NOTES ON CLINICAL MEDICINE.

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I.—ON THE ADMINISTRATION OF HEMLOCK AND ITS USE IN SCROFULA.

THE uncertainty and comparative inertness of the Pharmacopoeial preparations of hemlock are generally acknowledged; and hence this valuable drug is less used than it would otherwise be, and its remedial powers in certain diseases are imperfectly known.

For nearly twenty years I have from time to time adopted the following mode of administration with good results. The fresh green fruit is mixed with its own weight of white sugar and reduced to a pulp. Five grains or more of this conserve, formed into a pill, are given three times in the day. Thus administered, the drug produces the usual physiological effects—slight dimness of sight, weakness and dragging of the lower limbs, and languor—with much certainty. This preparation retains its activity for three or four weeks only, and has therefore to be constantly renewed.

As a sedative in curing whooping-cough, and in abating the cough of consumption, I have found it very useful; but my attention has been especially attracted to its value in scrofula. Its effects are most marked in favouring the absorption and removal of enlarged glands, and in promoting the healing of scrofulous sores. In those cases, I give it in conjunction with the iodide or bromide of iron. The old writers on the materia medica were fully alive to the value of hemlock in scrofula; and more recently, Dr. Baudelocque of Paris obtained excellent results from its use in the treatment of children affected with enlarged and suppurating glands.

Hemlock is sometimes recommended as an addition to cataplasms and to the warm bath in the treatment of diseases of the skin; and I have myself often found it useful in allaying pain and itching; but it is well to know that its external use requires caution. In the case of a child under my care suffering from severe eczema, decided physiological effects ensued from its use in mixture with linseed-meal in the form of poultice, and caused some anxiety. It is here that we experience the disadvantage of the uncertainty in strength of the preparation. The powder is often powerless either for good or ill; but should the drug be fresh, its action may, when thus applied, give rise to alarming symptoms. The following case may be cited in illustration of the value of hemlock in scrofula.

CASE I.—I was summoned to see in consultation Agnes S., nine years of age, on account of convulsions caused by a gross error of diet. She had been always delicate, and presented the usual indications of the scrofulous habit. There were, besides, enlarged glands in the neck, and an extensive strumous ulcer on the left leg. The convulsions were speedily relieved. It then occurred to me to recommend for the scrofula a trial of the hemlock, especially as at the moment it could be obtained fresh and in good condition. The iodide of iron was given at the same time, and suitable local remedies were applied to the ulcer. The scrofulous symptoms in this child, in spite of treatment, had been steadily growing worse for several months, but soon after beginning the hemlock a decided change was manifested. The glands in the neck became smaller, and the ulcer, assuming a healthy aspect, gradually lessened. At the end of nine weeks the tumescence of the glands had disappeared, the sore had cicatrised, and the child was restored to fair health.

II.—TUBERCULAR MENINGITIS: USE OF THE IODIDE OF POTASSIUM: RECOVERY.

I have long been satisfied of the inutility of mercurials in the treatment of tubercular meningitis, and am inclined to rely on the use of the iodides of potassium and ammonium, as recommended by the greater number of those who have made this disease the subject of special study. The treatment which I pursue may be briefly summarised as follows. Milk and beef-tea are given alternately every three hours; and, according to age, from one to three grains each of the iodides of potassium and ammonium, either singly or combined, in half an ounce of water sweetened with a little sugar, an hour before each meal; aperients by the mouth and rectum, and blisters to the back of the neck and behind the ears. The following case illustrates the advantage of this mode of treatment in this almost universally fatal disease.

