which, in these tables, the five thousand cases of cutaneous disease have been carefully sorted (and this information is accurately afforded by the census-returns), and then to compare the proportion of persons affected with skin-disease at each period of life with the number of persons ascertained to be living at each of such periods respectively. This computation is effected in the tables that follow.

Table III is a transcript of the (as yet) last published census of the population of London.

In Table IV, the ascertained statistics of the five thousand cases of cutaneous disease are contrasted with a parallel statement of a *general* population of five thousand, the items of which are calculated from the census of the population of London, shown in Table III; so that in Table IV is shown, at a single view, how a population of five thousand cutaneous patients is distributed amongst the various periods of life, and, at the same time, how a population of five thousand people of all kinds is distributed amongst the same periods of life.

In Table V is shown the results obtained by the comparison of the one with the other—that is to say, each of the figures in the first and third lines of Table IV has been divided by the corresponding figure placed beneath it; namely, in the second and fourth lines respectively, and the result expressed in decimals, which display the relative liability to skin-disease of each of the stated periods of life.

In the diagram drawn below is presented a pictorial view of the results obtained in Table V—the black zig-zag representing the results arrived in the cases of males, and the dotted zig-zag the results in the cases of females.

Further investigation is necessary to establish what may be the precise interpretation of these fluctuations; but it is clear at a glance that, in the female, skin-disease becomes suddenly and markedly more common at the two climacteric periods of life.

Diagram of the Comparative Liability (expressed in decimals) of Males and of Females, respectively, to Cutaneous Disease at different ages.
Thick line—Males. Dotted line—Females.

ALOPECIA: VITILIGO.

By GEORGE GASKOIN, ESQ.,
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IN my notes of last year, I find a group of cases which cannot but arrest attention—alopecia, not parasitic and contagious, but a form connected with degenerative change, and probably with subinflammatory conditions. I was much struck with what I found in a girl thir-

teen years of age. She had on the vertex a large round patch of alopecia areata. The hair had begun to recover itself freely in its growth, so that there was nothing locally to be remarked. On her neck, and following the margin of the right ear, were streaks and also spots of leucoderma. These were quite away from the hairy scalp. The spots were, as to size, like small *coque de perle*, an orange-pip, or small grape. This girl was of good condition and well fed, not remarkable for complexion, nor any otherwise than for a large-sized head.

Among my cases of leucoderma occurring during the year, I have noted two in which the hair was shed. In one of these, a man of dark complexion, forty-two years of age, numerous white spots or guttae were found on the arms, and, as is frequent, on the back of the hands; more of it also on the lower belly. Much itching accompanied the leucoderma, especially when he was warm in bed. His hair came off in large patches. He attributed his complaint to the small-pox which he had four years ago. In a very similar case, where the hair and complexion were light, there was little itching. The man's age was 47. He looked well-built, but complained of weakness. I have noted the loss and absence of hair in this case, but do not recollect its condition. He had suffered from the leucoderma for a year. The backs of the hands were spotted, and other parts moderately affected. There were none on the scrotum, but on the glans penis there was a pure white spot occupying half its surface. I may here mention a paviour under thirty years of age. Much of his hair came away irregularly and in patches. Of what he had left, a considerable portion was turned quite white; the rest had lost its gloss. He wore his hair long, and it gave him a mangy look. More striking is the following. A woman thirty years of age, married, but without children, had a large round spot of *area* upon the vertex, upon which there is at present some little hair, which obscures it. From this point there extends a narrow ribbon-like track, raised as it advances above the level of the scalp, and terminating on the forehead like keloid. Its path is first to the right parietal and temporal region; thence it bends abruptly to the central parting of the hair, and finally is produced downwards for the length of two inches or more to the centre of the forehead. This linear cicatricial band, denuded or nearly so of hair, opens out on the forehead into two extremities or claws embracing a spot of vitiligo sunk below the surrounding level, of a pure white colour, and as large or larger than a shilling. There is much itching in the affected parts, and elsewhere on the head there is scurf. The fold of the arm on one side displays much dark cloasma, the coincidence of which with alopecia has been remarked on by medical writers.

The occurrence of cases such as these has not been overlooked by physicians. The terms vitiligo of the scalp and *morphea alopeciatæ*, though not of common acceptance, are significant of study and observation; but yet a pathology is wanting, without which empiric practice is liable to error. I may here suggest that in these changes there is probably an early stage in which something of inflammation is concerned. In cutaneous disease generally, I find the hair come away with a facility that is pretty exactly proportioned to the intensity (I dare not say the duration) of a foregoing inflammation. This is eminently the case in syphilis. Very commonly, indeed, in alopecia, we hear of itching and heat; we also find redness. Thus one of my group of cases complains of "large heat-lumps rising in the head".

