A form of severe catarrh is occasionally met with, frequently recurring, but lasting only two or three hours. It usually begins and ends with sneezing and profuse watery defluxion from the eyes and nose. In some cases, an asthmatic element is superadded, and dyspnoea occurs; but, in the uncomplicated form, the malady is nothing more than transient nasal catarrh. The usual time of access is the early morning. It commences on rising, and ceases soon after breakfast. It occurs in summer only, but does not appear to be dependent, like hay-fever, on any definite irritant in the air. Though in no way dangerous, it is often extremely inconvenient. A gentleman, who once consulted me on account of this malady, had travelled all over the Continent, and remained some months at sea, yachting in the Mediterranean, and had several times changed his residence from low to high ground, and from sheltered to bleak situations, in the hope of escaping from his enemy. Several physicians, whom he had consulted, treated the matter very lightly, regarding it as ordinary catarrh; yet every summer it attacked him, and recurred nearly every morning, and sometimes in the afternoon, obliging him to leave the table or the society of those with whom he might be. Airy rooms and a cold bath act beneficially; and sal ammoniac has proved valuable. Very small doses of opium or ether, repeated several times in the hour, effectually control the affection.

Asthma is, as we all know, a wonderfully variable malady. One sufferer finds smoke and town-air the cause of a paroxysm, while another finds in the cure. To some, the air of brick-fields is most irritating; to others, it is as soothing balm. The form of asthma developed by hay or grass-seed is described by Dr. Salter as a "mild form of asthma"; but two instances that have come under my observation have been among the most severe. Indeed, it is difficult to exaggerate the horrors of the paroxysm. Certainly tobacco, if used early in the attack, or as a preventive, is of real value, though less, it has seemed to me, in this than in other forms of asthma. At the commencement of the paroxysm, a slight thing will determine its advance or retreat; but, when fully established, tobacco must be pushed to collapse before it relieves. Slade's stramonium cigarettes, or the compound of stramonium with Latakia tobacco, known by the name of Espic's "Fumigateur Pectoral", seems often to give relief, without producing the dreadful nausea that tobacco by itself does to the uninitiated; while to the initiated, or those accustomed to smoke freely, it may not be possible to produce nausea from smoking and even swallowing the smoke; and it is this that makes tobacco so useless a remedy to the majority of asthmatic men.

For the cure of this troublesome complaint, patients have subjected themselves to all manner of remedies. Strange theories as to the diathetic state which gives rise, or is supposed to give rise, to hay-fever, have led to equally strange methods of cure. The skin, the nervous system, the stomach, have been in their turn attacked; but the conclusion at which we arrive, from the study of all these methods, is, that we cannot treat hay-fever *en masse*. We must treat each case individually, according to its cause and character. It is clearly impossible to keep every one between the ages of five and forty confined to the house (*haus-arrest*) for two months in every year. We cannot make everybody a sailor who shows symptoms of the complaint, or even ensure all sailors being far out at sea for the dangerous time. People in England had better go to the north of Scotland while hay is made in England, and return before hay-time in Scotland comes; or go to the centre of a large city, or to the seaside. Yet there are many who cannot do this; and, for such, general and local measures, to which allusion has been made (and there are many others which naturally suggest themselves as meeting the plain indications present in each case), may be relied upon to mitigate the evil, and in a certain proportion of cases to effect a cure. The various attempts that have been made to remove by specifics the abnormal sensitiveness which leads to the development of disease have failed to maintain the reputation which has been promised by their promoters. The foregoing cases recorded serve to point to this conclusion, while they indicate in an unmistakable way that it is the grass which causes the malady, and not, as has been so frequently maintained, the more general causes of catarrh.

INCONTINENCE AS A SYMPTOM OF RETENTION.

By JONATHAN HUTCHINSON, F.R.C.S.,

Surgeon to the London Hospital, etc.