CASE II.—On November 26th, 1869, I was asked to see E. S., a girl aged 2½ years, in consultation with Mr. Thomas Swain of this town. The child was reported to have been for several weeks out of health; and, eight days before I saw her, there had been a slight discharge from the left ear, and some erythema of the same side of the face. These passed away, but the child gradually became insensible. When I saw

her, the little patient was quite unconscious, and could neither hear nor see. There was some twitching of the limbs; the pupils were equal and dilated; they responded to light, but very sluggishly. At first there had been vomiting and constipation; the bowels were afterwards opened by enemata. The child, when I saw it, was passing both urine and feces unconsciously. The pulse was 140, small and weak; the respirations 35. There was a little bronchitis. The *tache meningitique* was well marked. The treatment as to diet, medicine, and counterirritation, indicated above was pursued.—November 27th. The child was in the same state, but weaker. On the 29th there was a slight return of consciousness; the bowels were relaxed.—December 2nd. The child was quite conscious, and the pupils were normal. She was taking food better. The improvement continued, and she made a good recovery.

I have no doubt this was a case of unequivocal tubercular meningitis; and, however difficult it may be to determine precisely how far the iodides contributed to recovery, it would be unwise to neglect their probable agency for good in this disease. If the line of argument so often used be permitted; viz., that because a cure was obtained the case was not an example of this generally fatal disorder, all chance of arriving at truth on the subject is at an end. This same vicious mode of reasoning was used a few years ago to explain away the undoubted recoveries from consumption, and presented for long a serious obstacle to the employment of improved methods of treatment in that disease. The fallacy of this view has now been exposed, greatly to the benefit of mankind and to the advantage of medical science. We should be on our guard against accepting too readily the hopelessness of treatment in any disease, lest we paralyse effort and cease our endeavour to secure the means of cure; for with such a conviction the mind refuses to avail itself of resources that might have the best effect in averting the dreaded danger. This unhappy kind of reasoning tends also to foster a sceptical mode of viewing all medical treatment, than which nothing can be more enfeebling or erroneous.

NOTES OF OPHTHALMIC CASES.

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II.—CALCAREOUS FILM OF THE CORNEA.

THE curious affection which I have thus named is extremely rare, and in 1848, when I first met with an instance of it, I could find no record of its having been previously noticed. Since then, I have seen only two cases. Mr. Fairlie Clarke has lately published three which came under his observation, and he describes them as "Symmetrical Opacities of the Cornea." (BRITISH MEDICAL JOURNAL, October 8th, 1870; and *Transactions of Pathological Society* for 1870, p. 331.) I cannot accept this as a satisfactory term, for it does not imply the distinctive character of the disease, namely, the calcareous nature of the deposit; and, again, by Mr. Clarke's own showing, the opacities in his cases were not symmetrical. They occurred in both corneæ at the same time, but not in the same form; and, indeed, Mr. Clarke specially points out the difference in shape which existed between the two opacities in each of his patients. I use the word "film" as best describing the extreme thinness of the calcareous layer.

In all the cases hitherto observed, the patients have been adults. They give no account of any inflammatory stage, but describe the affection as a cloud or haze slowly coming over the sight. The deposit appears always to extend across the middle of the cornea, leaving the upper and the lower portions perfectly clear; at least, I know of no case in which the whole cornea was involved.

The deposit is of a dirty grey or drab colour, almost brown when the iris is of that tint; its margin is not abrupt, but shaded off into the transparent tissue. When closely examined, the layer has a minutely granular appearance, and here and there little cracks run across it, such as one sees in a coat of old varnish. In a well-marked case, the opacity is so dense as completely to hide the pupil when the eye is viewed directly in front. The epithelium covering the opacity seems to remain unaffected. In the case on which I operated in 1848, the deposit consisted of lime, either in the state of phosphate or of sulphate; some phosphate of magnesia and a considerable proportion of carbonate of lime were found, along with the phosphate of lime, in the case reported by Mr. Bowman.

The cases hitherto examined are too few to allow our determining the origin of the deposit. The fact of its being limited to that part of the cornea which is habitually uncovered by the lids, made me at first suppose that some external agency was the cause. My first case was that of a cabinet-maker; a patient who shortly afterwards came under Mr. Bowman's care was a house-painter; Mr. Clarke's cases

comprise a barometer-frame maker, a water-gilder, and a commercial traveller; and a particularly well-marked case which I saw a few years ago, was that of a clerk in a public office. In patients of such diverse occupations, one cannot recognise any common external agency.

