the adductors, and vastus externus muscles, in a partially disorganised state. The integument showed no symptoms of thinning in any part. The anterior crural nerve was found deeply imbedded in the clot, and was the only recognisable structure in the tumour. An incision was made from the middle of Poupart's ligament to the umbilicus, and thence to the sternum. The kidneys were in a healthy condition; the liver was enlarged, and showed appearances of waxy degeneration. On cutting across the aorta, and dissecting the external iliac artery downwards, it was found that an aneurism existed on the right superficial femoral artery. The femoral artery was then dissected upwards from the popliteal, as well as possible, to the tumour, and the mass removed for preservation. It consisted of a quantity of laminated fibrine, situated in Scarpa's triangle, where it appears to have burst, and this, I believe, took place before the patient applied for medical relief, at which time the tumour was localised, and about the size of two fists. The epigastric and circumflex ilii arteries were considerably enlarged. The upper part of the femoral artery leading into the tumour was pervious; that immediately below it and leading from it was impervious.

This case of diffused aneurism is, I think, worthy of record, on account of the close resemblance of its symptoms to those of malignant disease. If the nature of the tumour had been discovered during its early stage, an effort to cure it might perhaps have been made. This case clearly shows that cachexia, rapid growth, and severe pain must not be accepted as sufficient evidences of cancer. In reviewing the history of this case, there are some points which should have suggested its non-malignant character; namely, the absence of lymphatic enlargements, or symptoms of secondary deposit, and of any tendency to ulceration of the skin over the tumour; the favourable family history; and the fact that the tumour was definitely bounded superiorly by Poupart's ligament.

ON SOME CASES OF IDIOPATHIC NEURITIS.

By JOHN M'CREA, M.A., M.D.,

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THE recorded cases in which distinct evidence of idiopathic neuritis of spinal nerves has been obtained are not numerous. Among them are three or four cases of herpes, described by Bärensprung and others, in which, death having occurred from other causes, *post mortem* examination revealed serious lesions of the nerves supplying the herpetic parts. Bärensprung's theory is that the herpes depends on irritation of trophic fibres which start from the ganglia on the posterior roots. He does not, however, consider that grave disorganisation of the nerves is necessary to explain all his cases, for he cites some as examples of the results of peripheral irritation. Similarly, Dr. Lockhart Clarke does not look on neuritis as the only nerve-disorder which causes herpetic eruptions, for he speaks of these as resulting from neuritis and neuralgia. And, indeed, the general retention of the terms, herpes zoster and unilateral herpes, shews that no very settled opinion is held as to the nature of the change in the nerve. I have endeavoured to gain some information on this point, by examining carefully some cases of the disease in a more advanced stage than that in which they ordinarily come under notice, that is to say, after the healing of the skin. Many observers have remarked the occasional occurrence of annoying sequelæ, such as numbness, tingling, pain, hyperæsthesia, and anæsthesia. But I think a mistake has been committed in considering these as occasional, passing, and non-essential. In all advanced cases that I have seen local nervous derangement, more especially anæsthesia, has supervened at some period and persisted.

I have seen during the last two years twenty cases of herpes following the course of nerves. Of these, one is still recent; one is in a child from whom I have not been able to obtain satisfactory information; and seven others I have lost sight of and been unable to trace. The eleven remaining I have been about to examine in their advanced stages. In none has the cutaneous affection appeared to be the beginning, the end, or the most important part of the morbid process. Herpes zoster and unilateral herpes are quite inadequate expressions, not to speak of the special inaccuracy conveyed in the terms "zoster" and "unilateral." The necessity for a new name for the disease becomes more evident from the consideration that herpes is not the only cutaneous phenomenon known to be associated with local nerve-affections; for lichen, acne, pemphigus, urticaria, and, as I have myself seen, erythema, have at times a similar association.

After the healing of the skin, the general condition of the part may be described as presenting hyperæmia, pigmentation, and hyperæsthesia. Then the vascularity diminishes, there are depigmentation and anæ-

thesia. These two sets of conditions may be found mixed in different proportions according to the stage which the disease has reached.

