got ready. A change had also taken place in the family occupying the lower rooms of the station, a new inspector having come, and brought with him his newly married wife, a strong, healthy-looking young woman from Essex. On November 28th, 1885, this young woman was taken ill with diphtheria, and had a moderately severe attack which lasted till December 13th. On examining the walls of the two rooms on the ground floor, occupied as kitchen and sitting-room by her and her husband, I found them damp for a considerable distance from the floor, varying from one to two feet, along the outer wall of the house. No furniture could be left standing against this wall without becoming damp. Even in the kitchen, where a fire was constantly burning, and gas very often alight, as it was rather a dark room, the wall was constantly damp; and the floor-cloth covering the kitchen floor, on being turned up, was found to be damp and mouldy. I advised the authorities that these rooms were unfit for habitation, and the inspector and his wife were in consequence moved into the upper rooms, which the mounted constable and his family had to leave and find lodgings elsewhere. On December 23rd, 1885, this mounted constable, who still of course, was a good deal at the station seeing to his horse, was taken ill with the disease for the second time, not nearly so severely as the first time, and was convalescent on January 5th, 1886.

On January 8th, his youngest child, aged 3, had taken diphtheria, and was ill till January 22nd. Thus, out of a total of about forty persons immediately connected with the station (2 inspectors, 30 men, 2 wives living at the station, 3 or perhaps 5 children, ditto), there have been, in little more than twelve months, no fewer than seven cases of diphtheria, three of which happened after the graver sanitary defects of the building had been remedied, and the dampness alone remained perceptible to the senses. I am far from saying that there may not be other defects which a thorough examination into the drainage and foundations of the house would reveal; but, in the present state of our knowledge of the subject, the above facts seem worth recording.

CONTINUED FEVERS IN EGYPT

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THE discussion, at the Royal Medical and Chirurgical Society, on Enteric Fever, reported in the JOURNAL of February 13th, interested me greatly. During a considerable time I have been observing cases of fever at the Citadel Hospital, Cairo, which was used as a base hospital, and received sick from Suakin, far up the Nile, Suez, and from Cairo. The intestinal lesions seen in fatal cases of continued fevers may be divided into four classes.

1. There were the usual lesions observed and described as characteristic of enteric fever: tumefaction, ulceration, etc., of Peyer's patches.

2. Bodies, in some cases as large as almonds, and resembling lymphatic glands, were studded under the mucous membrane of the ileum, ileo-caecal valve, and upper part of the caecum. Most of these were in a broken-down ulcerated condition. In some cases, they were altogether broken down by ulceration and sloughing. Perforations were very frequent. Peyer's patches, as well as the colon and rectum, were normal.

3. In a few cases, there was a combination of the above lesions.

4. The usual lesions of the large intestine described as dysenteric, that is, thickening, softening, pigmentation, ulceration, etc., extending to, and most marked in the rectum, were found combined with Class 1 or 2. These cases have nothing to do with malaria, as they were observed in men who were not in any malarious place—for example, Cairo—where we do not see ague, except in men who contracted it elsewhere, as well as in cases from Suakin, Suez, etc.

The first class of cases ran a pretty uniform course, with typical enteric symptoms. The second class seemed to be of longer duration; remissions not so marked in the third stage, greater tympanitis. Abdominal tenderness was more extensive and more marked; there was more tendency to peritonitis, hemorrhage, and perforation. The stools were very offensive in smell, often containing a little slime or blood. Ipecacuhana did not seem to be of much use.

In Classes 3 and 4, the symptoms seemed to correspond with what would be expected in cases with the *post mortem* appearances combined as described above. Ordinary cases of dysentery, without any symptoms resembling enteric fever, are left out of consideration; many such cases were treated.

At present, I am having more regular and accurate observations of the fevers under consideration made, with a view to connect, if possible,

more definitely the symptoms during life with the *post mortem* appearances. Meanwhile, the following questions suggest themselves.

1. Are Classes 1 and 2 distinct diseases? 2. Is Class 3 a combination of 1 and 2? 3. Is Class 4 a combination of dysentery with Class 1 or 2? 4. Is Class 2 a form of dysentery or enteric fever, or is it a distinct disease?

During the early part of the occupation of Cyprus, I saw a case as described in Class 2. During life, I called it enteric fever. After death I adhered to the same name; but I remember that I was not very well satisfied with it. As to Dr. Squire's remark about scorbutic appearances, I have observed that, in places such as Suakin, where there is very little vegetation, men get scurvy occasionally, though they are supplied with vegetables. I remember that, when I was a young surgeon in India, one of my patients in hospital, with eight ounces of lime-juice marked daily on his diet-card, developed scurvy. On inquiry, he told me he never touched the lime-juice, and that he hated vegetables. Many a man gets on very well without eating vegetables, when he is surrounded by vegetation; but gets scurvy, under similar circumstances, in the desert or at sea.

Many cases, coming from Suez and Suakin, were modified by malarial taint; but I saw nothing which would lead me to wish for the term, typho-malarial.

Was it possible that the condensed water at Suakin became contaminated in distribution, and so spread enteric fever? The young soldiers at Cairo undoubtedly suffer most from enteric fever. Since our occupation of Egypt, a large proportion of our young surgeons have had the disease, eight of whom died of it; all, except one, being quite young. Not a single surgeon-major had the disease.

CLINICAL MEMORANDA.

MELANOSIS OFTEN NOT BLACK: MELANOTIC WHITLOW.

WHEN melanosis fungates, and when it affects the glands, we must not expect the larger growths to be of a black colour. The power of producing black pigment appears to be, in most persons, very limited. The original growth, beginning it may be in the rete of the skin, or in the choroid of the eye, is coal-black, but the later and larger growths are white, or show only here and there a pigmented streak. To make the diagnosis at these stages, it is necessary to look carefully at the skin near the margin of the fungus. Here a little coloured border may often be found, looking as if lunar caustic had been applied, which tells the tale.

Melanotic Whitlow.—There is a rare form of disease of the nail-bed which is malignant, and usually takes the type of melanotic sarcoma. It is generally attributed in the first instance to injury, and its diagnosis is always missed in the early stages. Because it resembles whitlow, and is usually so named at first, I prefer to give it that name. It is, however, from the beginning, malignant. Careful observation will find at the edge of the inflamed nail a little border of coal-black colour, and this, however slightly marked, must be allowed to make the diagnosis. I have seen at least half a dozen of these cases. Early amputation is demanded.

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OBSTETRIC MEMORANDA.

INVERSION OF THE UTERUS IMMEDIATELY FOLLOWING LABOUR.

ON February 21st, I was called to attend a patient, aged 32, pregnant for the first time. About 3 A.M. I found that the os had just commenced to dilate. The head was rather far down in the pelvic cavity, pressing on the anterior wall of the uterus; but this condition is not unusual in primiparae. Labour proceeded very satisfactorily, and a fine male child was born about noon. The cord was coiled once round its neck. I separated the child, and gave it to the nurse, and grasped the uterus externally, that being my usual procedure. About fifteen minutes later the patient complained of a pain in her left side, and I felt the uterus suddenly slip from my hand. Thinking the placenta was discharged, I placed my hand under the clothes to take it away, when I felt a hard substance, which I first thought was the head of a second child. On removing the clothes, I was horrified to find the uterus prolapsed and inverted, with the placenta still attached. I immediately separated the placenta, and endeavoured to return the uterus, which was then about the size of two large oranges. I placed a thin towel, previously well oiled, over the inverted surface, and pressed a large composite candle against the slight cup-shaped depres-