In a female aged 27, bookfolder, probably ill fed, there are several round bare spots on the scalp; "they become pink, and never white; they last three months," and then the hair returns, growing with much rapidity. On the face, there is a good-sized erythematous blotch, which she thinks is "all one with those on the head". She is weakly, with bad pain low down in the back. In a young fellow, a draper's assistant, the hair and whiskers are removed in large patches. He is much distressed. He has used the oxymuriate lotion. Every time he speaks with heightened colour in speaking, there are dark coloured erythematous patches, very observable on the face. As he relapses into silence, they are not observable. Still more interesting is the following. A sempstress, married to a broken-down gentleman, and probably overworked, sitting up late at night at her employment, has on each side of the face a very large erythematous blotch, occupying nearly the whole of the cheek, well defined, and level with the skin. The colour is deep red. The eruption does not correspond to any nosological species. It has been coming on for two years. There is no suspicion of syphilis. She has one healthy child, and has had one miscarriage. The treatment is tentative, but chiefly expectant. A lead lotion is employed to relieve irritation, and seems to suit best. During the later months that I had her under view, the following changes took place in the blotches. Near to the margin, and in proportion as it was approached, a paleness gained upon the original stains; it became, in fact, leucodermatous at and toward the circumference. Nor was this all: a copious deposit of brown pigment was

abundantly deposited in the surrounding skin, so that, in fact, the margin was better defined than heretofore. The whole on each side was set in a dark brown framework. About this time, a single small patch of similar erythema was developed on the forehead towards the roots of the hair; and I had an opportunity of remarking that where it encroached on the scalp, the hair was shed precisely as in alopecia. The case seems to come under the head of morphea or vitiligo, and to stand in correspondence with the foregoing cases. They all seem remotely allied to that degeneration and decay which is evident in the vitiligo and loss of hair observed in drop evil and elephantiasis.

SYPHILITIC GUMMATOUS TUMOUR OF THE BRAIN: WITH REMARKS.*

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THE woman from whose brain the tumour here described was removed, died in the Chorlton Union Hospital. I am indebted to Drs. Walshe and Law for the following notes of the case.

Sabrina Bradbury, aged 30, was admitted into the Lock Ward of the Chorlton Hospital on December 18, 1872. She was then suffering from ulceration of the soft palate, and a node over the left frontal bone. She was dull and lethargic, as if weary, and, in short, presented all the symptoms of simple melancholia. At the end of a week, she had much improved, and assisted in the washing and cleaning of the ward. She relapsed on January 15th, when she complained of general pains over the body, and severe hemicrania affecting the left side of the head. She continued in this state till January 20th, when, on getting out of bed, she fell senseless on the floor; when Dr. Walshe reached her, however, she had recovered consciousness. From this date she became rapidly worse; but although she was very helpless, losing control over the sphincters of both bladder and rectum, she still remained conscious to a certain extent; thus, e.g., she could, when roused, still answer questions rationally, and, a week before death, Dr. Law expressly states that there was no aphasia. This heavy state however, rapidly deepened into coma, in which state she continued till January 31st, when she died, exactly eleven days after the first symptoms of grave cerebral disease had manifested themselves. After death, every organ in the body was found to be perfectly healthy, with the exception of the brain. In the brain, a tumour of the colour and consistence of new Stilton cheese, of the size of a pigeon's egg, and presenting all the usual histological features of syphilitic gummata, was situated behind the left frontal bone, occupying a space midway between the second and third tiers of frontal convolutions, whose configuration it had somewhat copied, though it was readily enucleated from them, growing as it did from the intercerebral neuroglia. The membranes over the site of the tumour were a sixth of an inch in thickness, and the inner and outer tables of the skull were slightly necrotic, although the scalp was apparently quite healthy. The greater part of the left hemisphere had suffered from the pressure of the tumour, very complete softening having taken place, which extended through the entire thickness of the brain, reaching as far as the fissure of Rolando superiorly, and the interpeduncular space inferiorly; it was further noted that, while the puncta vasculosa were normally present in the right hemisphere, they had entirely disappeared over the diseased area in the left; this, indeed, explains the softening, which was due to the pressure of the tumour on the walls of the small cerebral arteries.

The points of interest in this case, are the absence of aphasia and the extreme rapidity with which the cerebral symptoms were developed; the significance of these facts I should like briefly to review.

When we consider the locality and extent of the brain-lesion, the absence of aphasia is both interesting and important. It is quite true that some discredit, or rather doubt, has from time to time been cast upon the theory of Broca, that the function of intelligent speech is located in the third left frontal convolution; but it is nevertheless very generally entertained as a plausible theory, and has never been directly disproved. If this theory be true, it necessarily follows that, when the entire convolution is destroyed by injury or disease, this faculty must be abrogated. Now here we have a case in which the convolution was as thoroughly destroyed as if ablation had been performed; and yet, when the patient was roused to answer, she used words in their proper sense and sequence. It is true that some idea of the contour of the convolution was still preserved; but under the microscope nothing was visible but granular matter and fat-globules, all trace of nervous

tissue having disappeared. This being so, I do not see how Broca's theory can longer be entertained, as it is one of those cases in which a single proved negative must be destructive of the entire proposition.