INCONTINENCE of urine is every now and then the first symptom of retention, and occurs without the patient having been conscious of any distension. I have recorded in vol. iv of *London Hospital Reports* a remarkable instance in which this occurred from enlarged prostate,

and was misunderstood both by the patient and his advisers; and another almost parallel one has just been under my care. It is, however, I think, decidedly rare for this symptom to occur in connexion with organic stricture. Now and then it occurs after extensive damage to the perinæum, with rupture of the urethra and cicatricial stricture.

A boy aged 12, whom I attended a year ago with Mr. Horton of Stepney, on account of ruptured urethra, for which we had to make free incisions, now suffers from an impassable stricture and constant incontinence of urine. He is obliged to wear an apparatus. Although I have failed, after most patient trials, in my endeavours to get an instrument through the stricture, yet he has no great difficulty in emptying the bladder; and incontinence is his only trouble.

A young lady aged 16, whom I saw not long ago with Mr. Mundie of Dalston, had had during several years occasional incontinence of fæces, in consequence solely of distension of the rectum by an enormous hardened mass.

In March 1869, a solicitor consulted me respecting one of his clerks, whom he suspected of malingering. The young man sometimes stayed away from the office on account of ill-health, and had asserted, in explanation, that he suffered from great difficulty in passing urine, and also from incontinence. These two conditions seemed to his employer to be incompatible. On the following day I examined the supposed idler, and found that he had a tight stricture in the bulbous urethra, which I could not pass. As there could be no doubt that his symptoms were real and in relation with the stricture, and as they were somewhat unusual, it seems worth while to state them in detail. Four years previously he had suffered from gonorrhoea, which was only cured after several months' treatment. After this he had no gleet whatever, and a year later he married. During the last year he had experienced great and increasing difficulty in micturition. The stream had become small and twisted; the act was attended by much forcing pain in the abdomen; the lower part of his abdomen was, he said, always uncomfortable, and he had much aching in the back. Sometimes he felt so nervous and weak that it was impossible for him to go to business. During the last two months he had had several attacks of incontinence. These had occurred sometimes during sleep and sometimes whilst walking. His bladder was full at the time he came to me; and after my unsuccessful attempt with catheters, he immediately voided two pints in a much larger stream than he had been accustomed to for months. My interpretation of his symptoms was that his bladder habitually retained a considerable quantity, thus causing him discomfort, and perhaps having already induced renal mischief. It is easy to see how insidiously serious disease might in this way be brought about. In one of the cases alluded to above, the patient had fatal disorganisation of the kidneys, induced before any obstruction in the urethra was suspected. So misleading is the symptom of incontinence to the patient himself, who never dreams that whilst his urine escapes freely there can be any accumulation, that it becomes of the greatest importance for medical men to be on the alert as regards it.

A SUGGESTION FOR THE PREVENTION OF INFECTION.

By JAMES STARTIN, F.R.C.S.,

Senior Surgeon to the Hospital for Diseases of the Skin, Blackfriars.

THE rapid increase and extension of small-pox, scarlet fever, and other infectious diseases at the present time, not only in those localities which may be designated their habitual haunts, but also within the wards of general hospitals, and through the agency of public vehicles, laundries, etc., induces me to offer a suggestion, which, during twenty-five years, I have been in the habit of recommending for arresting contagion in diseases of the skin. According to my knowledge, the proposition has not hitherto been employed against fevers and other sources of infection or contagion, although I am aware that it has been used in the arts for sweetening, deodorising, or disinfecting wine-casks, dairy-utensils, etc. The suggestion consists in the simple expedient of fumigating beds, clothing, closets, carriages, etc., with sulphurous acid gas, according to the following "ready method". In the case of disinfecting beds and bedding, five to fifteen minutes before the patient enters the bed, or during his removal whilst it is made, a copper warming-pan, containing a few live embers, on which a teaspoonful or two of flowers of sulphur have been thrown, is to be introduced between the sheets, and passed to and fro until the combustion of the sulphur is completed, when the pan is to be withdrawn; and, after the lapse of a few minutes, the patient may enter the bed, when, should the fumes still prove too stimulating for his respiratory organs,

these vapours may be intercepted by holding a loosely folded damp handkerchief before the nose and mouth until they have subsided. In localities where a copper warming-pan is not procurable, a common wicker hand-basket, or a small hamper, containing an old iron saucepan or flower-pot, or basin, in which a few hot cinders have been placed, may be substituted. This, like the warming-pan, must be put beneath the bedclothes, and moved about during the ignition of the sulphur, until the sulphurous acid gas has sufficiently permeated the linen, etc., to be disinfected.

