conditions of the eye mercury and potassium iodide are very uncertain in their action, sometimes much benefit resulting from their administration, and in other cases the results are nil.

I used this treatment in several cases, with much benefit, and in some patients who had previously been treated by other methods without good results; but in my experience the pilocarpin produced such profound depression when injected daily for ten or more days that I cast about to see if there was not some other method of stimulation of the ordinary physiological processes without this great drawback. In fact, in certain cases, the depression was so profound that the patients, although acknowledging their vision was better, refused to continue the treatment, remarking that the remedy was worse than the disease.

Of course the ordinary hot-air bath suggested itself, but was discarded as being too cumbersome, and finally guaiacol was recommended to me by a colleague. It is, I believe, not generally known that if a small quantity of guaiacol be smeared on the skin, profuse diaphoresis results in about one hour.

I have now tried this method in nearly 40 cases with most excellent results, irido-cyclitis, vitreous opacities, and interstitial keratitis seeming to be the most suitable conditions for the treatment.

The following is the routine usually employed: The urine is examined, and the mercury is omitted if any albumen is found. The ordinary alterative mixture of hydrarg. perchlorid. gr. $\frac{1}{8}$ and potas. iodid. gr. $\frac{1}{2}$ is given thrice daily; sometimes instead of the above hydrarg. creta gr. $\frac{1}{2}$ is given in a pill thrice daily, together with a mixture containing potassium iodide and tincture of nuxvomica. The patient is kept in bed between blankets with two hot-water bottles, then 1 drachm of a mixture of equal parts of olive oil and guaiacol is smeared, not rubbed, either in the axilla or over the epigastrium. If this dose does not suffice then 2 drachms are used, and in rare cases three, but mostly 1 drachm is enough. The part is covered with oil silk, and a pad of wool is applied over the silk. A hot drink is now given, and profuse general perspiration begins in from one to two hours and lasts for about five hours. It is difficult to make some patients perspire, and in these cases a hot bath beforehand assists and hastens diaphoresis. In one patient some irritation of the skin was produced by the guaiacol, but this was practically well in a week on ceasing the treatment; but the skin in this case was too irritable to stand the application on the same place two nights in succession.

Generally twelve applications are made, and then treatment is stopped for a few days and begun again if considered necessary. As a rule, the patients are kept in bed the whole time, but occasionally when the applications are made in the morning, I allow them to sit up for an hour or so in the evening, well wrapped up.

Our experience at the Shrewsbury Eye Hospital is that guaiacol is a far more certain diaphoretic than pilocarpin, and does not produce the after-depression of the latter drug, while the results are, as far as I can see, equally good.

I have not tried it in any very acute cases, but there does not seem any reason against its use in these conditions. Among the eye diseases for which this modification of the "combined" treatment has been used are interstitial keratitis, irido-cyclitis, vitreous opacities, sympathetic ophthalmia, and optic neuritis. In all there was some benefit, and in some the results were remarkably good. Very many of the patients had been previously treated with ordinary routine methods without good results. Certainly in syphilis the condition is more quickly controlled than when mercury and iodide are used alone. Recently I have been using this treatment in a case of syphilitic perichondritis of the larynx with very good results, when previously the use of mercury and potassium iodide has not influenced the condition very appreciably.

The idea of treating syphilis with diaphoretics and mercury is not new, but has, I believe, been carried out for some years, with the object of shortening the treatment.

REFERENCE.

¹ *The Combined Treatment of Diseases of the Eye.*

HYDATID DISEASE: RECURRENCE: EXTERNAL RUPTURE: RECOVERY.

By ARTHUR W. BRODRIBB, M.A., M.B. OXON., L.R.C.P.,
ASSISTANT PHYSICIAN EAST SUSSEX HOSPITAL, HASTINGS.

In October, 1908, there were published¹ in this JOURNAL notes of a case under my care of hydatid disease in an old lady, in which the disease appeared to be situated in Douglas's pouch. Rupture occurred into the rectum and large numbers of hydatid cysts were discharged. Recovery followed, and for three months the patient seemed completely well.

On October 12th, 1908, I was called in again, as she was in great pain in the abdomen, and was shivering. The temperature was 101°, the pulse feeble, and respirations rapid. I found some sharp crepitations at the left base, and in the abdomen a tender swelling to the left of the umbilicus, dull to percussion, and about the size of a seven months' fetal head. It appeared probable that there was recurrence of the hydatid disease, and possibly some pneumonia setting in, as she was suffering also from a short, painful cough. There was no obstruction in the bowels, as in the former illness.

The next day she was better, the temperature 100°, and the cough and crepitations less. By October 16th the chest symptoms had disappeared, the temperature had fallen to 98°, and the pulse to 88, but the patient did not seem so well; the abdominal pain was greater and the abdomen decidedly larger, the tumour developing a resonant prominence to the left and below the umbilicus. In the left flank there was some resistance and impaired percussion note, and great tenderness.

