iron, or nitric acid with decoction of cinchona. It seems to me that a combination of chlorate of potash with tincture of iron has a peculiar and most beneficial effect in all erysipelatos diseases, and I now invariably prescribe it. At the same time, plenty of milk, beef-tea, chicken-broth, and raw eggs and brandy should be given. Overstimulation, however, is to be carefully avoided, and the quantity of brandy given should be regulated by the amount of asthenia present. If the patient cannot swallow these articles they should be given in the form of enemata. If given thus, the benefit to the patient will be greatly increased by the addition to each enema of a little pepsine and hydrochloric acid about half an hour before it is administered. Local applications, as large linseed-poultices, hot fomentations, and poppy-stupes, should be applied, as they relieve pain and tension. However, all these measures are of small importance in comparison to the surgical treatment, as they have little or no curative power over the disease, and if they alone be used the patient will probably die. As Mr. H. G. Croly says, "The symptoms are urgent and alarming, and if relief be not afforded by prompt and bold surgical aid, the patient may be suffocated."

As soon as the brawny feeling of the tissues, with pitting on pressure, sets in, free and deep incisions should be made into the cervical fascia. When these incisions have been made, the relief which they give is immediate, even though no serum or pus escape; as the cervical fascia, being divided, stretches and tears, and the tension is thus greatly lessened. I have seen patients who had almost complete aphonia and dysphagia able to speak and swallow in five minutes after incisions had been made, and this even though no fluid escaped.

To illustrate the suddenness of the relief afforded I may mention a case which I treated at Fort Pitt, Chatham. The patient was admitted into hospital in January 1882, complaining of general febrile

symptoms and slight sore throat. On the evening of his admission he was seized with a severe rigor and pain in the right side of his neck. The symptoms and appearances above described soon manifested themselves, only in this case the disease was entirely confined to the right side of the neck. About forty-eight hours after the swelling of the neck began I was called to see him, and found that violent dyspnoea had suddenly set in. On examination, it was found that the swelling had greatly increased, and had pushed the larynx considerably to the left side. As the patient was in imminent danger of suffocation, an incision was at once made through the skin one inch to the outer side and one inch above the inner articular end of the clavicle, where

the swelling seemed to bulge most. The cervical fascia was then divided on a director, and a large quantity of sanious pus at once escaped. The man expressed immediate relief, the voice became clear, and he drank some beef-tea in a few minutes afterwards.

In making the incisions, it is only necessary to remember the anatomy of the neck to do so with perfect safety. On the accompanying sketch, which is taken from one by Mr. Croly, in his pamphlet on *Cellulitis of the Neck*, the lines of safety and danger are well shown. The lines of danger are shown by the black lines, while those of safety are shown by the dotted lines. The line extending from the angle of the jaw to the centre of the clavicle represents the course of the external jugular vein; while the curved line, along the inner border of the sterno-mastoid muscle, shows the course of the carotid vessels. The lines of safety will be seen to extend along the mesial line from the chin to the interclavicular notch, and along the posterior border of the sterno-mastoid muscle—taking care, however, to avoid the spot where the muscle is crossed by the external jugular vein. In making the incisions, it is best to adopt the method recommended by Hilton—viz., to make an incision through the skin with a scalpel; and then, having passed an ordinary pair of dissecting-forceps through the cervical fascia, forcibly separate their blades, and thus tear through this structure. In the supra-hyoid region, however, along the mesial line, this is not necessary, as here the scalpel can be passed to the full length of its blade without danger.

Before concluding, I would refer to a variety of this disease, first described by the late Dr. Osbrey of Dublin, and which is nearly always fatal—namely, that occurring in children recovering from malignant scarlatina. In these cases, the disease sets in very insidiously, and is invariably followed by sloughing. Dr. Osbrey believed it was not good practice to make incisions into the cervical fascia in these cases, as the patients are not able to bear them, and they, in his opinion, only hasten a fatal termination. These cases are to be treated with chlorate of potash and tincture of iron, together with all the nourishment the patient can be got to take.