It will be perceived that this latter plan of using the sulphur may be adapted to fumigating closets, carriages, passages, and, indeed, to the vacated chambers of the sick; the only precautions to be borne in mind being to take care that the quantity of sulphur or heat of the live embers be not too considerable, and that the wickerwork is of sufficient height and capacity to prevent the articles fumigated from being burnt in the operation.

With regard to disinfecting the clothing, articles of dress, etc., these should be lightly sponged over or sprinkled with water containing a little *well mingled* milk of sulphur, in the proportion of a teaspoonful of sulphur to each pint of water. The articles should be then ironed by means of a flat iron heated to a sufficient temperature to volatilise the sulphur, but not to burn the clothing. Of course repetitions of this process will be required, according to the extent and duration of the infection.

The daily journals have lately contained an account of a cabman who was fined £3, the cost of disinfecting his cab, after the carriage of a small-pox patient. By the means suggested, of sponging the cab-lining with the sulphur and water, and afterwards using the hot flat iron, and perhaps adding the basket-fumigation, about as many pence would be the cost of the disinfection.

It has been urged as an objection to the above procedure, that it might prove injurious to health, from the noxious vapours of carbonic oxide given out. I need scarcely observe that this objection falls to the ground if the directions given be faithfully carried out; as, if the live embers be properly incandescent, and not smoky, the sulphurous acid gas only will be produced.

CLINICAL MEMORANDA.

FATAL PULMONARY HÆMORRHAGE.

THE case of fatal pulmonary hæmorrhage reported by Dr. Bradbury in the last number of the JOURNAL for January 14th, is one of much interest, and Dr. Bradbury's opinion as to the source of hæmorrhage is doubtless the true one; viz., that it occurred through rupture of a dilated branch of the pulmonary artery in a cavity. Fatal hæmoptysis from this cause is not so rare, however, as seems to be generally supposed. I have myself examined *post mortem* twelve cases of the kind which have occurred at the Brompton Hospital within the last three years, and some account of which I gave at the Pathological Society in November last (see BRITISH MEDICAL JOURNAL, November 19th). In Dr. Bradbury's case, I presume the cavity was probably of old standing; and with a vessel crossing its wall superficially, it would present all the conditions necessary for the occurrence of aneurism. I am unable to agree in the view that atheroma of the vessel may have been the primary cause of its dilatation. (Rokitansky refers to atheroma as occurring almost exclusively in the aortic system of vessels.) Atheromatous disease of the pulmonary artery or its branches is of very rare occurrence. I did not observe it to exist in any of the cases above referred to. Local loss of support (as pointed out by Rokitansky) from gradual exposure of the vessel from one side, attended or not with ulcerative erosion of its wall, and the continued patency of the vessel, are the really essential conditions favouring the production of such aneurisms. I am inclined to think, therefore, that the difference between Dr. Bradbury's case and others resembling it, consists only in the peculiar position and isolation of the cavity, together with its obscure formation. The fact of its not having been of tubercular origin would not seem to be of much real importance as affecting the production of fatal hæmoptysis.

R. DOUGLAS POWELL, M.D.,

Assist.-Physician to the Hospital for Consumption, Brompton.
Nottingham Place, Jan. 1871.

A HALF-SOVEREIGN IMPACTED IN THE LARYNX.

A CASE similar to that recorded by Mr. H. Smith in the BRITISH MEDICAL JOURNAL of January 7th occurred to me at the York Hospital some years ago. It was before the laryngoscope had become available or the diagnosis of such cases, and the difficulties attending my case

show the need for the use of the instrument almost as much as Mr. Smith's shows the advantages of it.