The next point of interest is the extreme rapidity with which the symptoms were developed. Without attempting to prove too much, we may fairly conclude that the greater part of the very extensive change in the brain took place in a week. Now, the significance of this statement lies in the fact that, side by side with this fatal case, many others might be related which, although to all appearance of an equally grave character, have yet yielded to treatment as rapidly as this one passed on to a fatal issue. In illustration of this statement, it will perhaps suffice to quote two cases; the first of which, taken from Gambaco, is related by Mr. Berkeley Hill; the other was observed by myself. "A man had, in 1843, general syphilis; in 1847, he had nodes. Mercury was taken at both periods with benefit. In 1851, he felt pains about the body most intensely in the right leg; after a while these disappeared, leaving muscular weakness and stiffness in the limb, and loss of tone in the bladder. General tonic treatment was of no service; on the contrary, the feebleness of the right leg extended in some degree to the arm and side. In 1852, the patient passed under Ricord's care, who gave him mercury endermically, and iodide of potassium internally; after five weeks' treatment, great improvement ensued; nevertheless, he suffered relapses of his paralysis for four years more, complete recovery being ultimately obtained by large doses of iodide of potassium. Twelve days after his discharge, the patient again returned to Ricord, with strabismus of the left eye, diplopia, and mental confusion. Iodide of potassium removed these disorders in one month, whereon the patient omitted his medicine for a few days. His recovery was then interrupted by hemiplegia of the left side, and quiet continuous delirium. Specific treatment for three months again removed all symptoms of the disease. Sometime afterwards, the patient died of cholera. At the *post mortem*, no disease of the brain or its membranes was to be found." (*Syphilis and Local Contagious Disorders*, by Berkeley Hill, 1868, p. 178.)

The case which I myself observed was that of a gentleman who contracted syphilis in 1860, and who in 1870 was attacked with persistent hemicrania, inequality of pupils, rapidly recurring epilepsy, and great impairment of intellect, all which symptoms yielded in three weeks to a mixed course of mercury and iodide of potassium.

As a matter of fact, however, it is among the poor that we chiefly see the ravages of syphilis; and thus it happens that, while among the out-patients of our hospitals and dispensaries syphilis is a truly formidable disease, not unfrequently tending to death, it is the rarest thing in the world for syphilis to run on to a fatal termination among the better classes; indeed, it is very uncommon for it even to lead to extensive visceral or bone-lesions. This great difference is doubtless partly owing to the miserable hygienic conditions of the poor. Syphilis hits a man when he is down, and its poorer victims are thus peculiarly prone to suffer from its attacks, as they are already more or less prostrate: they eat too little, they drink too much, and they never wash, and so it comes to pass that they too often, when syphilised, suffer from the unholy trinity of drink, struma, and syphilis; but I venture to affirm that their low state of health is not the sole, or even the chief, cause of their suffering so terribly, but rather the want of proper treatment, and especially the want of proper mercurial treatment. Some time ago it was currently believed that the use, or perhaps I ought to say the abuse, of mercury was answerable for some of the most terrible lesions of syphilis. For some years I have tried to ascertain if there was truth in this statement, and I do not hesitate to say that it is about as groundless and mischievous a theory as any promulgated, and would be comparable to stating that the gravest evils of small-pox are due to the use, or abuse, of vaccination. My utmost care has generally failed to elicit the history of any mercurial treatment in the worst cases of bone and visceral syphilis which I have met with; and it is also true that these very cases, which certainly do not present the best field for showing the good effects of mercury, yet do nevertheless almost invariably improve under its cautious but continued use. It seems to me very desirable that we should be more concerted in our method of treating syphilis: nothing therapeutically is more certain than the powerful influence which mercury exercises over this dread poison, yet in spite of this the majority of patients are either not treated with it at all, or, what is nearly as bad, it is given up far too soon; for, if relapses are to be avoided, it is almost as important to keep up its action for some months as to begin it in the first instance. There are, it must be admitted, considerable difficulties in carrying out this plan in the out-patient departments of hospitals: patients come and go—go more often than come, as a rule, and so are lost sight of; they will not take their physic regularly; they fall into the hands of quacks; should inunction be ordered, they will not take the trouble of practising it. For similar reasons, it is impossible to carry out the treatment by mercurial baths; but, despite all these diffi-

* Read before the Manchester Medical Society.