CASE I.—A woman, aged 30, was first seen on December 18, 1872. A zone of skin entirely destitute of pigment extended around the body immediately above the umbilicus. It completely surrounded the body, except a handbreadth at the spine. The upper and lower edges of the zone, which were almost straight lines, were not darker than the neighbouring healthy skin, as sometimes is the case in *laucoderma*. Every part of the zone was completely insensible to pricking and pinching. She said that seven years ago she was seized with an acute pain in this region, that a "red flush" appeared on the site of the present whiteness. That then an eruption "like pox" came all over it, that this eruption never extended farther, and that it faded away slowly, and was followed by anæsthesia and blanching.

CASE II.—A girl, aged 17, was seen on December 14, 1872, for amenorrhœa. I noticed on the right side of the chest and below the level of the axilla a characteristic series of herpetic marks, extending from the spine to the middle line in front. Some of these were pits, but most were merely blanched spots. The point of a pin when pressed with considerable force excited almost no sensation in some of them, and in all the sensibility was far below that of the surrounding skin. The disease commenced six years ago, when she was told by her medical attendant that she had "shingles." She had quite recently complained of numbness of the right leg. A year before the appearance of the eruption I treated her for chorea of the right side. Mr. Hutchinson, in the second series of cases of shingles attributed by him to arsenic (*Medical Times and Gazette*, 1869, vol. i, case 14), mentions, without, however, tracing any connection between the two diseases, an instance in which chorea and shingles occurred in the same person. Dr. Borelli, of Turin (quoted in Dr. Brown-Séquard's article in *Holmes's System of Surgery*), records a case in which neuroma and chorea were intimately associated. I saw lately a case of dental neuralgia in which each recurrence of the neuralgic fit (it was quotidian) was accompanied by violent involuntary rhythmical movements of the arm and leg of one side. Hence the connection hinted at above between the shingles and the chorea is not so fanciful as at first sight it looks.

CASE III.—A boy, aged 8, was brought to the dispensary on April 22, 1872. The right side of his neck was covered with an eruption of herpes. The cutaneous branches of the upper cervical nerves, especially the superficialis colli, the auricularis magnus, the occipitalis minor, the acromial and clavicular branches, had their course and distribution sketched out by ramifying groups of vesicles. On December 23, I examined him. A multitude of white marks were seen on the site of the herpes. Portions of the original eruption have left no vestiges, and no nervous grouping can now be traced. Some of the spots are quite insensitve; all are much more so than the surrounding skin. This is a comparatively recent case, in which it would be rash to infer that the changes are complete.

CASE IV.—A girl, aged 9, came to the dispensary with a zonular herpes, on May 30, 1872. The eruption, preceded by a few hours of severe pain, had appeared the day before. It surrounded the body, except a hand-breadth at the middle line in front. The lower edge of the zone was two fingers'-breadth above the umbilicus. In the hand-breadth above its upper edge, on the right side, was a half zone of white spots evidently representing an old herpes. I again examined the child on January 2, 1873. In the white spots of the old herpes, sensation was very much deadened. The new one was red and very sensitive, except a few spots here and there over it, which were less sensitive than natural.

CASE V.—A man, aged 60, was first seen on June 7, 1872. A severe pain in the right side ushered in a dorso-intercostal herpes of the same side. On December 26, the only traces left of the eruption were a few white spots, and these were quite insensible. He had considerable pain in a zone immediately above the herpes.

CASE VI.—A girl, aged 4, was seen on January 7, 1873. Her mother stated that eight months ago the child had had shingles. She had when I saw her a dark-coloured half zone, with irregular edges, passing round the body and slightly downwards from the spine to the sternum, crossing the inferior angle of the scapula, and passing below the nipple. The dark zone was thickly mottled with white spots. Some of them are pits, but the majority appeared only as patches of whitened skin. Although the point of a pin was firmly pressed against the white spots, the child never winced. When the pin was pressed with much less force on the healthy skin, the child instantly cried out. The dark skin was in several places unduly sensitive.

