history was as follows. She had been confined on October 7th of her ninth child. The placenta was retained, and had to be removed. About a week subsequently phlegmasia set in, and the right leg became enormously swollen. When she was admitted to hospital, the pulse was 120, the temperature 102.8°. The usual remedies were applied; the symptoms became aggravated, hectic supervened, and her life seemed to be in the balance. A large pelvic abscess formed, which was opened, and continued to discharge for a month. From this time recovery was rapid and satisfactory; and, at the end of another month, the patient left hospital. The point of interest in connection with this case of phlegmasia in the right leg is, that this patient was unable to lie on her left side, and, as a matter of fact, had been on her right side continuously from the time of her confinement.

CASE II.—Mrs. R., aged 32, was admitted on January 4th, 1884, suffering from phlegmasia in the right leg. She had been delivered of her fourth child seven days previously, had a difficult labour, and considerable hæmorrhage subsequently. This patient, too, persistently lay on her right side, owing to some chest-affection. In her case, the symptoms were less aggravated than in the former, and recovery more rapid; but posture in this case, as in the other, suggested the probable cause, and accounted for the limb involved.

Whether the cause of phlegmasia be absorption of irritating and poisonous matter only, or whether it be absorption and pressure combined, or pressure of the uterus, or of the uterus and colon, on the veins crossing the brim of the pelvis, or thrombus and embolism, or any specific poison, is a question not easily determined; but these two cases go some way, I think, in establishing the doctrine that position, with perhaps mechanical pressure added, will account largely for the limb involved in *post partum* phlegmasia dolens.

Dr. DILL (Belfast) had been for some time much interested in such cases as were so well and so clearly introduced by Dr. Esler. Until he had seen these two cases, he had never seen one of phlegmasia dolens but in the left leg; and, consequently, he was very much impressed with the idea that the disease originated with a specific poison; but he now holds the opinion that phlegmasia dolens was induced, first, by the wearing down of the system from hæmorrhage and irritation of the womb, and somewhat by the position which the patient had kept for a length of time.

The PRESIDENT (Dr. Godson) had seen more cases of phlegmasia in the right leg than in the left; and could, therefore, not accept the position-theory. He thought the uterine hæmorrhage, in both cases, and in one, the removal of the placenta by the hand, much more likely to have been the primary causes of the attacks.

TUMOURS OF THE CEREBELLUM, AND PHENOMENA ASSOCIATED THEREWITH; WITH NOTES OF A CASE, AND PATHOLOGICAL SPECIMEN.

Read in the Section of Physiology and Pathology.

By S. A. K. STRAHAN, M.D.,
Medical Officer to the County Asylum, Northampton.

THE exact part played by the cerebellum in the production of nervous phenomena is not yet determined. Various functions have been attributed to it by physiologists at different times; but, of all these, co-ordination is the only one which now stands unquestioned, and in it we certainly seem to have hit upon one true function of this organ.

The experiments of Flourens, Ferrier, and other practical physiologists, certainly prove that mechanical destruction or irritation of parts of the cerebellum destroys wholly or in part the power of co-ordination in the muscular actions, and especially in those of the lower extremities. But, while injury of a lateral lobe of this organ causes pretty constant phenomena in the laboratory, it is found that disease of a lateral lobe in most cases causes no symptom pointing at all in the direction taken by the mechanically induced phenomena. In fact, it is the rule that in cases of tumour of the cerebellum a clear diagnosis is seldom or never made during life, except in those cases in which the middle lobe is affected.

Aitken, quoting Althaus, puts it shortly thus: "Symptoms occur only when the middle lobe is affected." The study of the minute anatomy of the organ does not clear up this strange absence of symptoms in cases where the central lobe is free; and why mechanical injury should act so very differently from disease we cannot explain, or even very clearly understand.

It may be worth while briefly to record the following case, more especially as it is one of the few in which the symptoms point directly to the seat of disease, and a correct diagnosis is possible.

