. She was perspiring freely; there was no cardiac murmur. Ten grains of salicylate of soda were ordered to be taken every hour for four hours, and then every two hours; and cotton-wool was wrapped round the joints, and placed over the cardiac region.

Two days of this treatment produced a very good effect; for, though the left shoulder became affected, the patient was very much easier, and was able to sleep a little at night. The temperature fell to 100° Fahr., and the pulse was 112.

On July 20th, the fifth day of illness, some giddiness was complained of after the medicine, which was, therefore, only given every three hours that day, and the interval was increased to six hours the next day.

On July 23rd, the eighth day of illness, at noon she had no pain. The bowels were open after castor-oil. Temperature 100.2°; pulse 96, very irregular and weak. The urine contained albumen. There was slight roughness with the first cardiac sound as heard at the apex. The salicylate of soda was discontinued, and half an ounce of brandy ordered to be given four times in the twenty-four hours.

On July 24th, the patient felt better; the pulse at 1 P.M. was 90, and much steadier and stronger; the temperature was 98° Fahr. On auscultation of the heart, a presystolic murmur was heard at the apex.

On the 25th, the murmur was very well marked; the temperature was only 99° at 3 P.M., and the pulse (88) strong and regular. The urine was free from albumen.

On the 26th, labour-pains came on about 5 A.M., and continued all day. The joints were still painful, especially the knees. The murmur was loud and high pitched; temperature 99°, pulse 86, fairly good, at 11 A.M. The patient was delivered at 10.30 P.M. The labour was, I was informed, not particularly difficult, but the patient became very faint. The child, a girl, was healthy.

The following day, the 27th, the patient felt much better as far as the pain in the joints was concerned (the nurse said the rheumatism seemed to go all at once), but complained of very sharp pain over the cardiac region. Temperature 100.8° at 4 P.M.; pulse very irregular.

On July 28th, the patient was much better; a belladonna plaster had relieved the pain over the heart; temperature 101.4° (3.30 P.M.), pulse still very irregular.

On August 1st, the pulse was regular, but very quick—120. Temperature 101°, at noon. The cardiac murmur was distinct, and higher in pitch.

On August 3rd, in the evening, the left shoulder was painful, and

the patient was much emaciated. The heart-murmur was distinct, and was heard up the sternum, and between the shoulders. There was heaving pulsation felt over the heart; temperature 102°, pulse 128 (intermittent). When she lay down quickly there was considerable cardiac dyspnoea.

On August 8th, the temperature in the evening was 104° Fahr., after two rigors during the day, which was accounted for by tenderness and induration in the left breast. Examination of the heart showed the apex-murmur to be less distinct, but a loud systolic *bruit* was heard at the base, and conducted up to the aortic cartilage, and was also heard over the pulmonary cartilage.

By the 12th, the fear of suppuration in the breast had passed, and the temperature was down to 99.8°. The patient was in every respect much better. The lochia, which at first had been very scanty and offensive, were now more abundant and high-coloured; on the 13th, their quantity had diminished. On the 15th, both heart-murmurs were much less distinct, and the patient was taking solid food. She was sitting up for the first time on the 22nd. On August 31st, the murmurs were almost inaudible; temperature 98.8°, pulse 84; and the patient was described as feeling well, and having a good appetite.

By September 17th, fifty-five days (nearly eight weeks) after the first appearance of a murmur, and fifty-three days after her confinement, there were no heart-murmurs audible. The baby was healthy and well, having completely recovered from an attack of ophthalmia neonatorum.

I had another opportunity of seeing the patient in April, 1884, when I was able to satisfy myself of the undamaged state of the heart. There were no murmurs, and the sounds were loud and clear.

REMARKS.—There are several points of interest in this case, apart from its satisfactory termination. Although this was the first confinement, the delivery of the child was not attended with any great difficulty, notwithstanding that the condition of the joints was such as to cause pain on the least attempt at movement.

