I must insist that this part of the operation should be done by the surgeon himself, and that an enema-syringe is calculated to pump the fluid into the uterus with unnecessary and even dangerous force. From this risk the Higginson's syringe is comparatively free. The propelling force, even when the ball is firmly compressed, is small.

Further, if the finger guiding the injection-tube be kept in the os uteri, information is given as to the effect produced in checking the bleeding, and the closure of the os upon the tube is obviated. As I have explained in my work on the *Diseases of Women*, when the os uteri is closed, the uterus, contracting concentrically upon fluid contents, tends to drive the fluid along the Fallopian tubes. Dr. Swayne's comment to this effect is perfectly in accordance with observation. It is an imperative condition to preserve patency of the cervix for the outflow of the injected fluid. In the work referred to, and in the third edition of the *Obstetrical Operations*, which will shortly be published, I have discussed with some care the subject of intrauterine injections in the puerperal and non-pregnant woman. In the first work, I have given an example similar to that of Mr. Hodgson of severe collapse, following an ordinary vaginal injection of sulphate of zinc in a non-pregnant woman suffering from prolapse, with patency of the cervix uteri.

Mr. Clark's case is an excellent illustration of the beneficial use of iron-injection in *post partum* flooding. Here again, as in many other cases, it acted after the failure of grasping, ergot, firm pressure on the abdomen, and the injection of cold water. It is not unworthy of remark, that Mr. Clark had previously injected a solution of permanganate of potash. It did no good; although, had the uterus been excitable, the cold might have been expected to act. I have recently been informed by an excellent provincial practitioner that, in a case where previous experience had led him to anticipate flooding, when he had consequently given ergot and used all other means of prophylaxis, hæmorrhage occurring, he injected permanganate solution with apparent advantage. But the uterus relaxed again, filled with blood, and death ensued. He has since trusted to the iron-injection in similar cases, and always successfully. He believes that, had he not been deterred from using it in the case described, the woman would have been saved.

ON THE CAUSE OF DEATH AFTER USING PERCHLORIDE UTERINE INJECTIONS FOR *POST PARTUM* HÆMORRHAGE.

By EDWARD JOHN TILT, M.D.

UNDER the head of "Obstetrical Memoranda", in last week's JOURNAL, Mr. Hodgson of Brighton relates how, while making a vaginal injection, a patient of his passed the tube into the cervix, and thereby caused a solution of zinc to flow from the womb through the Fallopian tubes into the peritoneum, thereby producing what he calls "short-lived peritonitis". I doubt this explanation, unless Mr. Hodgson ascertained that, in this patient, the cervical canal was sufficiently patulous to freely admit the tube of the instrument.

I should not presume to doubt the validity of his explanation, had I not met with half a dozen cases during the last thirty years, in which the use of a vaginal injection was suddenly followed by pelvic symptoms sufficiently acute to suggest peritonitis; symptoms yielding to appropriate treatment in one, two, or three days. In these cases, I had found more or less trouble to introduce the uterine sound, so I cannot suppose that my patients could have possibly passed into the cervix an elastic tube ten times the size of the uterine sound. I should add that, in these cases, the liquid injected was a weak solution of acetate of lead, and that the women had been in the habit of using injections. I submit that a better way of accounting for such cases is to admit that the patients have been awkward, and roughly jammed the extremity of the tube against the sore extremity of the cervix, the concussion being sometimes intensified by the patient, in her fright, pressing the instrument farther in, instead of withdrawing it. Those who so frequently explain the sudden advent of formidable symptoms in disease of the unimpregnated womb, by the passing of a fluid through the Fallopian tubes into the peritoneum, should remember that any surgical treatment of the womb, or even the rough use of the uterine sound, may cause the most formidable pelvic symptoms, and leave traces of pelvic peritonitis even if these symptoms soon abate. They should also bear in mind that Dr. Fontanes has published an account of various experiments in which he found it impossible, by distending the dead womb, to make fluids pass through the Fallopian tubes into the peritoneum. Neither should it be forgotten that the unimpregnated womb has often been injected with various fluids; that the patients have sometimes died and been examined; and that, as far as I am aware, in no case has the fluid in-

jected into the womb been found outside the fimbriated extremities of the Fallopian tubes, except in two cases mentioned in the discussion of my paper on Pelvic Lymphangitis, at the Obstetrical Society of London; one by Mr. Ross Jordan of Birmingham, the other by Dr. Palfrey—cases which have not been published, I believe. It would be singularly illogical to let these occasional untoward results of using injections weigh against their great value in the treatment of diseases of the sexual organs; the more so as these accidents can be prevented by telling the patients to use a flexible tube, and by showing them how to bend it, and how to introduce it into the vagina so that the nozzle of the tube may not run any risk of touching the os uteri.