I do not know any medical treatment likely to remove the deposit. The only method seems to be by operation, but this requires extreme care and delicacy of hand. The very thin earthy film adheres to the anterior elastic lamina of the cornea, and to cut or scratch the latter would frustrate the object of the operation. No lancet or fine-pointed instrument should be employed. The minute spatula, which is so useful in tilting out small bodies from the cornea (figured in the first and second editions of my *Guide to the Practical Study of Diseases of the Eye*) is the safest and most suitable instrument. First, the epithelium is to be scraped off from the centre of the cornea, to an extent sufficient for exposing the area of the pupil. This lays bare the hard, brittle surface of the earthy deposit, which is to be chipped off bit by bit to the desired extent, care being taken to avoid, as much as possible, any scratching of the cornea itself. This operation, trifling as it seems, causes severe pain, such as generally attends accidental abrasion of the corneal epithelium. A drop or two of oil upon the part, and the closure of the lids for a day or two, will prevent further suffering. Whether the clear space of cornea thus obtained will remain clear, or whether a fresh film of calcareous material will by degrees become deposited, I have not had the opportunity of determining; but in the case which I treated in 1848, there was no trace of fresh deposit a year after the operation.

CLINICAL MEMORANDA.

EXAGGERATED IRRITABILITY OF MUSCULAR STRUCTURES OF THE SKIN.

A MAN, aged 39, an out-patient of St. Mary's Hospital, was stripped for the purpose of examining the chest, when an eruption was observed on the right side of the neck, which in character, grouping, and situation, exactly resembled commencing herpes zoster of the region of the cervical plexus. On one patch, however, larger than the rest, a small wheal of urticaria was present. This led to experiment being made for the production of artificial urticaria. The back of the finger-nail was drawn sharply across the front of the chest, on both sides, several times. There was produced immediately a broad line of elevated hair-follicles, as in goose-skin; this subsided, and in two minutes was succeeded by a similar line of elevated hair-roots, but this time of bright red colour, which in four minutes and a half or five minutes had developed itself into a long, smooth, elevated wheal of urticaria, pale, with red margins. In ten or twelve minutes, the mark had almost faded again.

The patient was a strong well-built man, thirty-nine inches round the chest, turning grey, a good example of the nervous temperament. The circumstances under which the condition described had come on were as follows. He was a porter in the goods department of the Great Western Railway, and just before Christmas had been at work for three days and three nights consecutively, passing constantly from a heated office into the cold air. He took cold, and ever since had had cough in the morning, expectorating a little blood at times. He felt weak and nervous; had pain in the epigastrium after food; the bowels were relaxed.

The simulation of incipient zoster in the area of distribution of the cervical plexus, may possibly have been accidental, but it was most striking, both as regards the size, shape, appearance, and situation of the patches. It is more probable that the seat and character of the eruption were determined by the nerves, perhaps under the influence of irritation by the clothes. On this supposition, the association of a bastard zoster and urticaria—two nervous affections of the skin—would be interesting.

It is interesting, again, to compare the phenomena observed in this case with what occurs on similar irritation of the skin when not unduly sensitive. There is first produced a pale line, which disappears immediately and completely. At a variable interval (from fifteen to thirty seconds) it is replaced by a red line in a broader pale tract, the red line gradually fading out of the pale tract, which itself lasts from two to five minutes. Or the red line may not appear at all. This succession of changes, more particularly the recurrent and persistent pale tract, has been attributed to the contractile element in the capillary walls, and has been used as an illustration of its action; but it is really due to the organic muscular fibres of the skin itself, which compress the capillaries and exclude the blood, and is rendered obvious by the fact that their contraction carried farther raises the wheal seen in this patient.

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ON THE TREATMENT OF STRICTURE OF THE URETHRA.

