erythema, or non-specialised dermatitis. As the contagiousness of true erysipelas has been placed beyond question by the experiments of Koch, Tillmanns ("Erysipelas," *Deutsche Chirurgie*, p. 9), and especially Fehleisen (*Deutsche Med. Wochenschrift*, 1882, p. 553), as well as by many clinical facts, an accurate diagnosis is obviously of importance. It has been shown that the virus of erysipelas may be collected, cultivated by appropriate methods, and transmitted to animals and to man by inoculation, the resulting disease being often of great severity. The question then arises, can the virus, when inoculated, give rise to a mild affection similar to that under consideration? The experiments of Tillmanns (*loc. cit.*, pp. 14, 18) seem to show that it can. Out of twenty-five inoculations on dogs and rabbits, five were followed by marked erysipelas with high fever; in two there was erysipelatous redness and swelling, but only a slight rise of temperature, while in several others (the number is not stated) the inoculation was followed by spreading redness and swelling, which resembled erysipelas in every particular, but ran their course without fever. Now Tillmanns considers that as these cases were apyretic they were not genuine erysipelas, but I must admit that I fail to see the force of his reasoning. The selection of high fever as the pathognomonic sign of the true disease seems to me altogether arbitrary, and, even if it be accepted, impossible to apply with accuracy. It is surely true that the cases with the highest fever and those with the lowest, or even with none, are connected by transitional forms which establish an insensible gradation between the two extremes, and I am quite unable to see where the line should be drawn, on one side of which we are to place all the genuine cases, and, on the other, all the spurious ones.

If, then, we admit that true erysipelas may occasionally run a mild course, practically without fever, and if we also recognise the fact that some forms of erythema, and even urticaria (*e.g.*, the "acute circumscribed cutaneous oedema" of Quincke), may have a close resemblance to erysipelas, we have to inquire by what means we may distinguish between these affections. I think there is one character of importance which is present in erysipelas and not in the others, and that is rapid spreading at the margins. Mr. Jonathan Hutchinson, in an able paper on Certain Diseases allied to Erysipelas (*Medical Times and Gazette*, January 1883), insists strongly on this point. After pointing out that erysipelas may be often wanting in vesication, in abrupt margin, and even in hyperemia, he defines as erysipelatous any inflammation which *travels* and is attended by oedema. But, even if we pay attention to this valuable sign, I think we shall still meet with instances in which diagnosis must remain uncertain. Tillmanns, referring to such cases (*loc. cit.*, p. 196), says that it must remain a question how far they are true erysipelas; and, further, that a correct diagnosis has no practical importance; but I do not think it would be wise to accept this view without reserve. Erysipelas is unquestionably contagious; and, although this may not be equally true of all cases, the severe ones being probably far more dangerous in this respect than mild examples, we cannot do wrong in taking all necessary measures to avoid communication of the disease to others. The severe cases shade off into the mild and doubtful ones by such gentle transitions, that it is certainly not always an easy matter to decide as to the rank which should be occupied by any particular case under notice. The difficulty is, perhaps, best solved by Mr. Hutchinson, who concludes that there is a family of erysipelatous affections, rather than a single disease erysipelas—some closely, others remotely, connected with the typical complaint. He holds that, in all, a virus is probably produced, which enables the disease to spread by contagion; and, whenever transmission to another person occurs, the disease, he believes, is intensified.

If these views are correct (and we shall at least be on the safe side if we adopt them), it is plain that there may be a danger of infection from any case, however mild; and caution will be always desirable. This possible danger of infection should, I think, be specially guarded against by those who are engaged in the practice of midwifery, and in the performance of vaccination and other trivial operations. The close relation of erysipelas to a grave form of puerperal fever is well established, and the slightest wound may become the starting-point of erysipelatous inflammation; indeed, it is nearly certain that some breach of surface, however trifling, is a necessary antecedent of all erysipelas. Under these circumstances, I have no doubt whatever that he will be the best practitioner who takes the minutest precautions against the possible conveyance of infection, however remote and improbable such a contingency may appear.

THE Duke of Devonshire has been elected President of the Chester-feld and North Derbyshire Hospital for the ensuing year.

