given in full doses, and often requires to be pushed to its physiological limit; improvement seldom sets in until six-minim or eight-minim doses of the liquor arsenicalis are reached, but the dose should be small at first, and gradually increased. Where that has failed—and, like all such remedies, it fails sometimes—I have usually succeeded with tincture of belladonna, also given in unconventional doses, up to thirty minims or more. Dr. Tilbury Fox advocated quinine in two-grain to five-grain doses; and, no doubt, it is useful in some cases—for example, Case vi, in which atropine failed; while cod-liver oil for the broken-down is strongly indicated.

Locally, the object is to relieve the pruritus; for this, the best agent, in my hands, has been a lotion of two drachms of liquor carbonic detergens to eight ounces of water, applied freely whenever the pruritus is troublesome; this has always given temporary relief, and the prevention of scratching is very important. Other antipruritics may be used, such as sanitas diluted with equal parts of water, etc.

ILLUSTRATIONS OF EXCEPTIONAL SYMPTOMS AND EXAMPLES OF RARE FORMS OF DISEASE.

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I PURPOSE, in a series of short papers, to describe, very briefly, certain rare symptoms and conditions of disease. I shall not attempt to observe any order, or to classify, but shall endeavour to make each record as much as possible complete in itself.

I.—ADVANCING HYPERTROPHIC LESIONS, ALMOST CONGENITAL, AND LIMITED TO THE ULNAR REGION OF ONE HAND AND FOREARM.

THE subject of the following narrative was an intelligent young farmer, aged 34. His hand presented a most peculiar condition. At first sight, it might have been thought to be the seat of multiple cartilaginous tumours in the phalanges and metacarpal bones. But on more minute examination, the lumpy swellings (which affected the little and ring fingers, and the ulnar part of the hand) were found to be, in part, hypertrophies of cellular tissue and skin, and in part bony outgrowths. There was also ankylosis of two of the phalangeal joints of the little finger, and of one, the second, of the ring finger. These fingers were, both of them, bent downwards to the palm, and there fixed. They were fixed by the ankylosis of their joints, not as in Dupuytren's disease, by any contraction of their fascia. The hand looked much wider than its fellow, and measured in girth round the knuckles two inches more. There was also an increase in the girth of the wrist, of three-quarters of an inch, as compared with the other side. The bony outgrowths were near to the articular ends of the bones; they were low and sessile. The exact appreciation of their shape was rendered difficult by the hypertrophy of the soft parts over them. There were thick ill-defined pads of hypertrophied subcutaneous tissue, and the skin itself was thick and horny. My patient told me that he had been assured by his mother that nothing was noticed amiss with the hand at birth. It was not until he was three or four years old that the thickenings were observed.

A very remarkable feature in this case, is the restriction of the disease to the ulnar region, and to the little and ring fingers. That this restriction is due to the distribution of the ulnar nerve seems improbable, for there is no defect of sensation, and the whole of the ring finger is affected, not alone its ulnar side. There is even a small pad of hypertrophied cellular tissue in front of the middle finger. The localisation of the changes is, perhaps, due to some cause more analogous to that which induces arrest of development of certain associated parts, as when the radius is wanting together with the thumb and forefinger. The man's belief that the condition was not congenital, is by no means conclusive. It is true that it was first noted at the age of three; but, in all probability, some peculiarity of the parts which led to these strangely progressive changes of growth was present at birth.

On passing the finger up the ulna, at several places, the bone seemed somewhat thickened and enlarged. The olecranon projected much more than its fellow, and seemed to be thicker. I speak cautiously as to there being any real enlargement of bone, because there was a bursa over the olecranon, and the subcutaneous tissues along the course of the ulna presented little masses of ill-defined induration. I believe, however, that the bone was in the general condition of slight hypertrophy, which was more pronounced at some parts than others. The patient had been under the care of different medical men, and had taken a good deal of medicine under the diagnosis of gout, from which his father had suffered. There did not appear to be, however,

any reason for believing that the changes present were in any way directly connected with that disease. They were slowly progressing, and the patient was in great anxiety lest his hand should become more disabled. I suspected that the enlarged bursa under his olecranon was due to some pressure on a table or chair-arm. He assured me that he never sat in an arm-chair, "except on Sunday afternoons," but added, in confirmation of my opinion, that it was on one of these occasions that pressure on the elbow had first caused him pain.

The only case really analogous to this which I have seen, was that of a certain Miss B. In Miss B., the little and ring fingers of one hand have undergone changes almost precisely similar, being made lumpy and distorted by enlargement of the bones, and of the soft parts over them. She also inherits gout, and has a very feeble circulation. The latter feature is so marked, that, when I first saw her hand, I was inclined to attribute the changes to a sort of periosteal chilblain limited to these two fingers, due to some peculiarity of innervation in connection with the ulnar nerve. The investigation of this second case, however, leads me to doubt this hypothesis, and inclines me to refer them both to some more obscure and congenital defect in developmental tendency. They are exceedingly different from Dupuytren's contraction of fascia, not only in that they both began in very early life, but also in their final results. Yet we may perhaps profitably keep in mind that the same fingers are affected in the two affections, and that the disease advances in a not dissimilar manner. Nor must we wholly forget that, in each case, the parents had suffered from gout, although it is very difficult to trace any connection with that diathesis.

[To be continued.]

ON THE AFFECTIONS OF THE JOINTS, WHICH COMPLICATE OR FOLLOW SCARLET FEVER.*

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It serves an useful purpose at times to take stock, as it were, of some group of allied diseases, and, while refreshing our memories with the collective wisdom of the past, to compare with it whatever personal knowledge or experience we may have to add to the common store.

With this end in view, I propose considering an important group of complications which are apt to be associated with a disease which has much of interest and importance for every practitioner of medicine. Scarlet fever is truly many-sided, and claims our interest, not only in consequence of its infectious and fatal character, but also on account of the many complications which attend it, and the sequelæ which may supervene when the disease itself has spent its force.

It has been known since the beginning of the century that, in some epidemics of scarlet fever, the joints became affected; but it is only in later times, through the writings of Underwood, Betz, Trousseau, Henoch, and others, that we have any definite information concerning these affections, or any attempt to clear up their pathology.

Trousseau, in his clinical lectures, calls especial attention to what he designates "scarlatinal rheumatism," stating that it occurs much more frequently than is generally believed, and he does not appear to doubt its identity, or at least close relationship with acute rheumatism, though he notes some of its most important eccentricities. His description has been largely followed in our own text-books, though the accounts given have been meagre; most writers, like Bristowe, remarking that scarlet fever is at times followed by rheumatism, which does not differ from the ordinary kind, though noting the fact that suppuration occasionally occurs. The opinion that the common form of joint-lesion occurring in scarlet fever is due to the rheumatic diathesis of the patient, rather than to any synovitis produced by the scarlatinal poison, has been commonly held by continental and English writers; and, in a discussion which took place at the annual meeting of the British Medical Association, in Liverpool, in 1883, on "rheumatism in childhood," nearly all the speakers stated their belief that scarlatinal was essentially the same as the ordinary form of rheumatism. In a short paper (see BRITISH MEDICAL JOURNAL, vol. ii, 1883, p. 514), which I read on that occasion, I tabulated some cases which had come under my care, and pointed out that they supported the belief that one form at least of the joint-affection is connected rather with a septicæmic than with a rheumatic condition. A further experience has made it clear to me

* Read at the Manchester Medical Society.