Dr. Swayne of Bristol has lately explained a death that occurred after the injection of a solution of perchloride of iron into the womb to check *post partum* hæmorrhage by supposing that the solution had passed into the peritoneum. I am not aware that this explanation is warranted by the finding of the perchloride outside the fimbria in similar cases when the bodies have been opened. During the last few years, in the Paris hospitals, a solution of carbolic acid has been often injected into the womb soon after parturition. Many of these patients have died and been examined; but it was not found that the carbolic acid had passed through the Fallopian tubes into the peritoneum. I do not, therefore, think the fear of such an occurrence should bar the use of Dr. Barnes's method of checking incoercible *post partum* hæmorrhage; but I think it would be advisable to use tincture of iodine instead of the perchloride of iron, for reasons that I have given elsewhere.

A CASE OF GENERAL EXFOLIATIVE DERMATITIS (PITYRIASIS RUBRA), ACCOMPANIED WITH FEVER AND GENERAL PROSTRATION.

By EDWARD I. SPARKS, M.A., M.B. (Oxon.), M.R.C.P.,
Physician for Diseases of the Skin in Charing Cross Hospital, etc.

THE report in the BRITISH MEDICAL JOURNAL of March 13th, 1875, page 359, of a case of pityriasis rubra exhibited to the Glasgow Pathological and Clinical Society by Dr. Gairdner, has induced me to publish an account of a case in which the temperature was also elevated, which was under my care in 1873, and to which I had previously been unable to find a parallel. The history is as follows.

M. A. D., aged 48, was admitted into Charing Cross Hospital, under my care, on August 9th, 1873. She was brought in a cab, and was too ill to walk. All that could be discovered about her previous history was, that she had for some years been subject to rheumatic attacks. She was in Guy's Hospital twelve years ago with rheumatic fever, and, five years ago, was laid up with another attack for nearly five months. She had had eight living children, the youngest now four years old. Her husband was a strong healthy man. She had lived at Woolwich several years; but, two months ago (June 13th), she moved to New Cross, and had not been well since. She had ailed all the year, and had pains in her elbows and knees, and her joints had been swollen sometimes, but not so much as to prevent her from getting about. Her skin had been for some time rough and dry, but without scaliness, until about two months ago, when it became somewhat redder than natural, and inclined to peel in the bends of the elbows and in the axillæ. About a month ago, her hands were rough and scaly, and she believed that the redness and roughness of her body became much worse about a week before her admission. For some time, she had slept badly, and been thirsty and scarcely able to satisfy her thirst. Her bowels had been much confined; her appetite had been bad for some time. The remainder of the history will be given *verbatim* from the daily notes.

State on Admission, August 9th.—She complains of pains in her knees and shoulders on movement; but the joints are not swollen nor tender. Tongue very white on the dorsum, with red edges. Pulse, 120; temperature, 102.5 deg. Fahr. (4 P.M.). The most striking thing about her is the condition of her skin. There is a diffused redness of the chest and arms; but the legs are less affected, except the inner parts of the thighs, which are of a very deep red colour, and at first sight suggest the idea of scarlet fever. The skin is at the same time considerably thickened and dry, especially below the clavicles and over the front of the chest, and there is a large amount of scaly desquamation about the popliteal spaces, outer sides of the hips, both shoulders, and the front of the chest. The face is unaffected, except that there is a slight patch of redness inclined to scale on the left of the nose. The hands, to the tips of the fingers, are red, dry, and shiny, and there is desquamation in the flexures of the finger-joints. There are three or four flat pustules, of the size of small peas, over the lower end of the sternum. The patient is very weak, and unable to sit up—

right. Her heart and lungs are perfectly healthy. Bowels confined. Ordered a saline mixture (one ounce) every four hours, and spoon diet.