Among the candidates for the *externat* of the Paris hospitals, Mdlle. Mathieu, a negress, has competed with success.

ON THE YELLOW PIGMENTS FOUND IN THE VISCERA IN CASES OF ARSENICAL POISONING.

By THOMAS STEVENSON, M.D.,

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IN an interesting communication on the above subject (*BRITISH MEDICAL JOURNAL*, 1884, vol. i, page 506), Dr. Campbell Brown and Mr. Davies record their examination of a bright yellow pigment, met with in three bodies exhumed after death from arsenical poisoning; and conclude that the pigment resembled one of the products of decomposition of bile-pigment. They, moreover, state that "no proof has ever been adduced, so far as we are aware, that the yellow substance" observed in such cases "is really sulphide of arsenic."

This novel and valuable observation accords with what is known of the occasional yellow discharges from the bowels, during the course of cases of arsenical poisoning, referred to in Dr. A. S. Taylor's *Principles and Practice of Medical Jurisprudence* (third edition, edited by myself, vol. i, page 257), where it is stated that "the matters discharged from the stomach and bowels have had in some instances a yellowish colour, as it was supposed, from a partial conversion of the poison into sulphide, but more probably from an admixture of bile."

The authors of the paper in question go too far, however, when they assert that no proof has been adduced that the yellow substance, met with in exhumed bodies, is sulphide of arsenic. Christison (*Poisons*), in speaking of the solid particles of arsenic found in the stomach, speaks of the brilliant yellowness of the surface of these particles, and adduces four cases of this character which came under his own notice; and adds that, in all these, he found the oxide as well as the sulphuret of arsenic. In one of these cases, besides the oxide and sulphide, he found sulphuretted hydrogen gas in the stomach. In the case of Margaret Warden, yellow arsenical solid particles floated in the stomach fluid. In the case of Regina v. Jennings (Berkshire Lent Assizes, 1845), Dr. Taylor describes how, in a case of exhumation, he obtained abundant evidence of the arsenical nature of the yellow substance, by means of general reactions, which are given in detail. (*Guy's Hospital Reports*, 1845, page 187.) In another case, Regina v. Garner and Garner, tried at Lincoln in 1863, Dr. Taylor found, in a case of exhumation, arsenic "partly in a soluble and partly in an insoluble form—that is, as orpiment, or yellow arsenic," the quantity of which he put as six or eight grains. (*Pharmaceutical Journal*, 1862-3, page 377.) I well remember seeing these yellow powdery masses of yellow arsenic in one of Dr. Taylor's cases.

To these, I may add an observation of my own on the body of Elizabeth Kittle, exhumed in 1872, six months after burial (Regina v. Kittle, Chelmsford Summer and Autumn Assizes, 1872), where there was extensive yellow staining of the stomach, orange-coloured staining of the duodenum, and also a considerable amount of solid yellow matter in the stomach, gritty to the touch. The yellow portion of this was insoluble in water, and could be seen coating the surface of pigments of white arsenic. The yellow matter was conclusively proved by chemical tests to be sulphide of arsenic.

I think there can be no doubt that gritty yellow sulphide of arsenic is not very rarely formed from arsenious oxide in the viscera after death; but this must not be confounded with the yellow substance described by Dr. Brown and Mr. Davies.

EPIDEMIC OF FOLLICULAR TONSILLITIS DUE TO DEFECTIVE SANITARY ARRANGEMENTS.¹

By G. ARTHUR CARDEW, M.R.C.S. Eng.

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THE following are a few notes on an epidemic of sore-throats which occurred at the Cheltenham Training College (male department) during May and June 1882.

The first man attacked complained of a sore-throat, and stated that the previous day he had a shivering fit and a splitting headache, and, on awaking the following morning, found he had a sore-throat. He had never before suffered from any such affection. The following notes I took of his condition, progress, and treatment, and they are typical of most of the other cases which followed.