NOTES OF A CASE OF GONORRHOEA, WITH ACUTE RHEUMATISM AND ENDOCARDITIS OCCURRING IN ITS COURSE.

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THE following case, which I shall endeavour to report as briefly as possible, is of considerable interest, and deserves to be recorded on account of the rarity with which gonorrhoeal rheumatism is complicated with endocarditis. Rosenstein, in Ziemssen's *Cyclopaedia*, vol. vi, almost denies the occurrence of endocardial complication in this form of rheumatism; while Senator, in vol. xvi of the same work, asserts that, if more than two or three joints be affected, if there be abundant sweating and affection of the heart, we have not to deal with gonorrhoeal rheumatism at all, but with a case of acute rheumatism, accidentally associated with a gonorrhoea. It is difficult to see why this so-called gonorrhoeal rheumatism, very similar in its character to the forms following scarlet fever or childbirth, in which endocarditis is by no means of uncommon occurrence, should differ from them in any special immunity from valvular complications, or in any of the other clinical features. In all three, there appears to be reason for assigning their origin to something akin to pyæmia.

J. R. C., aged 21, bookbinder, was first seen on September 17th, on account of a sore-throat. His previous and family-history were as follows. He had never suffered from rheumatism in any form, nor from scarlet fever. He had always enjoyed good health. His parents were both dead from phthisis, neither of them having had rheumatism to his knowledge. About the beginning of August, he contracted gonorrhoea for the first time in his life; for this he had an injection prescribed, which caused the discharge to diminish. On the 25th, he discontinued using it, thinking he was cured; but he still noticed the end of the urethra to be occasionally glued up, and a drop of pus to escape when the orifice was pressed open.

Without having been particularly exposed to cold or wet previously, on September 15th he began to feel ill. He had repeated shiverings, aching in his limbs, and sore-throat, and felt feverish.

On the 16th, his throat became worse; swallowing was painful and difficult, and his head ached excruciatingly.

On the 17th, when seen for the first time, his tonsils were swollen, and intensely red; his headache was so severe, that he said it almost blinded him. His temperature was only moderately high (102° Fahr.).

On the 18th, the throat was as before; he complained also of great pain in the lumbar region of the back, aggravated by the slightest movement.

On the 20th, the swollen tonsils had commenced to diminish in size without having suppurated. He had great pain in the right wrist, which was found to be slightly reddened and swollen. Copious sour-smelling perspiration had come on during the previous night. The heart was examined for the first time, and was found to be free from murmur, and with a normal superficial dulness. He was ordered salicylate of soda.

On the 22nd, the throat was perfectly well; but, during that and the following days, the left wrist, both ankles, and the knees were successively attacked with pain, redness, and swelling; the pain in the back continued, and there was also pain in the anterior muscles of the thighs. The case during this period presented the typical appearance of acute rheumatism; the patient was sweating copiously, was restless and sleepless, and every movement gave pain in the parts affected.

Upon auscultating the heart on the 22nd, a very faint systolic murmur was to be heard at the apex, in an area about two inches in diameter, extending only as far as the left mammary line. He complained of no pain in the region of the heart. There was no cough. He continued in this condition until the 25th, with the temperature moderately high; the joints affected as above.

On the 25th, the fever, pain, and sweating began to abate. The systolic apex-murmur was still present, and the pulmonary second sound was found strongly accentuated. The superficial cardiac dulness remained unchanged, the apex-beat was in the fifth interspace within the mammary line.

On the 29th, the systolic murmur at the apex and the accentuated pulmonary second sound were as before. On October 3rd, a second murmur became audible, systolic in rhythm, with its maximum intensity at the aortic cartilage. It was conducted down the sternum towards the ensiform cartilage, and towards the left nipple as low as the third interspace, at which place it was lost, leaving a distinct interval between it and the apex-beat, where the mitral murmur was to be heard. The area at which this latter murmur was audible was as contracted as before. It could not be heard at the back. The second sound was reduplicated, and the accentuation of the pulmonary second sound, though still present, was not so marked. The fever and pain having entirely subsided, he discontinued the use of the salicylate of soda. On October 4th, he got up.