Any attack of acute rheumatism causes anxiety as to the ultimate effect on the heart, however satisfactory the conditions under which we are able to keep our patient; and we are accustomed to enjoin perfect rest, and avoidance of the least exertion which might throw extra work on that organ. In the above case, parturition occurred while the inflammatory condition of the endocardium was active, and there was fear lest the severe strain on the heart might increase the mischief.

Before labour came on, there was some transient albuminuria, which may be referred rather to the pregnancy than to the rheumatism. After the confinement, the rheumatic pains were lost or forgotten, but sharp pain over the cardiac region showed that the extra work had not been without effect on the injured heart.

The subsequent history of the case is one of gradual but steady improvement, broken only by a threatening of milk-abscess in one breast, which was fortunately averted. It is noticeable that the stages of convalescence after delivery were later than is usual in normal confinement. The temperature, which usually falls about the fourth to the eighth day, was persistently above 101° Fahr. for more than a fortnight after delivery, the febrile period being further prolonged, by the inflammation of the breast, from the thirteenth to the seventeenth day.

The systolic murmur, which was heard over the base of the heart, was probably of hæmic origin, and not dependent on organic changes in the valves.

The effect of salicylate of soda in this, as in every case of acute rheumatism in which I have used it, was satisfactory in reducing the temperature, and relieving the pain; and, though it may not have shortened the illness, it enabled the puerperal complication which followed to be treated under more satisfactory conditions.

ON WASH-LEATHER SKIN.

By P. H. EMERSON, B.A., M.B. Cantab., Southwold, Suffolk.

IN the BRITISH MEDICAL JOURNAL for March 8th, 1879, Dr. David Ferrier first recorded a peculiar condition of the skin, in which certain metals marked it with black lines; this condition he termed "wash-leather skin." Dr. Ferrier tried numerous experiments with a view to discovering the cause of this phenomenon, and he came to the conclusion that "it would appear that, though the property of taking on metallic markings belongs to the skin, to a greater or less extent, in the healthy state, yet in certain conditions, especially in that of œdema, which may not be otherwise evident, this property is greatly intensified, and may be of some diagnostic value." With a view of eliciting any new facts, I observed fifty cases in the wards of King's College Hospital, a table of which I append. It will be seen that, since only fifty cases are recorded, there is a liability of error, which,

Table of Fifty Cases observed in the Wards of King's College Hospital.