August 11th. The skin is in much the same state as on the 9th, but perhaps a little less red. Morning temperature, 101 deg. Fahr.; and the evening, 102.5 deg. Fahr.; pulse, 120; tongue dry. She is very thirsty, and is continually wanting to drink. She sleeps very badly. The abdomen is not tender. She still complains of pains in the shoulders when she moves.

August 12th.—The evening temperature to-day reached 102.6 deg. (its highest point), and her urine contained a trace of albumen. Her lungs and heart were again carefully examined, and found healthy.

August 13th. The skin is peeling freely; the redness is decidedly less. The urine is passed involuntarily. Pulse, 116, full and soft, very weak; lips dry; tongue fairly moist; no sore-throat.

August 14th. The temperature is still high; it has not been below 101 deg. Pulse, 120; tongue dry and brownish; but her general aspect is somewhat improved. She rambled a good deal last night. The abdomen is not tender anywhere; there is no tympanites, no enlargement of the spleen. The bowels are very confined. She was ordered to have an enema of warm water, and to omit the saline mixture; to have six ounces of wine, and a draught containing four grains of sulphate of quinine every six hours. The skin is less red, but just as scaly. The pustules on the sternum have died away. A curious appearance was noticed at this time on her tongue, for the description of which I am indebted to the notes of my friend and colleague Dr. Bruce, then medical registrar. He says: "On the left border, about one inch from the tip, is a very peculiar group of white bodies. They are in three masses: one is single and circular in outline, and smallest; the second and third apparently compound (each of two), and more irregular. In colour they are almost pure white; they are distinctly raised above the general surface, and so appear as boldly defined tubercles of about the size of a split pea. They are firm and resisting to the finger, and are not to be removed by scraping. No other similar tubercles on the mucous membrane of the mouth are to be seen. They are somewhat painful."

August 16th. Temperature at 2 P.M., 101.2 deg. She seems decidedly better. She can turn on her side, and has not passed her urine under her since yesterday. She is quite sensible, and has slept much better the last two nights. The skin over the chest is still pale red, dry, and desquamating. The back is nearly free from scabiness, except over the sacrum and buttocks. She has been for several days on a water-mattress, in consequence of a tendency to bed-sore.

August 19th. The skin of the legs is now only dry and rough, thickened and parchment-like, and there is only slight desquamation in the popliteal spaces; the greatest amount of scabiness occurring about the hips. The whole of the trunk and arms are dry and thickened. Desquamation is going on about the axillæ and shoulders. The skin of the face is slightly thickened. The colour of the skin is deepest over the chest; but even there it is much less than when she was admitted. Temperature—morning, 101.2 deg.; evening, 102 deg. During the last three days, a crop of papules and pustules has been coming out on the front and back of the left forearm and on the back of the arm, as well as on the back below the level of the scapulæ; there are also a few on the face. They begin as slightly raised red elevations about the size of a small pea, and, while some never go beyond this stage, others become converted into flat pustules. There are none on the right arm or on either hand, and they are of the same character as those which she had on the sternum when admitted. The quinine is reduced to two grains three times a day, and the enema is to be repeated, as her bowels are very confined. The skin is to be washed with soap and water every day, and well greased afterwards.

August 21st. Temperature, 100 deg.; pulse, 90; tongue quite moist, but covered with white fur. She still has pains on movement in the shoulders; but the joints are not swollen. The pustules are more numerous to-day on the back and face, but their characters are the same. The skin generally seems more thickened to-day, and there is a good deal of redness and desquamation in the bend of the elbows.

August 22nd. Temperature, 98.6 deg., morning; 100 deg., evening. There are no fresh pustules anywhere except on the face; there are none on the scalp or inside the mouth, and there have been none on the lower extremities. The patient's appetite is better.

From the time when this note was taken, she continued to improve; the pustules dried up, leaving a red stain, without scabbing, and the tongue began to clean and the appetite returned. Desquamation was free over the sacrum in large flakes, and also about the root of the neck, the shoulders and the forearms, and on the latter patches of smooth normal skin began to be visible as the scales fell off.