Charles L., aged 7, was admitted as an idiot into the asylum. He was a small squat boy, with convergent strabismus and some nystagmus. He talked incoherently in a semi-distinct manner, answered simple questions sensibly with "yes" and "no," and made peculiar noises with his mouth at times. He was dirty and destructive in his habits at first, but he improved much in this respect. He always had an awkward gait, although nimble on his feet, and he generally kept the hands and wrists half flexed, as though semi-paralysed. Co-ordination in the hands appeared good, but in the legs it was from the first imperfect; vision was good, and sensation normal.

The family-history is worthy of attention; it was as follows. His grandmother was an epileptic; his mother was an inmate of an asylum; his father had been a certified lunatic on at least one occasion, and an uncle had died in an asylum.

The boy lived five years after his admission into the asylum. After one year's residence, he began to have attacks of vomiting at irregular intervals, which were attributed to over-eating, and a year later he developed what was looked upon as true epilepsy. During the third year of residence, the fits, which had been few, began to increase in number; and he made no mental advance from this time. During the fifth and last year, he became unable to walk safely. His gait was exactly that of a child giddy from turning round; when he got started in a straight line, he would get along pretty well at a kind of half run, but when called back he would stop, sway about, and seem unable to turn for fear of falling. During the six months before death, the giddiness increased, and he was soon totally unable to walk alone, although he could do so fairly well if supported by the hands. Then he became worse, and could not stand alone. If left standing, he swung round and fell. The body did not in its gory movements always swing to the same side; the direction seemed to be determined by the relative position of the body and lower limbs at the time.

A month before death, he was found to be totally blind; but, in consequence of his limited mental development, it was not known when the optic neuritis had set in. Five years after admission (age 12), he was seized with a fit, in which he died from apnoea.

I must mention that, during the last year, when able to walk about, he was noticed to turn round when seized with a fit, and before he fell, he was seen to make more than a complete revolution.

Necropsy.—The arachnoid was thickened generally over hemispheres, and the pia mater, on removal, tore the brain-tissue considerably. The convolutions were somewhat flattened; the grey matter was thin; the sulci were shallow, and the white centres of rather more than the usual consistence; in fact, it was a typical imbecile brain. The brain could not be removed entire, in consequence of adhesion between the posterior part of the cerebellum and the dura mater. The adhesion was sufficiently firm to drag the tumour out of its bed in the surrounding softened brain-tissue. The adhesion was entirely made up of connective tissue; there was no vascular connection. The tumour lay in the centre line, and extended almost equally into each lobe. The surrounding brain-tissue was much softened, and it was impossible to make out even the arbor vitæ on section. The tumour weighed over an ounce, and made up more than a third of the whole cerebellar mass. It occupied the whole depth of the inner and posterior parts of each lateral lobe of the cerebellum, and extended forwards over the roof of the fourth ventricle to the peduncles.

NOTES OF A CASE OF INCONTINENCE OF URINE, FROM MALFORMATION.

By THOMAS MORE MADDEN, M.D., F.R.C.S. Ed.,

Obstetric Physician to the Mater Misericordie Hospital; Physician to the Hospital for Sick Children, Dublin; formerly Examiner in Obstetric Medicine in Queen's University, Ireland, etc.

INCONTINENCE of urine, although so common and generally curable an affection amongst children, is by no means, even under ordinary circumstances, unworthy of more consideration than is generally accorded to it in text-books of the diseases of childhood. In many instances, within my own experience, this complaint has proved intractable to medical treatment. Nor does even Time, that great panacea for many of the chronic diseases of youth, as universally effect a cure in such cases as some writers contend. For, in several cases, I have known the most serious consequences result from incurable or uncured incontinence of urine; and I have seen life thus rendered

miserable, and the fairest prospects of success completely marred, by this unfortunate ailment. On the present occasion, however, I desire to confine my remarks to a cause of incontinence of urine which, as far as I am aware, has not been noticed by any previous writer on the subject, and which is exemplified by a case still under my care.