No.	Name.	Sex.	Previous Illness.	Chronic Disease.	Occupation.	Alcohol.	Skin.	Skin Disease if any.	Present Illness.	Date of Illness.	Temp.	Drugs.	Perspiration Acid or Alkali.	Mark.	Metal.	Surface of Body where most visible.
1	G. H. I.	M	Scarlatina	Dialetes	Warehouseman	Beer at meals	Dry	—	Diabetes mellitus	5th month	97.4	Codeia. strych. quin.	—	Invisible	Silver	—
2	S. S.	M	Varicella	Chronic Rheumatism	Labourer	Intemperate	Moist	—	Acute renal	5th week	98	Scam. jalap. scop. eth.	—	"	"	—
3	C. G.	M	Acute Rheumatism. Bronchial Pneumonia	Cardiac	Machinist	Temperate	"	—	Cardiac	9th week	97.2	Digitalis	Faintly acid	"	"	—
4	E. D.	M	Renal	—	Servant	Total abstinence	"	—	Acute renal	12th week	98.4	Ferrum: strychnine	Acid	"	"	—
5	E. W.	M	Scarlatina	Atheroma	Accountant	Temperate	"	—	Hemiplegia	8th month	97.2	Ferrum	Faintly acid	"	"	—
6	W. P.	M	Bright's	Chronic Bright's	Cabinetmaker	Temperate	"	—	Cardiac	5th week	98.6	Digitalis: pot. acet. scop. nit. amyl.	—	"	"	—
7	G. F.	M	—	—	Labourer	"	"	—	Intestinal obstruction	3rd week	97.8	—	Faintly acid	"	"	—
8	W. W.	M	Ague	Chronic Diarrhea	Blacksmith	"	"	—	Diarrhea	13th month	98.2	—	—	"	"	—
9	R. E.	M	Gout	Chronic Rheumatism	Housekeeper	Intemperate	"	—	Chm. bronchitis	3rd month	97.2	Digit. scop. pot. acet.	Faintly acid	"	"	—
10	J. G. B.	M	Acute Rheumatism. Asclina	Hypochondria	Vegger	Temperate	Dry	—	Hypochondria	8th week	98	—	—	"	"	—
11	J. W.	M	Acute Rheumatism. Scarlatina	Subacute Rheumatism	Bookbinder	"	Moist	—	Enteritis	1st week	99.2	Quinine	Acid	"	Silver & gold	—
12	G. G.	M	Acute Rheumatism	—	Van driver	"	"	—	Acute Rheumatism	9th week	99	Pot. iod. pot. bicarb.	"	"	"	—
13	T. B.	M	—	—	Waiter	Intemperate	"	—	"	3rd week	101	Sodii Salicyl.	"	"	"	—
14	G. B.	M	—	—	Printer	Temperate	Dry	—	Pleuritis	4th week	99.4	—	"	"	"	—
15	S. V.	M	Scarlatina	—	Carpenter	"	"	—	Asthma	12th year	96.3	Morphl. Atropine	"	"	"	—
16	R. A.	M	Acute Rheumatism	Cardiac	Labourer	"	Moist	—	Cardiac	3rd week	97.4	Digitalis: Iron	Faintly acid	"	"	—
17	T. F.	M	Scar. Measles.	Lumbrago	Coachman	Intemperate	Dry	—	Sciatica	8th week	98.2	Potass. iodid.	Acid	"	"	—
18	R. W.	M	—	Phthisis	Cornman	"	Moist	—	Phthisis	6th week	101	Linectis	Neutral	"	"	—
19	J. B.	M	Ague	—	Porter	"	"	—	"	4th week	100	Morphe. atrop. benz.	"	"	"	—
20	T. S.	M	—	Renal	Printer	"	"	—	Febricula	2nd week	98.8	Quinine	Faintly acid	"	"	—
21	J. S.	M	Acute Rheumatism. Scarlatina. (?) Pneumonia	—	Law writer	"	—	—	Renal	3rd week	97.4	—	—	Visible	Silver	Below ribs to sacrum. ¹
22	W. B.	M	—	—	Schoolboy	Temperate	—	—	Acute Rheumatism	3rd day	101.2	Sodii salicyl.	Acid	Invisible	Silver & gold	—
23	D. S.	M	—	—	Stonemason	"	Moist	—	Erysipelas	4th week	100.2	Liq. ferri perchlor.	—	very marked	Silver	Over lumbo-sacral region. ²
24	W. S.	M	Acute Rheumatism	—	Beerseller	Intemperate	"	—	Hemiplegia	10th month	97.8	Quinine: potass. iod.	Neutral	"	Silver ³	—
25	G. G.	M	Dysentery	—	Soldier Labourer	Temperate	"	—	Phubism	6th week	97.4	Syr. ferri. iod.	Faintly acid	Invisible	Silver & gold	—
26	C. K.	M	Typhus. Gall Stones	—	Shoemaker	Intemperate	Dry	—	Intercostal Neuralgia	4th week	97.4	Tinct. gelsem.	Neutral	"	"	—
27	E. C.	M	Acute Rheumatism. Pneumonia	—	Millmaker	Temperate	"	—	Enteric fever	3rd week	97.2	Quin. nit. hydroch. acid	"	"	"	—
28	S. M.	M	—	—	Shoemaker	Intemperate	"	—	Lupus	4th week	98.2	—	Faintly acid	"	"	—
29	C. A.	M	Acute Rheumatism. Enteric. Ague	Subacute Rheumatism	Scene shifter	"	Moist	—	Pyloric obstruction	2nd week	97	Morphine	"	"	"	—
30	W. P.	M	Varicella (?)	—	Schoolboy	Total abstinence	"	—	Eczema	"	98.2	Chloral hydr.	Neutral	"	"	—
31	H. J. H.	M	—	—	Blacksmith	Intemperate	"	—	Chorea	"	99	—	"	"	"	—
32	R. L.	M	—	Phthisis	Printer	Temperate	"	—	Anaemia	4th month	97	Ol. morrh. Quin.	very marked	"	Silver & gold	—
33	S. W.	M	—	Phthisis	Printer's laborer	Temperate	"	—	Phthisis	2nd week	98.2	—	Acid	"	"	—
34	E. B.	F	—	Alcoholism	Farm labourer	Intemperate	Dry	—	Alcoholism	8th week	99.4	Potass. iodid.	Neutral	"	"	—
35	E. W.	F	Acute Rheumatism. Bronchitis	Cardiac	Theatre dresser	"	"	—	Cardiac	4th week	97.4	Digitalis	—	"	"	—
36	E. P.	F	—	—	Charwoman	Temperate	"	—	Enteric	2nd month	98.3	Quin. potass. brom.	Faintly acid	"	"	—
37	P. B.	F	—	—	Needle worker	Intemperate	Dry	—	Compression of inferior vena cava	5th week	96	Potass. bromid.	—	"	"	—
38	E. N.	F	Acute Rheumatism. Bronchitis	Bronchitis	Servant	"	Moist	—	Bronchitis	3rd week	98	Digitalis: scop.	Faintly acid	"	"	—