By W. P. SWAIN, F.R.C.S.,

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THE admirable paper read by Mr. Teevan at the Medical Society of London, and the discussion which took place at a later date at the Clinical Society on the Treatment of Stricture of the Urethra, both tend to bring this subject prominently under the notice of the profession, and to provoke discussion on the various modes of treatment propounded. Perhaps the best evidence which we can have of the advance that surgeons have made in the treatment of stricture of the urethra is the fact that so many methods—I was about to write of *cure*, but I would rather use the term *alleviation*—exist. We can as yet lay no claim to cure this disease, but we can justly promise to our patients in by far the majority of cases considerable mitigation of their sufferings, if only they will abide by our advice and permanently follow the directions given them. The misfortune is, that patients will seldom do this, and the result is sure and certain relapse.

Whilst it is a matter of congratulation that the surgeon has the choice of many procedures in order to restore the urethra to its natural calibre, it is unfortunate that not a few, and amongst them some of our most eminent surgeons, espouse but one method, to the emphatic condemnation of all others. Thus one surgeon will always cut from without, another from within, and a third will, at the slightest provocation, tap *per rectum*. One will gradually dilate with metal instruments; another will use none but flexible bougies. forcible rupture is the cure for all strictures in the hands of one; rapid dilatation and over-distention finds favour with another. Now, to those who are unbiassed, it will probably appear that each one of the above-mentioned modes of relief has its advantage, and that one is eminently applicable to a certain case, but exceedingly inappropriate to the next one that turns up. Take an example from actual practice. A man has a so-called impermeable stricture; he is in the utmost suffering, worn down to the last extremity. A surgeon comes to his relief who does not believe in the impermeability of stricture, and who, after a very prolonged trial, succeeds in passing an infinitesimally small catheter into his bladder, and ties it in. The man dies in a few hours. Suppose that in this case the bladder had been tapped through the rectum, would it not be reasonable to suppose that the stricture would have given way, and that in the course of a short time a fair-sized instrument might have been introduced? I venture to think it might; but then, how about the theory of the non-impermeability of strictures?

Then, as to the use of flexible or metallic instruments:—we are told upon the highest authorities that there is nothing like the flexible French bougie, and that all metallic bougies are to be cast aside. Now, I am ready to admit the very great advantages possessed by the French flexible probe-pointed bougies and catheters. They are wonderfully painless in their use; and I have frequently succeeded in passing one when all other instruments have failed: but they have their drawbacks. In the first place, they are *very* perishable, and after a few usings become dangerous. I have known the catheter break off at the eye in the urethra, and that, too, in the hands of a careful and skilful surgeon. Then in old, long, grisly strictures, they double up and refuse to pass onwards; and even if we succeed in passing one of a small size, it is very difficult to continue the dilatation with them. I have every reason to speak well of Sir Henry Thompson's silver probe-pointed catheter. It is a dangerous instrument in a rough hand, but with light handling and patience it is most useful in retention from old tight stricture. I have frequently succeeded in passing it after having failed with other instruments, and, having once got it in, I have taken good care to keep it in for the next eight-and-forty hours, and have thus been able effectually to relieve the stricture.

With regard to gradual dilatation, Thompson's conical bougies of solid steel are most useful instruments. I have a set made running up to No. 16, and with them I seldom fail to make most satisfactory progress. Here is a case in point at this moment under my care. An old gentleman, aged 80, has a tight subpubic stricture, and some very slight prostatic complication. His micturition is very frequent, night and day, and the urine is loaded with mucus. I run him up to No. 8 with the French elastic bougie, and beyond that there is no progress. I then attack him with the steel-sounds; and at three sittings I pass 7-9, 8-10, 9-11, 10-12, and that with very little distress. His urine is now perfectly clear, and he does not micturate oftener than once in four or five hours.

Of forcible rupture by Holt's dilator, I have now had some experience, ranging over about fifty cases, and I have never yet had an un-