He complained of a severe throbbing headache, sore-throat, great thirst, and inability to sleep. The temperature on the second day was 103° Fahr., with a pulse of 130 per minute. The whole of the pharynx, tonsils, soft palate, and uvula were intensely congested. On the tonsils were three white looking ulcers, as large as threepenny-pieces, of an irregular shape, covered with a white membranous material, which

¹ Read before the Gloucestershire Branch.

gave a raised appearance to them, but, on removal of this, leaving an ulcerating surface, which bled slightly.

On the following (third) day similar ulcers appeared on the soft palate, the uvula, and the posterior wall of the pharynx. There was no difficulty in breathing, no hoarseness, or anything to indicate mischief in the larynx. The highest evening temperature was 104.2° Fahr., and defervescence ensued by crisis on the fifth day, followed by rapid convalescence.

The line of treatment adopted was a brisk purge of calomel and colocynth, chlorate of potash internally and locally, and a milk diet. On the fifth day, he was given perchloride of iron solution internally, and the ulcers were painted with a ten-grain solution of silver nitrate. Beyond great weakness, there were no sequelæ of any kind.

This case was followed by thirty-four more, all of which ran similar courses. Twenty were very severe, the temperature averaging 103° Fahr. Eleven were milder, the temperature never exceeding 102° Fahr.; and the remainder were so slight, that they recovered without any treatment beyond a gargle of chlorate of potash. The congestion of the fauces remained in nearly every case two to three weeks after the ulcers were healed. I examined the throats of nearly all the men in the college, and found that most of them were red and congested, but giving rise to no discomfort.

At the first appearance of these cases, I simply attributed them to cold, but, on their increasing rapidly in number, I made a careful search for a more satisfactory cause.

Accordingly, Mr. Darby, the college architect, and I made a thorough examination of the premises. We first examined the drainage, the main sewers being found to be intact, well laid, and disconnected from the town sewer by an efficient trap, but with no ventilation-shaft. All the closets and urinals, which are in the quadrangle on the west side, were found in good working order, and well ventilated, only being half roofed in.

In the large dormitory, containing sixty cubicles, were two water-closets, both of which were found to be badly ventilated, the soil-pipes thin with age, much corroded and pinholed, and without any ventilating shaft. Into one of these pipes an overflow from a large cistern opened direct, without any trap. The pipes from the lavatories were in direct communication with the sewers, and were half filled with a thick black looking mud. The water-supply for drinking and cooking purposes was good, and supplied from special cisterns, but that for the closets and drains was insufficient. The household refuse was not removed frequently enough, but nevertheless had given rise to no apparent nuisance. The ventilation of the institution was very defective, being only that obtained by windows and louvres, which were always securely closed at night, making the dormitories and class-rooms very foul and close when in use.

In making this examination, both the college architect and myself were much indebted to Dr. Wright, the medical officer of health, who gave his assistance and the benefit of his sound experience, and, at our combined recommendation, the committee made all the necessary alterations to put the college into the best sanitary condition.

Fortunately, this outbreak was in the latter half of the term, and ended with the commencement of the holidays, and from that date (Midsummer 1882) till now (Christmas 1883) there has been no re-appearance of the disease. This outbreak is reported by Her Majesty's Inspector of Training Colleges for England and Wales, the Rev. T. W. Sharpe, in his report at page 554 of the Report of the Committee of Council on Education (England and Wales), 1882-1883.

OBSTETRIC MEMORANDA.

PREGNANT ANTEFLEXED UTERUS.

I MUST take exception to both the treatment and remarks of Dr. J. Courtenay Haslett, in the JOURNAL of the 8th instant, on a case of the above treated by the production of abortion. Notes of a very similar case will illustrate my views on the former. Six years ago, Mrs. K., aged 23, married for eight months, consulted me on account of vomiting, which, she said, had been increasing for three weeks, until she thought she retained positively no food. She had missed two periods, and suspected herself pregnant. She complained of some bearing down and difficulty in passing urine. Her general health, too, had suffered much. All the usual remedies by the mouth were tried during a week, without the slightest beneficial effect. By this time, she had become so emaciated and weak, that she could not get out of bed. I repeatedly entreated her to allow me to examine the uterus, but she as often flatly refused. Even sucking ice now aggravated the incessant retching and vomiting. The patient continued to become weaker,