¹ Slight cedema. Bedsores imminent.² Bedsores imminent (water-bed).³ Bedsores imminent (water pillow).⁴ Anaemic and waxy-looking. Does not like fat.

No.	Name.	Sex.	Previous Illness.	Chronic Illness.	Occupation.	Alcohol.	Skin.	Skin Disease, if any.	Present Illness.	Date of Illness.	Drugs.	Perspiration Acid or Alkali.	Mark.	Metal.	Surface of Body where most visible.
39	E. S.	F	Acute Rheumatism	Cardiac	Hawker	Temperate	Moist	—	Hæmatemesis	3rd week	Morphi: cod liver oil	Faintly acid	Invisible	Silver & gold	
40	K. B.	F	—	—	Draper	"	"	—	Pleurisy	1st week	Opium	Neutral	"	"	
41	E. C.	F	Variola	—	Housemaid	"	"	Herpes	Phthisis	1st month	Sodæ bicarb.	Faintly acid	"	"	
42	M. B.	F	Fever (?)	Diabetes	Helps in home	"	Dry	—	Diabetes mellitus	2nd week	Codæia	—	"	"	
43	M. A. C.	F	Pleurisy	—	Laundress	"	Moist	—	Scarlatina	101.2	—	—	"	"	
44	M. N.	F	Acute Rheumatism	Cardiac	Housekeeper	"	"	—	Cardiac	98.2	—	Faintly acid	"	"	
45	E. S.	F	Measles	"	Barnmaid	Total abstainer	"	—	Compression of cord	5th month	Sodii salicyl.	"	"	"	
46	E. S.	F	—	—	Cook	Intemperate	Dry	Eczema	Eczema	3rd week	—	Acid	"	"	
47	A. R.	F	Measles	—	—	Temperate	Moist	—	Hemiplegia	5th week	Unguenta.	Faintly acid	"	"	
48	A. C.	F	Scarlatina	—	Tailor	"	"	—	Dementia	6th week	—	—	"	"	
49	E. B.	F	"	—	Housemaid	"	"	Scrofulous ulcer	Scrofulous ulcer	3rd week	Ammon. bromid.	—	"	"	
50	E. F.	F	—	Lupus	Straw bonnet-maker	"	Dry	Lupus	Lupus	"	—	—	"	"	

varying between the two extremes, is considerable. Bearing this in mind, therefore, the conclusions arrived at must be regarded as approximate only.

An analysis of the table shows the following facts.

Age.—The peculiarity does not seem confined to any age, for in the four cases cited the ages were respectively 46, 61, 41, and 16. I have seen it in cases younger than 16, and older than 61, not recorded in the table.

Sex.—It occurs more generally in the male sex.