On October 5th, the gonorrhœa, which he had not noticed at all during his illness, returned with a copious purulent discharge.

On October 22nd, after having used an injection assiduously, the gonorrhœa had almost ceased. On auscultation of the heart, the murmurs were found to have disappeared, but the accentuation of the pulmonary second sound was still audible, as also the reduplication above mentioned. The superficial cardiac dulness was still unchanged.

I should not have brought forward this case in contradiction to the statements of Senator and Rosenstein, were it not for the fact that the gonorrhœa seems to have been intimately connected with the rheumatism. The occurrence of the latter at a comparatively late period of the gonorrhœa by no means contradicts this, for it is acknowledged that the limited and subacute rheumatism, which is the usual form taken by this complication when it occurs, makes its appearance most frequently when the discharge has been in existence some time. The abeyance of the discharge during the acute attack, and its reappearance in full force upon recovery, appear to me to point to some intimate causal relation, though what that may be I do not pretend to say, between the two phenomena.

As regards the heart-symptoms, I believe that the apex-murmur was the result of valvulitis affecting the mitral opening; and, although both murmurs have disappeared, it is extremely probable, from the continuance of the accentuation of the pulmonary second sound, that some slight chronic change in the mitral valve is still taking place. The occurrence of this murmur within a week after the commencement of the rheumatic fever points to the conclusion that it was due to endocarditis rather than to anæmia. The absence of right hypertrophy does not affect this supposition, as this is not usually met with in the early stages of mitral disease, but creeps on in the course of time.

The aortic systolic murmur may, perhaps with reason, be ascribed to anæmia, since it occurred at the end of a fortnight's illness.

If the view I have taken of the case be accepted, and subsequently supported by other cases of a similar character, it will certainly give a more serious aspect to an attack of gonorrhœa than we have hitherto supposed possible.

A SUBSTITUTE FOR THE OPERATION OF PLUGGING THE POSTERIOR NARES, AND AT THE SAME TIME APPLYING PRESSURE AND COLD TO A LARGE PORTION OF THE NASAL TRACT.

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In a case of hæmophilia, which recently came under my observation, and in which there was severe and persistent epistaxis, the posterior nares was several times plugged, causing very great distress to the patient, and only affording temporary relief. I devised the accompanying appliance, but regret that, owing to the fatal termination of the case, I was unable to test it practically on the living subject. I did, however, test it on the dead subject, having previously made "Bichat's" section, and found it, apparently, fulfil all the required conditions admirably. When collapsed and oiled, it is inserted without the least difficulty. The only point on which I have any doubt is as to whether it would exert sufficient pressure to check the hæmorrhage; but, if the India-rubber bag were made of thicker texture, any desired amount of pressure could be obtained. The materials and construction are very simple. The end of a gum-elastic catheter, four inches long; a piece of India-rubber tubing; an article of "French" manufacture, in common use, but usually applied to a less laudable purpose; and an ordinary clamp, are all that are required.

If pressure alone be required, it can be simply inflated. If the application of cold be required, the tube should be attached to a water-bag, only partially filled, and kept in a vessel with ice, when, by opening the clamp, relaxing, and then compressing, the water-bag, freezing water can be applied to the nostril, and changed as frequently as desired. The drawing shows the instrument in use, with the bag inflated.

EXCISION OF THE SCAPULA.—At the Alfred Hospital, Melbourne, on March 19th, Dr. Blair, with the assistance of his colleagues, removed the entire scapula from a man who had previously had his arm amputated for disease of the shoulder-joint, and in whom the disease of the bone had subsequently extended. The *Australian Medical Gazette* for April reports that the patient was doing well. It believes that this is the first time of performing the operation in Melbourne.