In this instance, the patient is a young lady, now in her sixteenth year, about whom I was first consulted four or five years since. She was then going abroad, and, her ailment being only casually mentioned to me when visiting another member of her family, I merely advised the usual routine treatment—namely, iron with belladonna, blistering the sacrum, etc. No benefit whatever followed this; and, as her family were leaving home, I lost sight of her for some years, when I learned that she had been at first taken to a school in Belgium, where the incontinence of urine became so troublesome to herself and so unpleasant to others, and exposed her to such derision on the part of the other children, that, after a short time, she had to be removed to another school, and thence again to another, with the same result. Ultimately, she was brought over to London for medical advice, and went the round of several eminent physicians and surgeons. Still the incontinence of urine remained uncured. Finally, she was brought back to Dublin, and I again saw her.

As the flow of urine was now incessant, although she evidently had the power of retaining and voiding at will a certain quantity of urine at long intervals, I concluded that there must be some malformation; and accordingly proposed an examination. In this, I had the benefit of Dr. Kidd's advice and assistance. She was placed under chloroform: and we convinced ourselves by examination, first, that there was no fistulous communication between the bladder and vagina; and, secondly, that, half an inch above the meatus urinarius, there was a minute aperture, from which a small stream of urine was continually escaping, almost *guttatim*. This opening was so small, and concealed by the ruga of the vaginal mucous membrane, that it was only discovered after a long and careful exploration. We traced this passage by a No. 1 elastic catheter, introduced to its full length, between the bladder and urethra, and above this upwards and backwards. The length of the canal, and the constant dribble of urine through it, were sufficient to distinguish it from either the supposed duct of the Wolffian body, or from the peri-urethral duct recently described by Dr. Schüler of Berlin, as situated within the longitudinal folds of the urethral mucous membranes that converge towards the meatus, on each side of the middle line, and into which a sound can be passed, of from one to four millimetres in diameter, for a distance of from one-half to two and a-half centimetres. In the case now reported, however, the orifice discovered near the meatus was quite distinct from Schüler's duct. This was proved by the anatomical character of the parts, as well, as already observed, by the length and permeability of the canal and the escape of urine through it.

The conclusion arrived at by Dr. Kidd and myself, as the result of our examination, was, that we were dealing with an instance of malformation and malposition of the right ureter. Accordingly, we suggested the possibility of establishing a communication between the bladder and ureter, and of closing the external orifice of the latter. At the same time, we placed the possible risks, as well as the chances of success, of such an operation before the patient's relations. As the case is still *sub judice*, I have ventured to bring it forward, not only on account of the pathological interest and rarity of the condition described, but still more with the view of seeking any hint that the experience of others may suggest; by which the treatment of this puzzling, and, I may add, distressing, case may be facilitated.

NOTES OF A CASE OF ERYTHEMA MULTIFORME.

By H. E. SPENCER, L.R.C.P.E., YORK.

LAURA R., domestic servant, aged 19, came under my care on April 25th. She was an anæmic, delicate, somewhat hysterical blonde. Anæmia, and an excitable emotional system, were family characteristics. Several near relations have suffered from rheumatism. The girl was vaccinated in infancy, and subsequently had measles and varicella. For some days before the invasion of the present illness, the patient had been engaged in the arduous toil of "spring-cleaning," and was much exhausted in consequence. During this period, she had slept in a damp room.