Previous Illnesses.—In two of the cases there is a previous history of acute rheumatism; this point is interesting, for, acute rheumatism being a disease which leaves permanent injury to particular tissues, especially those of the heart, it may not be improbable that this disease (the pathology of which is involved in obscurity) profoundly modifies the skin as well as other tissues. Could this fact be more certainly established, it would do something to help the theorists who maintain the "neurotic" origin of the disease, and also it would not be incompatible with the "chemical" theory of the origin of the disease; for the *matrices morbi*, flowing through the capillaries of the skin, might easily modify and alter the nutrition of the surrounding tissues. At any rate, the fact that two of the cases have previously had acute rheumatism is noteworthy.

Chronic Illnesses.—I have under this subhead included chronic illnesses from which the cases observed were actually suffering at the time. In Case 1, the patient was suffering from renal disease, and in another case from phthisis; in fact, in these particular cases, these were the diseases for which the patients were admitted. As Dr. Ferrier has already shown, exudatous skin takes on this property, and my observations showed that often the skin of phthisical patients does so too. In several cases of phthisis previously experimented upon, but not here recorded, I obtained the markings most distinctly. It is probably due, in phthisical cases, to derangement rather of the trophic fibres than of the sensory fibres; whereas, in renal cases, it is probably *vice versa*, or maybe a mixture of the two.

Occupation.—From this, we do not get much information; two were indoor livers, and two outdoor livers. The same remark applies to the exercise taken.

Alcohol.—Two were intemperate. This may determine gradual changes in the skin, but in these particular cases nothing definite can be said, as the cause is sufficiently accounted for in the renal disease and phthisis; and there are no positive facts to register, as many of the cases observed were intemperate, and yet there was no marking visible.

Dryness or Moisture of the Skin.—In three of the four cases, the skin was moist; and this I have observed to be the rule, though there are exceptions. This is, therefore, additional evidence corroborating Dr. Ferrier's experiments, which showed it was not due to chemical action. The alkalinity or acidity of the perspiration does not affect the matter, for we do not find either causing it.

Drugs and Diet have no effect. — *Meteorological Conditions* have no effect. *The Metal used.*—Silver gives the mark much more readily than gold. Gold will not give the mark in all cases. It is desirable to use silver.

Disease.—In referring to chronic diseases affecting the skin, two were cited as cases of renal disease and phthisis. Curiously enough, in the two remaining cases, one is directly connected with the skin, that is, erysipelas, and the other indirectly, that is, hemiplegia. Dr. Ferrier's case cited was also of nervous origin.

Temperature.—In two it was subnormal, in two supranormal; thus it does not seem to have any influence in the matter.

REMARKS.—It is most interesting to note that in all cases the markings were most pronounced in the lumbo-sacro-gluteal region, and that in three cases precautions had been taken to prevent bed-sores, two patients being on water-beds.

The chief conclusions arrived at are these. 1. As a rule, wash-leather skin does not occur in the healthy. 2. It does not occur in many diseases, being observed only four times in fifty cases of illness. 3. It occurs in patients suffering, as a rule, from diseases which directly or indirectly affect either the trophic or the secretory nerves of the skin, such as renal disease, phthisis, erysipelas, and hemiplegia. 4. Silver is the best metal to use for bringing out the marks. 5. It may precede, and in the cases cited does precede, bed-sores. 6. It is of diagnostic value in testing the vitality of the skin, and the site for experiment is the lumbo-sacro-gluteal region. 7. So far as one can judge at present, it may be of value in foretelling bed-sores; and, should this be thoroughly established, it would be of great use, for the proper precautions might be taken as soon as the black line is diagnosed; this, at present, seems to be its only probable use.