CASE VII.—A woman, aged 45, was seen on May 5, 1872. She had a right herpes commencing at the spine, passing round the body slightly downwards, below the mamma and on to the middle line

She has had uneasy sensations in the side ever since. She was again seen on December 24. The half zone showed extensive white spotting on the dark ground of her natural complexion. The insensibility of the spots was great everywhere, but more so in front.

CASE VIII.—A woman, aged 40, was first seen on October 7, 1872. After a night of severe pain there appeared a half-zone of herpes, reaching from the lower dorsal vertebræ, around the left side, downwards and forwards towards the umbilicus. There was sharp fever. On December 24, the eruption had faded, leaving a half-zone of marks, those in front white, those behind red. The white ones had lost sensation; the red ones were little different from the surrounding skin. Marked tenderness on deep pressure at the spinal end of the herpes persisted.

CASE IX.—A woman, aged 40, had been treated by me for syphilis, in the beginning of 1872. I again saw her in September. She then had a series of herpetic crusts commencing on the right side near the lower lumbar spines, passing across the right iliac crest in a slightly curved direction to the great trochanter, and throwing out a few crusts even below the trochanter. There were also a few crusts above and in front of the anterior superior spine of the ilium, and a few nearer the middle line as well as on a lower level than the last. It was undoubtedly unilateral herpes. At the same time there was incipient paralysis of the right lower extremity, and numbness of the left. There was acute pain referred to the external iliac region; this I considered to be the herpetic pain. Iodide of potassium was prescribed. I then lost sight of her for a considerable time. I afterwards found that she had become unable to attend the dispensary. After a difficult search for her, she came to me on January 16. I found that after leaving me she had first almost completely lost the powers of sensation and motion in the lower extremities, and that then under the use of iodide of potassium she had improved. At the last-mentioned date, there was no general anæsthesia or paralysis of the limbs. The herpes had left much fewer traces than usual. These were whitish spots that could barely be distinguished from the surrounding skin. In a few of these sensibility was dull, but in the majority I could detect no difference from the sensibility of the region. Points of interest in this case are that the herpes was associated with a grave neurosis; that it appeared not on the side of dulled sensation but on that of acute pain; and that it underwent a much more favourable course than usual, this result happening, be it remarked, in a syphilitic patient taking iodide of potassium.

CASE X.—A boy, aged 13, was seen on January 13, 1873. Two years ago he had a unilateral lumbar herpes, preceded by severe pain. The affected skin remained red for a long time. At the date of examination, the white marks were large and numerous beyond the common. The insensibility was greatest in the anterior spots, and existed in many places between the spots. There was no spinal tenderness.

CASE XI.—A man, aged 60, was first seen for herpetic abscess in November last. He had been jaundiced for a year. He called my attention to a loss of power in the left upper arm. He could flex the elbow, and carry the arm across the chest; he could not raise the arm from the side, draw it backwards, or extend the elbow. The muscles of the shoulder and arm were much wasted, especially the deltoid. There was a severe pain referred to the point of the shoulder. An almost linear herpes reached from the interspinous space below the vertebra prominens, across the spine of the left scapula. It continued in the same linear form down the back of the arm and the outer side of the forearm to the wrist. On January 18, the eruption had almost disappeared. The wasting of the arm had progressed. There was hardly a vestige of the deltoid left. The general malnutrition of the arm made it difficult to obtain evidence as to whether the anæsthesia in the track of the herpes was greater than in the surrounding skin. At no period in the case did the patient's keeping his eyes fixed on the arm facilitate movement. Nor did faradisation appear to have the least effect on the deltoid or triceps. This case runs counter to Bärensprung's statement that herpes is not associated with paralysis.

On the foregoing cases I may make the following remarks.

1. In all there was evidence of disorganisation of the nerves of the affected part.

2. In some cases there was an association with general nervous disorders. In connection with this, it is curious to remark, though the observation may not have much scientific value, that Schwartz (*Diss. de Zona Serpiginosa*, Halæ 1745, p. 7) says he saw in three instances herpes zoster follow violent fits of passion, and that Plenck affirms that he saw it occur twice after violent anger and a copious potation of beer (*De Morb. Cut.*, p. 28).