and with no abatement of the symptoms, for three days longer, except about six hours' partial relief, which minim doses of ipecacuanha wine every quarter of an hour gave her. I then stated that, unless I were permitted to make the necessary examination, my retirement from the case altogether must ensue. The following day, a digital examination of the vagina revealed an anteflexed uterus, evidently pregnant. The fundus was tender, enlarged, and firmly fixed at a lower level than the os. With considerable difficulty, and much pain to the patient, two fingers in the vagina, with the assistance of the other hand over the pubes, served to forcibly push up the fundus until both hands met behind the pubes. The patient was left with the hips raised about a foot. Vomiting ceased at once; and beef-tea and milk, with sola-water, were taken freely. The next day, a cradle-pessary was placed, after the fundus had again been pushed from the position which it had to a comparatively slight degree reassumed. The patient gradually regained her strength and loss of flesh, though it was thirteen months before she had done so entirely. The pessary was removed as soon as the fundus ceased to lean on it; and the patient was safely delivered, at the full term, of a healthy child, which is still alive. She has since borne three children, exhibiting similar symptoms, but in a decreasing degree, in each pregnancy. Identical mechanical treatment has been adopted, with the desired result. I found the uterus slightly anteflexed after the first involution was complete; but she declined treatment, except when driven to submit to it. She has never miscarried. At each labour, the head was very loth to leave the ilio-pectineal line on which it rested, and to enter the true pelvis; this always protracted the first stage. A very determined attempt with the hands alone—under chloroform, if necessary—ought always to be made to restore to the natural position a flexed uterus, more particularly if pregnant; and where there is no adhesion, and the surrounding parts are in a normal state, I fail to see why it should not succeed. The use of the sound at such a time is improper. If the uterus can be erected by dragging at the cervix (which might render an anteflexion more acute), it certainly ought to be as easily replaced by the simpler and less hazardous plan of pushing up the fundus.

With regard to Dr. Haslett's remarks on the rarity of anteflexion in the early stages of pregnancy: since that condition is merely an exaggeration of the normal position of the organ, and so in a less degree in the pregnant state, and considering the varying pressure it is subjected to from above, I am not surprised to find, in practice, that a morbidly anteflexed uterus in the early months of pregnancy is of very common occurrence. But that a womb much bent forwards on its own axis often becomes pregnant, I think most gynecologists will agree, seldom happens. Were it happily otherwise, a little judicious management would place us in the best position to see the case cure itself in many instances, in a way most gratifying to the patient. Secondly, in the absence of any complication whatever—and the course and result of the case show none—Dr. Haslett advances no reason why the treatment should not have included the prevention of abortion, instead of its production. Ought not the difficulties of the operation referred to by Dr. Haslett to be obviated, rather than incurred?

ROBERT DAVIS, Low Fell, Gateshead-on-Tyne.

CLINICAL MEMORANDA.

BLACK TONGUE.

As far as I am aware, this disease has not been seen in England, though it has been described on several occasions by French writers. Cases are mentioned in the *British and Foreign Medico-Chirurgical Review*, as being reported by Dr. Eulenberg and M. de St. Germain. The former mentions one case, that of a boy, "whose tongue was black from base to apex." The papillæ were much hypertrophied, and the condition continued for three months. Scrapings of the tongue, when viewed under the microscope, showed "numerous thickened brown coloured epithelial cells, and on their borders pigment-granules were enclosed by cell or membrane."

The cases reported by M. de St. Germain are four in number. He "four times met with a spot of an oval shape and intense black colour in the middle of the organ:" 1, a girl, aged 13, with increasing emaciation and paraplegia; 2, a girl, aged 11, convalescent from enteric fever; 3, an asthmatic old lady, aged 70, whose health was not otherwise impaired; 4, an old man in fair health.

The case I have under my observation is one of a man, aged 70; he is a painter by trade, but has not been in active employment for five years. He is one of seven brothers, and his "family history" is excellent. He has suffered with painter's colic, and had two strokes of paralysis eight years ago. He first noticed the discoloration of his tongue three years ago; commencing by an ellipse of black in the centre