I have been unable to find any reference or mention of it in the literature of the trophic nerves of the skin. The condition of the skin does not seem in any way akin to that seen in erythema, for there is no evident vaso-motor disturbance; nor to that in urticaria, eczema, herpes, etc., for there is no eruption. It seems to be in no way connected with glossy skin, myxodema, or abnormal pigmentation. As stated above, it seems only connected with bed-sores; and it would be of great interest if observations could be obtained on cases of bed-sores following severe spinal or cerebral lesions, for the connection in the cases observed is rather with simple decubitus, the result of pressure and malnutrition, than with acute decubitus. It seems in no way connected with symmetrical gangrene or Raynaud's disease. The pathology of the phenomenon is difficult to discover. It seems, however, to be the effect of a lesion of the trophic fibres, and of a paralytic lesion rather than an irritative one, for in no cases has there been a history of pain, spasm, etc. With these few facts, it seems probable that it may be the combined result of (1) general malnutrition, due to hydermia, etc.; (2) injury to the trophic fibres of cutaneous nerves from pressure, and consequent changes in the skin due to a hyperemic paralysis leading

to degenerative changes; and the reason of its being most marked in the lumbo-sacro-gluteal region may be due (1) to the comparatively small number of vessels in that region; (2) to pressure from decubitus. Further investigation of the subject is at any rate desirable; for the study of any phenomenon, however apparently insignificant, may in time lead to important discoveries.

MALTHUS'S LAW AND TUMOUR-GROWTH.

By RUSHTON PARKER, B.S., F.R.C.S.,
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MR. JONATHAN HUTCHINSON has asserted several propositions, under this head, in a short pathological memorandum, on March 20th last, beginning "Malthus's law of population-increase, by geometrical progression, applies to the growth of tumours. The larger they have become, the more rapid is their rate of progress." If this law be ever really applicable, it can only hold in the case of tumours that are solid from the commencement and throughout. Whether, even in these cases, it exist or not, I cannot say; but that it cannot in a great many cystic tumours, and in numerous solid tumours that have become cystic in part, is evident. For Mr. Hutchinson says of their progress: "It is a process of cell-multiplication; and the more numerous the cells, the greater the result of their doubling." To be of any service in clinical practice, such law should, at least, be generally applicable. That, however, it can never be; because of a feature in the life of tumours, an apparent rate of growth, that entirely transcends the real rate. I allude to the adventitious effusion into solid tumours of serous or colloid fluids, or liquid or solidified blood. These effusions are quite common in malignant tumours of all kinds, especially the sarcomata, as well as in solid benign tumours composed of, or containing, cystic structures capable of serous and sanious distension; and are also met with in the simplest solid benign tumours. It is quite a common history, of this or that tumour, that it has steadily grown in size during so many weeks, months, or years after first notice; but has increased with rapidity during the few days, weeks, or months preceding a certain inspection. Even apart from cases in which cystic or hæmorrhagic effusion is discoverable to the touch or trocar, there is always a proportion of cases in which this effusion, previously unsuspected, is first made apparent when the tumour is laid open. Many a benign tumour, that has remained stationary for a period, by sudden increase becomes inconvenient, and may be thought to simulate malignancy. After removal, or otherwise, or laying it open, the cause is perceived in effusion, that may or may not have been previously suspected. Such rapid increase may overdistant the coverings of the tumour; and so, by ulceration and bursting of the skin, lead to protrusion and a kind of fungation of the growth, another feature that may be thought to simulate malignancy. Even a malignant tumour, on rapidly becoming enlarged, is easily supposed to have assumed a character of unwonted or hopeless inveteracy; such increase being found, on dissection, to be merely due to adventitious effusion; whereas the tumour, in its solid portion, is sometimes seen to have been little more than stationary. These adventitious effusions are no part of the increase proper to the tumour-tissue; but they are a clinical reality that should always be taken into account under circumstances of rapid enlargement.

I, therefore, cannot see that "it is important to remember this law," or that "it may help us, in prognosis, in emphasising the importance of early treatment," or, for the matter of that, in any way at all; since the rate of a tumour's apparent growth is no sure guide to the rapidity of its real increase.

CLINICAL MEMORANDA.

SHOULDER-JOINT FRICTION AND INCIPIENT PHTHISIS.

My object in this brief communication is to draw attention to a certain physical sign that not unfrequently leads to error. As the first physical sign of incipient phthisis is frequently a mere adventitious sound heard over some part of the apex of the lung, and as the friction produced in the shoulder-joint, by breathing, often imitates very closely these pulmonary adventitious sounds, it is not difficult to understand how mistakes in diagnosis should occur.