A man was struggling to recover from his wife a half-sovereign which she held in her hand. Hoping to hide it more effectually, she put it into her mouth. The husband, suspecting this, but not seeing it, seized her suddenly by the throat to make her disgorge it. She was immediately attacked by alarming dyspnoea, and was brought to the hospital almost unconscious and quite unable to explain the cause of her distress. It was not quite clear whether the dyspnoea was due to the presence of the coin in the windpipe, or to some injury to the cartilages of the larynx produced by the rude grasp of the husband.

A careful examination of the pharynx and larynx was made with the finger and probe, and a probang was passed into the stomach, but no foreign body could be found. As the dyspnoea continued as urgent as ever, and as it was deemed probable that the coin had found its way into the trachea, tracheotomy was performed in order to explore that tube, and, if possible, relieve the distressed breathing. The operation at once effected this latter object, and proved that the obstruction must be in the larynx. After awhile a further and more searching examination was made, but with no better results than before. On the third day the patient suddenly discovered the coin in her mouth, but could not explain whence or how it came there. The tube was at once withdrawn from the trachea, and she made a rapid recovery. It is quite impossible to say what was the position of the coin, but there can be no doubt that it was in the larynx, as the patient had been able to eat solid food without any difficulty. I ought to add that the patient was, when first seen, placed on a table with her head and shoulders hanging over to allow the coin to fall out if free.

CHARLES ROBERTS, late House-Surgeon, York

2, Bolton Row.

County Hospital, etc.

TREPHINING.

THE perusal of the case reported by Mr. Thorp of Todmorden in the JOURNAL of Dec. 17th, reminds me of a similar case which I attended some months ago. A number of labourers were employed in cutting down timber in the demesne of the Earl of Bantry. A large branch was cut off, but remained suspended to the branches of adjacent trees. When the trunk was being removed, the branch was loosened and fell with great force on the head of a young man, the sawn end being the first point of contact. He was immediately rendered insensible. When I saw him, in about twenty minutes, he was convulsed; the eyelids were closed, but greatly distended and ecchymosed; there was bleeding from the nose and mouth, mixed with froth. There was no wound of the scalp, but evident flattening of the skull over the parietal bone for an oval space about two inches long and one-and-a-half broad.

After some days the symptoms of concussion passed off and consciousness returned, and he recovered perfectly; but the depression is still in the bone. The question of trephining was considered, but it was decided to wait and watch the symptoms.

Bantry.

J. R. SWANTON, M.D.

A SOURCE OF LEAD-POISONING.

As the columns of the JOURNAL have been already opened to two freshly discovered sources of lead-poisoning, perhaps I may be allowed to state a third possible source. A young engineer applied to me the other day for relief from symptoms which were clearly those of lead-colic. He had the well-marked sallow complexion characteristic of this disease—the blue line on the gums, the constipation, and the attendant gripping pains in the abdomen. After careful cross-questioning, I elicited that he used a large quantity of white lead in fixing the joints in the iron-work of the engines. This is at all events a probable source of poisoning by lead, and one which I have not seen noticed in books.

W. H. HOLLIS, Casualty-Physician to St.

53, Harley Street, Jan. 1871.

Bartholomew's Hospital.

SPONTANEOUS FRACTURE OF A RIB IN COUGHING.

SEEING the notice of a case of fractured rib caused by coughing in last week's JOURNAL, and that it is so rare, I send the following which occurred in my practice here.

G. B. is a bleacher, between fifty and sixty years of age, short in stature, and of a full relaxed state of body. For some years past she has been troubled with a convulsive cough and shortness of breath. One morning in January of last year, while sitting by the fireside, she was seized with a fit of coughing (not so severe as sometimes), during which, as she expressed it, something gave a great crack in her side, like breaking a stick, accompanied with a severe pain, almost stopping her breath. She at once said to a relative sitting near her that one of her ribs had