August 27th. The quinine was discontinued, and she was ordered fifteen minims of tincture of perchloride of iron three times a day.

August 30th. Pulse, 84; temperature, 99 deg. The face is now nearly clear of scales, and there are three or four hard red papules on the brow and cheeks, and one pustule on the brow. The skin of the chest and back, and of the arms above the elbow, as well as that of both legs, is dry and shining, parchment-like and tough to the feel. It is slightly thickened, and, especially on the back and chest, is thrown into creases and wrinkles, the edges of which on the back are reddened, so that it is crossed by raised red lines. There is considerable desquamation, in papery flakes of the size of the finger-nail, on the forearms. The skin of the legs below the knee seems more thickened and wrinkled than before, and desquamation is going on over the back of the toes and the dorsal surface of the feet to a considerable extent. The colour of the skin is deepest in the bends of the elbows. The patient is in rather a stupid state, but is quite sensible if roused. Her temperature is normal, and her appetite improving.

September 4th. The skin of the forearms has almost regained its natural colour. There are a few very thin scales on the palms of her hands. The amount of general desquamation is considerable; so much so, that the nurse talks of the scales in the bed as "a nuisance". The back and front of the chest are dry and wrinkled, "like a hide". The patient can now raise herself in bed and sit up without help, and she is more cheerful. There are still a few indolent pustules and papules on the forehead.

From this time, no special note was taken, as I was away for my autumn holiday; but I was informed that she steadily improved, though desquamation continued very abundantly for some time, so that, as the nurse expressed it when I saw the patient again on October 2nd, "she peeled all over again in the last three weeks". At this date, however, she appeared to have almost entirely recovered, and the notes state that "she eats and sleeps well, and her bowels, which, during her illness, were obstinately confined, are now regular. The skin of her whole body is now normal, and of natural colour and texture, and all thickening has disappeared. Her hair is coming out rather freely, especially in the middle of the scalp. She still has a few stains where the pustules were, on the left forearm; but there is no trace of scars. The patient has taken no medicine except the iron mixture for more than a month." She left the hospital the same day.

On October 14th, she came up again to show herself, looking much fuller in the face and generally more healthy than when she went out. She still felt rather weak, and was easily knocked up by her housework. She complained of "crampy pains" in the right shoulder and arm in the mornings, and of stiffness in the hip-joints, so that she could not stoop well. The skin was quite normal, and entirely free from scabiness or thickening; but her hair was coming out in large quantities. She volunteered the statement that "she did not remember anything about herself in the first fortnight she was in the hospital". She did not come up again until April 30th, 1874. She had then had no return of the eruption, and was looking healthy and well. As she was suffering from dyspepsia, the result of mental shock caused by the attempted suicide of her husband a few days before, she was transferred to my colleague Dr. Green. In March of the present year, in answer to my inquiries, she wrote me that she had had no return of the skin-affection since she saw me.

REMARKS.—I have called the disease above described exfoliative dermatitis (pityriasis rubra), because that is the only subacute affection of the skin which corresponds with the phenomena observed. It is the only disease in which the whole surface of the body is affected with simultaneous redness and desquamation in flakes. That the disease was not eczema, was proved by the absence throughout of any kind of moist discharge, of crusting, or of pruritic irritation; besides which, as Devergie has pointed out, eczema never involves the whole skin at once. That we had not to deal with one of those cases of general psoriasis which had assumed the aspect of an exfoliative dermatitis such as have been described by three or four observers, is at once clear from the patient's history, as she had never had any of the characteristic patches of psoriasis on the knees and elbows, or on other parts of the body, previously to the general eruption. No two observers have given an exactly similar description of the symptoms of exfoliative dermatitis; and the present case differs in one or two important points from others which I have found recorded. The high temperature and the severity of the general symptoms (dry, brown tongue, mild delirium, and incontinence of urine) made one at first suspect that the skin-affection was not the essential feature of the disease, but that there was some other abnormal process underlying it, and perhaps independent of it. The pains in the joints, however, which at first suggested the presence of rheumatic fever, were found to partake more of the character of chronic rheumatism than of the acute form. There was no implication of the smaller joints, no shifting of the pain from one joint to another; tenderness on pressure was completely absent; nor was there the slightest