I think that there are good grounds for believing that lives are sometimes rejected at insurance-offices, from a want of knowledge on this point.

The sound produced at the shoulder-joint is almost always of a dry quality, rather creaking than crepitation; but its character varies considerably. It is difficult to prevent its occurrence in those subjects

in whom it is heard; so that fixing the joint hardly aids one much in the diagnosis. But the sound is always loudest over the joint itself, and is better conducted along the bones than along the muscles, over which it is usually faintly heard; but in some instances it may even be audible over the pectoralis major below the clavicle. An important point in the diagnosis is the character of the breath-sound at the apex of the lung; when mere joint-friction is heard, there is of course no prolongation or increased loudness of the expiration. This friction-sound, simulating pulmonary adventitious sounds, was first pointed out to me, and, so far as is known, was first drawn attention to, by Dr. Gowers, in his class of clinical medicine at University College. It is of frequent occurrence, and especially, I think, in patients who have suffered from "rheumatism." I have not heard it often in children, and less often in women than men. There can be no doubt that the practical physician must have become acquainted with the sound, even though he may not have formulated his opinion thereon. If this note should lead to its wider recognition, my end will have been answered.

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A FOREIGN BODY IN THE VERMIFORM APPENDIX.

IN the report of a meeting of the Clinical Society of London, held on December 11th, 1885, I find a statement, made by Mr. Bryant, to the effect that he had heard Sir William Jenner express his disbelief in the vermiform appendix ever becoming the seat of a foreign body. Mr. Symonds also stated that, of twenty-four recorded cases, twenty-three were due to concretions, and only one to a foreign body. I am thus induced to place on record a case which came under my observation recently.

The patient was a young man, aged 23, and had, for several weeks, been complaining of abdominal pains, referred chiefly to the umbilicus. Besides this, there had been a general failure of health. He had not taken to his bed till the day before I saw him, and on which he died, and had been going to his office to the last. His condition had become suddenly worse on the day before he died. Dr. Mackellar and myself were asked to see him by Dr. Kingdon, and he died in our presence. His later symptoms were vomiting of bilious matter and those of general peritonitis. His bowels were freely opened the night before he died. There was nothing to point to any particular portion of the intestinal tract, and the general agreement of opinion was in favour of perforation from an unknown cause. On *post mortem* examination, I found general peritonitis, with numerous adhesions, some of which were partially organised. In the vermiform appendix, there was a perforation, but no collection of pus in its neighbourhood. In the pelvic cavity, I found a cherry-stone, which had evidently set up all the trouble.

The case is of considerable interest, partly as showing that there is some foundation for the name of cherry-stone catcher, as applied to the appendix in the dissecting-room, and also in showing how long peritonitis may exist without causing very serious inconvenience. The probability is, that an abscess had formed at the seat of irritation; and from it the peritonitis had extended, and become general. The climax was brought about by the bursting of the abscess, and the accession of the acute attack. No doubt, the presence of the general chronic peritonitis diverted the attention from the real seat of trouble.

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SURGICAL MEMORANDA.

REMOVAL OF FOREIGN BODIES FROM THE EAR.

I WISH to suggest another mode of extraction of foreign bodies from the ear, which has never yet failed me, and seems simpler and better than the "best," as recommended by Mr. Hutchinson. I do not offer it as new, and certainly not as my own; but I have used it for years, and with constant success, even after the failure of others. Yet the article in the JOURNAL of April 10th would lead to the inference that it is not generally practised.

A large syringe holding four or six ounces, a basin of rain-water soap-suds as hot as can be borne, and a steady hand, are all that is required. With this simple apparatus, I have, over and over again, removed cherry-stones, beads, buttons, slate-pencils, etc., from the ears of children, and always without pain; nor has it ever failed me. The injection of a few syringefuls will generally suffice.

I can imagine a substance so forcibly driven into the ear that this method would not dislodge it; but then neither would the loop.

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