3. There may occur paralysis of the muscles supplied by the same nerve-trunk as that which supplies the herpetic part.

Those who wish to study the literature of the subject will find full

information in Dr. Lockhart Clarke's article on Diseases and Injuries of Nerves in Holmes's *System of Surgery*, and in the recently published edition of Dr. Tilbury Fox's work on Skin-Diseases.

CLINICAL MEMORANDA.

REMARKS ON AN UNUSUAL COMPLICATION OF PARACENTESIS ABDOMINIS.

Dr. HUNTER of Matlock asks to have some light thrown on a case in which an unusual impediment occurred in the escape of the fluid after tapping an ascitic belly. A somewhat similar circumstance occurring in my practice a few months ago, led me to seek an explanation of it; and such illumination as I have been able to obtain, I beg to place at his service. My case was that of a child, seven years of age, suffering from a severe form of mitral regurgitant disease, with congestive bronchitis, the result of an attack of scarlet fever. At the time tapping was performed, the child was suffering from very distressing dyspnoea, contributed to, to a great extent, by pressure on the diaphragm from a considerable dropsy of the peritoneal cavity. It was to relieve this dyspnoea, and at the urgent desire of the parents, that the operation was performed. Mr. Duncan, our house-surgeon at King's College Hospital, was kind enough to perform paracentesis for me, in the usual way, through the linea alba, about three inches above the pubis. On the withdrawal of the trocar, we were much disappointed at seeing only a little pinkish serosity drain away through the tube; and on passing a probe along the cannula, a spurt of a few ounces of fluid took place, and there was again a block. On withdrawing the cannula, a portion of toughish membrane protruded through the opening; this we drew out and cut away, and again introduced the trocar and cannula. Several times we had to do this, and with much difficulty drew off about three pints of fluid, to the great relief of the dyspnoea, but still leaving a considerable quantity of fluid in the abdominal cavity. The fluid was a deep pink, and contained much more of the solid constituents of blood than is common in dropsical effusions. I imagine that, in a case of this kind, there is a deposit of loose and toughish layers or curtains of fibrinous material on the inner surface of the abdominal wall, only slightly adherent to it; that the trocar and cannula, unless they are unusually long, simply push these layers before them, and when the trocar is withdrawn, there is just a slight escape of fluid, and then the orifice is blocked by layers of fibrinous membrane. In the course of my inquiries, I heard of a similar accident occurring in the practice of my friend, Dr. Bowles of Folkestone, who, with his usual skill and ingenuity, suggested an appliance which overcame the difficulty; this was the introduction through the cannula of a long wire, bent like a hair-pin (I am not sure it was not a hair-pin itself), which would, of course, push the fibrinous curtains away from the orifice of the cannula. Another expedient which occurred to me was the introduction of a small catheter-tube through the cannula, but we had nothing of the kind with us. I shall be careful to see that such a tube is at hand when I again advise paracentesis abdominis.

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THERAPEUTIC MEMORANDA.

DIET IN HEALTH AND DISEASE.

A MOST important passage occurs in Dr. Radcliffe's valuable Lecture on Cerebral Exhaustion, in the JOURNAL for April 12th, where the author speaks of diet, and says, perhaps not unfairly, that in pushing full diet upon invalids we are apt unduly to exalt the nitrogenous elements, and to neglect the hydrocarbonaceous. Indeed, in his reasoning, if not in his practice, he reverses the matter, and exalts the hydrocarbons at the expense of the nitrogenous; for he says, among other things, the strapping gillie, fed on oatmeal and a little milk, will walk his master down on a hard day with perfect ease, etc. Now my only reason for venturing to question this is, that for some years I have been hard at work upon this very question of dietary in training, and on the other conditions of hard exercise; and I think, although the old trainers went to absurd and irrational extremes in forcing meat diet, that nevertheless, a diet rich in nitrogen is of immense value to those engaged in rapid and severe muscular work. The easy decomposition, or what I may even refer to as the explosive nature of nitrogenous compounds, may render them peculiarly fitted to quick work. For monotonous labour, such say as