During the next week her condition varied; at times the abdomen was enormously distended with flatulence, and the tumour was larger, the skin over it becoming red and oedematous. The whole of the left side of the abdomen and left flank was dull to percussion. On October 26th the prominence was much larger, the skin more angry in appearance, and she was extremely weak.

On October 29th she passed from the bowel about a pint of mud-coloured liquid, very offensive, but containing no cysts. The next day she passed another three-quarters of a pint, and was evidently relieved; the abdomen was smaller and less tender. During the next few days she seemed better, but the tumour began to increase again, and the condition of the skin became worse. On November 6th she was decidedly worse, and became delirious. Small beads of clear fluid began to ooze through the skin over the tumour from two minute holes. In this way large quantities of clear fluid came away during the next few days, the small holes developing into wounds half an inch long with jagged edges. No cysts were passed. The tumour became rapidly smaller, and the general condition of the patient improved. On November 11th, instead of clear fluid, white creamy very offensive pus was coming away. The wounds were beginning to heal, and an attempt was made to keep them open to get as much drainage as possible. The tumour no longer projected. Within ten days of the first discharge of liquid the tumour had disappeared, and no further discharge occurred. The wounds healed remarkably quickly. The patient made a rapid recovery, and is now in splendid health, in spite of her age, which I believe to be well over 80. She seems none the worse for her two severe illnesses.

The contrast between the two illnesses was chiefly marked by the different direction in which the cyst pointed. Probably the peritoneum was the seat of the trouble, and it may have been the same large cyst in each case, but in the first illness it pointed into the colon, which was almost blocked by it. This cyst refilled, and fortunately pointed, and burst, externally. An alternative view is that in the second illness an entirely new hydatid cyst developed, and the fluid was drained off through the abdominal wound, leaving the daughter cysts within where they have atrophied.

A hydatid cyst situated in the peritoneum can only point in four ways: (1) Into the gastro-intestinal tract; (2) into the bladder; (3) into the peritoneal cavity; (4) externally.

REFERENCE.

¹ BRITISH MEDICAL JOURNAL, vol. ii, 1908, p. 1271.

INTRA-ABDOMINAL HAEMORRHAGE ASSOCIATED WITH LABOUR.

By MAURICE C. BARBER, M.R.C.S. ENG., L.R.C.P. LOND.,
STAPLE HILL, BRISTOL.

THE intra-abdominal haemorrhage which occurred in the following case must, I think, be a very unusual complication of labour.

C. B., aged 32, enjoyed good health until the age of 15, when her mother says she was paralysed in both lower extremities for

five years, and it took another five years to completely regain the power of her limbs. She had been married about six years and had had five children, but all died from convulsions. During the whole time she was carrying the sixth child she had been suffering from diarrhoea and vomiting, the vomiting being so troublesome that she could not take sufficient food.

The labour began on the evening of November 13th, 1908. When I saw her at 8.30 p.m. the os was about the size of a five-shilling piece, and pains were occurring about every ten minutes. The labour progressed in the ordinary way, and she was delivered of a full-term child about 12.30 a.m. on November 14th. There was no great loss of blood at the time, or after, externally. On leaving the patient the womb could be felt hard and contracted. The pulse was 85. I saw her again about 5.30 a.m., as she complained of feeling very faint. There was slight abdominal distension, but the womb still well contracted, and the pulse 90. She remained in much the same condition during this day; she was very weak and exhausted, but no more than one would expect, considering her condition before labour.

On November 15th the general tympanic distension increased very much. She vomited frequently, and complained of general abdominal pain. The temperature was normal, but the pulse was 120. For the first time the mother said her daughter, just before sending for me, whilst walking about, suddenly called out, "Oh, there is something gone!" and said she had severe pain in the lower part of the back, and a feeling as if something had snapped in the bowels. She was very faint, and perspired a good deal; but, after sitting down, she felt better, and thought no more about it.

About 10 p.m., on November 15th, she was removed to the Bristol Royal Infirmary, and was admitted under Mr. Mole, who has very kindly supplied me with the following notes.

NOTES BY MR. H. F. MOLE, F.R.C.S.

Condition on Admission.

Patient was very pale and collapsed, the pulse was small and rather rapid (128). The temperature was only 97° F. The abdomen was greatly but uniformly distended; it was tympanic, except on quite light percussion in the flanks. This dullness disappeared on deep percussion, and I could not satisfy myself that it shifted when the patient lay on her side. The abdomen moved well, and no localized resistance could be felt.

On bimanual examination the uterus was found to be freely movable, but the fundus could not be defined, owing to the abdominal distension. The external os uteri was contracted. She presented the appearance of a person who had lost a large quantity of blood, and I attributed the distension to intestinal paresis following childbirth. She was given a T.E. with a fair result.

