Central Provinces. The old men would tell how villages had been devastated by small-pox, and how the terrors of small-pox had been almost abolished since the introduction of vaccination. Ask these villagers what are the greatest boons which have been conferred on them by the British Government, and they will reply, first, security of life and property, and, secondly, the prevention of small-pox by vaccination. They have seen the evils of small-pox and they appreciate the benefits of vaccination, but how many of the antivaccination party have seen half a dozen cases of small-pox? How many of them have even seen a single case?

Miscellaneous Objections.

It is sometimes stated that diseases like syphilis have been conveyed by vaccination. That, however, is not an argument against vaccination, but is an argument against carelessness in preparing the lymph, or carelessness in performing the operation; and since the introduction of glycerinated calf lymph dangers of this kind are reduced to a minimum if not altogether abolished. We do not ask for the abolition of railways because a train has run off the line; we merely demand that extra precautions should be taken in future. Then it is well known that parents sometimes object to the vaccination of very young children, and in a country where all are vaccinated there is not the same necessity for early vaccination. The greater the success of the antivaccination campaign, the greater will be the necessity for early vaccination of children.

Conclusion.

The antivaccination party have recently been spreading their literature in India, where it is likely to do much more harm than in England, and I should like to appeal to them to weigh the evidence in favour of vaccination carefully before it is too late. I do not ask the antivaccinationist to accept my statements or figures; but I suggest that before spreading abroad literature in which vaccination is strongly condemned he is bound to ascertain, either by direct personal observation or by inquiry in a country in which vaccination has not been well carried out, what are the results when vaccination has been neglected.

TWO CASES OF AFEBRILE ERYSIPELAS.

BY

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THE following two cases appear anomalous in that in both the temperature was, for the most part, subnormal and in both the cerebral symptoms were early and profound. The latter manifestation was perhaps due to the fact that there was very little effort on the part of either patient to combat the disease—the one being an elderly man of enfeebled constitution and the other an infant of 3 weeks. The diarrhoea in the first case also appears unusual, constipation being the rule. It probably indicated a profoundly toxic condition.

CASE I.

A meat market clerk, aged 58, short, stout, alcoholic, and gouty, a sufferer from chronic bronchitis and emphysema, complained on December 9th, 1909, of great pain in his right foot and leg. He ascribed this to another attack of gout. His great toe, on which was a bunion surmounted by a corn, was very inflamed and swollen but not very tender; the chief pain was along the front of the tibia, where were several small, irregular, dark red purpuric spots. The temperature was subnormal and the pulse 76 and of good quality. It was ascertained that he had been cutting a corn on his bunion and applying a corn solvent. The urine contained sugar, though the specific gravity was not abnormal. The swelling of the rest of the foot followed, and by December 11th the skin of the whole foot and lower part of the leg was involved. Sensation in the foot was normal, and it remained warm. A bright red blush with distinct and clearly defined, though irregular, margin preceded the swelling by some hours. Vesicles now appeared over the great toe and elsewhere on the inflamed area. Almost from the beginning of his illness the patient was delirious, suffered from delusions, and defaecated involuntarily. He had, however, lucid intervals of very short duration. The stain gradually crept up the leg, and by December 17th was as high as the knee. On December 19th the knee was passed. The temperature still remained below 98° F. On December 20th diarrhoea of a stubborn nature

commenced, and coincident with this the temperature rose to 99.8° F., and remained so for three days, when it fell to 97° F. The patient now showed signs of progressive weakness and despondency. A sample of blood taken from the margin of the stain proved to be sterile. Injection of polyvalent anti-streptococcic serum (in 20 c.cm. dose) produced no beneficial effect. The stain spread steadily up the thigh to the buttock, following the lymphatics, and on December 27th the patient died. He was able to take nourishment to within half an hour of the end.

During the last four days the temperature remained subnormal (97° F. to 97.6° F.). In the daytime the patient was in a condition resembling the "typhoid state," and during the night he was almost maniacal, only his weakness preventing him from getting out of bed. During the last twenty-four hours he was constantly picking imaginary small objects from the bedclothes.

CASE II.

A female child, aged 3 weeks, born on December 1st, 1909. There was nothing abnormal about the birth: the umbilicus appeared healthy, and the child was apparently quite well till the present illness. On December 26th, 1909, it was noticed to be drowsy, and was difficult to feed and keep awake. On December 27th it was in a state of profound narcosis; its temperature was 97° F.; the heart and lungs were normal. A minute examination of the body revealed nothing. During Christmas time the mother had taken for a cough a mixture, obtained from a chemist, containing tr. camph. co., and, as it was thought this might in some way account for the condition, the infant was temporarily removed from the breast. It was artificially fed, and a few drops of brandy were administered from time to time. During the night the child roused somewhat; but on the morning of December 28th a rash appeared of bright red-brick colour, commencing round the right ear and spreading over the neck and right shoulder. The margin of the stain was not raised and was quite defined, and showed a very marked and abrupt contrast to the healthy skin. The temperature in the right axilla was 99° F., while that in the left axilla and of the body generally was 97° F. On December 29th the rash had spread over the whole of the thorax and down the arms to the elbows. In advance of the margin were some discrete isolated patches on the arms. The pinna of the right ear was now very swollen, and the external meatus almost occluded. The skin over the right mastoid process and right scapula was somewhat oedematous, but there was no fluctuation. The same night the child died. Twelve hours after death a small area of the skin near the margin of the stain was cauterized and incised, and a small piece of the subcutaneous cellular tissue was removed and submitted to bacteriological examination. A long-chained streptococcus in pure culture was obtained of the variety *S. erysipelatosus*.

Although there was no obvious external lesion, there is no doubt infection started in the neighbourhood of the ear in Case II, and judging from the fact that the cerebral symptoms preceded the cutaneous manifestations by quite forty-eight hours, there is a likelihood that the middle ear was first infected, and possibly from the throat.

My thanks are due to Mr. W. Sampson Handley, M.D., M.S., F.R.C.S., for his kindness in seeing the first case, and for his advice in the second.

THE OPERATION FOR ELEPHANTIASIS SCROTI.

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In marking out the incision of separation in the operation for the removal of elephantiasis scroti, the textbook that I have by me directs that, having made a shallow skin cut across the back of the tumour, "a similar shallow cut is made across the pubes. The corresponding extremities of these two cuts are then united either by a straight cut, or, if there be a little sound skin on the thigh aspect of the tumour, by a semilunar incision."

As no diseased skin should be left behind, the chief difficulty in most operations is to get sufficient healthy skin to cover the penis when the tumour is removed. The disadvantages that may arise are:

1. That when the flap is formed the lower edge may be $1\frac{1}{2}$ in. or much more away from the corona of the penis, to which, if possible, it should be stitched.
2. That when it is possible to get some flap the weight of the tumour has so stretched the skin that the penis may be covered by thick, hairy, pubic skin.
3. That when the wound of the operation has healed up, and all retraction has taken place, the penis is carried in a semi-erect position.