swelling in the right shoulder-joint, which was the most painful. Typhoid fever could be excluded, after a few days' observation, by the absence of splenic enlargement, tympanites, and diarrhoea; and no disease could be detected in the other organs of the body after repeated examinations. The course of the disease further showed a close relation between the general symptoms (temperature, pulse, etc.) and the hyperæmia and desquamation of the skin, both appearing to reach their height and to subside *pari passu*. I may also say that the diagnosis of exfoliative dermatitis or pityriasis rubra was acquiesced in by others who saw the case. The most remarkable features in Mrs. D.'s illness were the attendant fever and the extreme prostration in the first two weeks, accompanied by blunted condition of intellect and other nervous symptoms. The maximum temperature did not reach quite as high a point as in Dr. Gairdner's case (103.8 deg. Fahr.); but the morning temperatures were much higher, never falling below 101 deg. for seven successive days after admission; while the evening temperatures ranged from 102.2 to 102.5 deg. from the 7th to the 16th of August. On the 17th, the morning temperature was 100.2 deg., and that in the evening 101.2 deg.; and, on the 18th, there was a further fall, the morning temperature being 99 deg., and the evening 100 deg.; and this range continued pretty uniformly until the 24th, when the evening temperature reached 99.2 to 99.5 deg., with a nearly normal morning temperature, until September 9th, when the thermometer was no longer used.

Dr. Gairdner's is the only other case (but see Postscript) which I have found reported, in which any special mention is made of the temperature in connection with exfoliative dermatitis. Hebra (*Lehrbuch der Hautkrankheiten*, zweite Aufl., 1874, erster Band, s. 399, article Pityriasis Rubra) merely says: "The temperature of the affected skin is somewhat raised." Devergie (*Traité pratique des Maladies de la Peau*, 1857, p. 443) only seems to speak of the patient's own sensations when he says "dans la période d'acuité, le malade brûle dans son lit, il ne peut supporter qu'un drap même en hiver". There can be little doubt that in the chronic cases, such as Hebra and Professor Wilson describe, fever, if present at all, is so extremely slight as to pass unnoticed; in the present case, as in Dr. Gairdner's, this symptom seems attributable to the rapid onset of the inflammation of the skin, for we can understand that an acute interference with the functions of so large an area of skin would be, *à priori*, more likely to be followed by constitutional symptoms than a chronic one; for example, a diffused psoriasis, which, as we know, may be associated with perfect health. I hope that, now attention has been called to this point, all those under whose care any example of this rare disease may come will make as careful observations of the temperature as they are able, and publish the results. In this way, we may be able eventually to deduce the law followed by the fever in exfoliative dermatitis, and to prepare a typical tracing.

I am unable to explain the development of crops of indolent pustules on various parts of the arms and body, unless they were due in some way to obstruction of the ducts of the sebaceous or the sweat-glands by the inflammatory process around them. They have not been noticed, however, by other observers. Those on the face had, in their early stage, a great resemblance to the shotty papules of small-pox; but there the resemblance ceased, for the resulting pustules had no definite duration, were always flat, and non-umbilicated, and dried up without crusting, and there was no relation between their appearance and the general condition of the patient.

I question whether the treatment adopted had much, or any, influence over the disease, except in so far as it tended to maintain the patient's strength. She got quite well without any specific remedy, such as arsenic, with the simple use of tonic remedies; no external application was made to the skin, except soap and water and simple ointment.

POSTSCRIPT.—Since the above was written and ready for publication, my attention has been called by a notice in the *Gazette Hebdomadaire*, No. 12, 1875, to an essay, entitled *Dermatite Exfoliatrice Généralisée* (Thèse Inaugurale, Paris, 1875), by Dr. E. Percheron, in which nearly all the recorded cases of exfoliative dermatitis, or pityriasis rubra, are collected and commented on in a very careful and lucid manner. To me, Dr. Percheron's essay has a special interest; for in it he describes a case in which a considerable amount of fever existed for several weeks, and the temperature (a chart of which he appends) was accurately taken. It is curious that, like Dr. Gairdner and myself, he was under the impression that his was the only case in which the thermometer had been used. The highest temperature noted was 40.4 deg. cent. (104.7 deg. Fahr.), and there was often a difference of from 2 to 3 deg. cent. (3.6 to 5.4 deg. Fahr.) between the morning and evening temperatures, owing to considerable morning remissions. The trace also shows the existence of short periods of several days characterised by a gradual rise in the evening temperatures, and which corresponded to the presence of complications (endocarditis, bed-sores, etc.); but, as Dr. Percheron re-

marks, there is no indication of a cyclical course, such as we find in pneumonia and the specific fevers.