The next morning her condition was much the same; if anything, the tympanites was more marked. Laparotomy was performed that morning.

Operation.

The abdomen was opened by a median incision, which extended at first from the umbilicus to the pubes, and was afterwards enlarged in an upward direction for about another inch. The intestines, and particularly the stomach, were markedly distended; the peritoneal cavity was filled with blood—dark, some clotted, some fluid—there was nothing to suggest that bleeding was going on at the time.

The blood and clots were partially cleared out, but no evidence was forthcoming as to whence the blood had come, after the most careful examination. The uterus was large and soft.

The patient vomited several times during the ensuing twenty-four hours, but the bowels were well opened by enemata, and the abdominal distension rapidly subsided.

The patient was discharged on December 16th, wearing a belt, but with the wound soundly healed.

Mr. Mole is of opinion that the bleeding must have come from some vein in the pelvis—perhaps in the broad ligament—but there was no evidence of it at the time of operation.

If the bleeding had been more severe, the patient would have died during labour, which, besides being very distressing for the friends, would also have been damaging to the doctor in attendance, although in no way to blame. Probably the vessel gave way when she complained of the pain.

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

A POINT IN THE USE OF KOLLMANN'S URETHRAL DILATOR.

HAVING recently had occasion to use Kollmann's urethral dilator, I found that the blades as they were being screwed back into their unexpanded position were apt to nip off small portions of the urethral mucous membrane, greatly to the discomfort of the patient. To avoid this, I placed a thin rubber covering over the instrument, which did not

materially interfere with the expansion of the blades, but prevented the approximating blades from including any tissue. A rubber tube similar to that employed in the Luy's segregator worked admirably. The difficulty experienced in getting the tube over the dilator was easily overcome by using soap as a lubricator. The mechanism was also protected from soiling by contact with the urethra. Anyone using this instrument will find this plan an advantage.

Glasgow.

ALEX. MACLENNAN.

UNILATERAL DEVELOPMENT OF THE MAMMA IN THE MALE.

ON page 1006 of the JOURNAL of April 24th there appears a most interesting report entitled, "Apparent Unilateral Development of the Mamma in the Male."

In examining conscripts for the Siam Police, about 500 men during the last six months, I have met with two such cases, both on the left side and both secreting a "clear fluid." In these cases there was no aesthetic feeling about the abnormal tissue, and I am, therefore, unable to append a microscopical report.

JAMES C. FYSHE, B.A., M.D., D.P.H.,
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BIOTRIPSIS.

MR. LENTHAL CHEATLE's paper in the BRITISH MEDICAL JOURNAL of June 12th on what he designates "biotripsis," and the coloured illustration which accompanies it, serve to remind me of a somewhat similar case which came under my observation many years ago.

An old man, an agricultural labourer, was admitted into the York County Hospital in a weak and failing state of health, for which, apart from his age, there was no obvious cause, beyond a curious dry, chronic rash on the backs of the hands, and the malar prominences of the face, obviously of neurotrophic origin. I had had some experience of skin affections, having been house-surgeon to Sir (then Mr.) Jonathan Hutchinson, and having attended his clinical lectures on diseases of the skin, but I had never seen anything resembling the condition presented by this old agricultural labourer. I could make nothing of the rash, nor could I influence its course in any way. It was pigmented and had the appearance of heaped-up epidermic scales; it was absolutely symmetrical, and it did not give rise to irritation or discomfort of any kind. I had it photographed with a view to publication, but the picture did not convey any clear idea of the condition. After some weeks' residence in hospital, during which time the rash did not undergo any change, the old man died from asthenia.

London, W.

OSWALD BAKER.

ARSENIC IN LOCOMOTOR ATAXY.

IN view of the important discoveries in experimental medicine as regards the use of arsenic against spirochaetes, my own experience of the drug may be of interest. I have used it in several cases of locomotor ataxia with eye-symptoms, some of which have benefited greatly. In two cases the severe lightning pains quite disappeared. In one very bad case in which the patient was almost unable to walk, and whose efforts to do so were painful to witness, a series of ten injections helped him to the extent of ridding him of his distressing pains, and enabled him to come to the hospital without any assistance—indeed, he comes quite alone now.

A few words may be in place as to the method of administration. I use soamin,¹ and it is quite unnecessary to give it intramuscularly. The following are the most important points in the technique of injection:

(a) Dissolve the soamin in not less than 2 drachms of water. If this is not done, and the injections are made in the subcutaneous tissues, very unpleasant and slightly painful indurated masses remain for several weeks. Adequate dilution prevents this effectually.

(b) After injecting the last of the soamin, inject a little sterilized water, so as not to leave arsenical solution in the needle track.

(c) Apply firm pressure over the little wound, and a few seconds later put on a film of cotton-wool and paint with collodion.

¹ BRITISH MEDICAL JOURNAL, 1909, VOL. I, P. 370.