The illness itself began on April 20th. During the first four days, she suffered from weariness, aching in the limbs, much lumbar pain,

headache, and slight cough. There was constipation, but not vomiting. On the fourth evening, a few spots were noticed on the back of one of the wrists, and on the sixth morning the rash consisted of flat ovoid red papules, about the size of a split pea, involving the cutis vera; they were scattered about the limbs, cheeks, neck, and chest; but were absent from the forehead and abdomen. They were the most numerous on the extensor aspects of the wrists and ankles, and were also congregated, in a less degree, near those of the elbows and knees. On the sixth day, the papules were doubled in diameter, and in many places had coalesced, forming irregular congested patches, separated by healthy skin. Both spots and patches had now a faded centre, surrounded by a congested ring, but had no fluid contents. On the eighth day, the congestion began to disappear, and on the twelfth day the eruption was hardly perceptible. Branny desquamation followed. The patient was menstruating from the fourth to the ninth day. No evidence of any visceral mischief was obtained.

The general symptoms were those of high fever, which on the ninth evening was accompanied by very considerable excitement, not, however, amounting to delirium. On this evening there was profuse sweating, and an odour was exhaled which was indistinguishable from that characteristic of acute rheumatism. On the eleventh morning she was in a very prostrate condition, with a dry brown tongue, and rapid irregular pulse; but from the noon of that day the general condition began slowly to amend.

The temperature and pulse were as follows. Sixth day: evening temperature, 102°; pulse, 110. Seventh day: morning temperature, 103.5°; evening temperature, 104.5°. Eighth day: morning temperature, 104°; pulse, 120. Ninth day: morning temperature, 103°; pulse, 120; evening temperature, 104°; pulse, 130. Tenth day: morning temperature, 103.5°; pulse, 130; evening temperature, 103°; pulse, 120. Eleventh day: morning temperature, 101.5°; pulse, 130 to 140; evening temperature, 101.5°; pulse, 120. Twelfth day: morning temperature, 100.5°; pulse, 100; evening temperature, 100°; pulse, 90. Thirteenth day: morning temperature, 98°; pulse, 80. Fourteenth day: temperature, 98°; pulse, 80.

The coexistence of a high degree of fever with a papular rash, preceded, amongst other symptoms, by lumbar pain, led me at first to suspect the presence of small-pox, against which, however, were 1, the absence of a source of infection; 2, the absence of vomiting; 3, the distribution of the eruption; 4, the non-subsidence of the fever as the rash developed. When, on the third and fourth days of the eruption, it still remained papular, I was sorely puzzled as to the diagnosis; and my difficulty was shared by my friend Mr. S. W. North, who saw the case with me. The diagnosis of erythema multiforme is, I think, confirmed by the following considerations: 1, the character and distribution of the rash; 2, the age and constitutional state of the patient; 3, the family history of rheumatism; 4, the history of fatigue and exposure to damp as the apparent exciting cause. The fact that such marked pyrexia—at one time giving the disease a really serious aspect—may be associated with this exanthem, though mentioned by Dr. Bristowe (*Treatise on Theory and Practice of Medicine*, 2nd edition, p. 307), and treated of fully in Trousseau's *Clinical Lectures*, is not, I believe, a matter of common information. I have ventured to report the case, in the hope that it may serve to suggest an alternative diagnosis, when cases of possible small-pox present themselves.

THERAPEUTIC MEMORANDA.

TREATMENT OF HAY-ASTHMA.

LAST year I was led to try a well known powder for hay-asthma, and found that it afforded great relief during the attacks of dyspnoea. This year I again used it, but a natural repugnance to have anything to do with secret remedies led me to try to find out something which would act in a similar manner.

I find that a powder, composed of six drachms of each of the following, namely, *datura tatula*, *stramonium*, *cannabis Indica*, and *lobelia inflata*, mixed with one ounce of powdered nitre, and half a drachm of eucalyptus oil, burns well, gives off dense fumes, and affords great relief during asthmatic attacks. A teaspoonful burnt in the bedroom will often enable the patient to sleep; and, should he awake with an attack, a little more will generally afford relief.

I hope that any gentleman using the above will report the result. I may add that it only relieves the asthma, not the nasal catarrh, sneezing, or coryza.

W. H. BEVERLEY, L.R.C.P. Lond.
Scarborough.