Dr. Percheron finds, from a view of the literature, that it is not, as Dr. Gairdner seems to think, the exception, but the rule for the nails to be affected. He says the hair and nails are generally lost; the latter are raised by an accumulation of epidermic scales beneath them, so that the finger-tips are surmounted by a kind of coarse shell (*carapace grossière*). I did not observe any alteration of the nails in Mrs. D.'s case, but her hair came out in great quantity towards the end of her attack.

The curious spots which formed beneath her tongue are paralleled, to some extent, by two cases to which Dr. Percheron alludes, in one of which "plaques diphtheroïdes" occurred on the lips and the mucous membrane of the cheeks; and in the other "the papillæ and tongue seemed quite destroyed, and the surface had a varnished look".

Without entering into any further account of Dr. Percheron's essay, the perusal of which I can strongly recommend to anyone interested in the subject, I will make one observation, in conclusion, on the title which he gives to the disease under consideration, namely "generalised exfoliative dermatitis". Most writers—Devergie who first described it, Hebra, Dr. Tilbury Fox, and others—call it pityriasis rubra, a name which has the advantage of brevity, but which is nevertheless inaccurate. The objection may seem pedantic; but, considering how dermatology is already overlaid with unmeaning terms (lichen, sycosis, herpes, etc.) when new ones have to be coined, it is as well to select a correct title. Pityriasis (*πυρίσις*) implies that the scales thrown off are small like bran; whereas, in "pityriasis rubra", a striking feature is their size and abundance. For this special reason, I agree with Dr. Percheron, that Professor Erasmus Wilson's name "general exfoliative dermatitis", although somewhat long and cumbersome, is preferable for scientific purposes to that of "pityriasis rubra".

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN.

LONDON HOSPITAL.

FRACTURED PATELLA; ANKYLOSIS OF KNEE-JOINT; SUBCUTANEOUS OPERATION: GOOD RESULT.

(Under the care of Mr. MAUNDER.)

[Reported by Mr. BRAMWELL.]

GEORGE W., aged 33, was admitted into the London Hospital on May 12th, 1875. The patient stated that rather more than three years ago he fell and broke his right patella into three pieces. He was taken to a metropolitan hospital, and remained in bed upwards of three weeks. He was soon discharged, wearing a plaster of Paris bandage. He wore this bandage for some weeks, when it was replaced by a leathern knee-cap. The joint remained stiff ever since this accident. On two other occasions he sustained an injury to this joint, and on both he went into hospital.

Amputation had been suggested, but this not according with the patient's views, he came to the London Hospital for relief.

On admission, the patient was found to walk like a man with a wooden leg, swinging the limb in a half circle as he progressed. The right knee-joint was the seat of fibrous ankylosis; it was extended and stiff. The slightest possible passive flexion of the leg could be made, but not without causing pain. The patella was in three pieces, having been fractured transversely. These fragments seemed to be connected by a fibrous band, which was drawn backwards into the joint. Mr. Maunder believed that the synovial and cartilaginous constituents of the joint had been more or less destroyed, and a false ankylosis had resulted. To overcome this, it was determined to try the effect of forcible flexion.

May 19th. The patient being under the influence of chloroform, Mr. Maunder slowly bent the leg, and the adhesions broke down audibly. There was considerable swelling at once, and ecchymosis soon followed. This attempt having failed, Mr. Maunder determined to try another plan.

June 2nd. The patient being again under the influence of chloroform, the blade of a strong tenotomy-knife was entered just above the inner side of the superior fragment of the patella, and, having been insinuated between this and the femur, was made to divide subcutaneously the fibrous tissue which united the fragments of the patella and their bond