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.

The following method may obviate or lessen some of the above difficulties: After the tourniquet has been applied figure-of-eight fashion round the tumour and round the patient's loins, and the shallow skin incision marking the line of separation of the tumour has been carried across the base of the tumour at the back so far each way that when the tumour is let fall forward on the patient's legs

both ends of this cut may be seen, the tunnel leading to the penis should be slit up as far as the tip of the gland. This tunnel should be held open by an assistant using broad retractors, and the condition of the skin should be carefully inspected. It not unfrequently happens that some healthy skin is to be found close to the penis. This skin, which was formerly the inner surface of the prepuce (in the uncircumcised), may be separated by a circular cut across the base of the tunnel, the knife being held almost perpendicular. A thin cuff may then be dissected up and left adherent to the corona of the penis. The ends of the primary incision of separation of the tumour are now brought forward, forming, as far as healthy skin will allow, a U-shaped flap. The testes and penis having been shelled out in

the recognized way, this U-shaped flap under favourable circumstances may be sutured round the penis and the cuff at the end adherent to the corona turned back and sutured to it.

It is not always possible to carry this plan into execution, but when it is done it has the following marked advantages: 1. It helps to bridge the gap between the lower end of the flap and the end of the penis. 2. It leaves some natural penile skin at the end of the penis, and not the thick, hairy skin of the pubes, or insensitive cicatricial tissue. 3. When the patient is standing up the penis will hang in a more natural position.

In the patient of whom a photograph is reproduced the tumour when detached weighed 22½ lbs. I found quite half an inch of healthy skin wherewith to form the cuff. The tunnel leading to the penis was 5 in. long.

THE INTESTINAL STITCH.

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METHODS of intestinal suturing have been with us for about a quarter of a century, and the sutures of Dupuytren, Lembert, and Cushing have been handed down to us in the succession of textbooks, and so carefully described and fully illustrated by the various famous teachers, that it may seem sacrilegious to criticize them at this hour, whilst to add another method should be the height of absurdity. However, I shall take the risk of defaming the gods and do both.

First, let us ask what we aim at in the ideal stitch; and, in answer to this, let me lay down four fundamental principles which must be carried out in every method of stitching which aims at the ideal.

1. The stitches must not tear through.
2. Broad surfaces of union must be brought together evenly.
3. The stitches must be buried.
4. The application must be simple.

The ideal will be the stitch which carries out these principles in the best way. In regard to this we must remember that the internal muscular coat of the intestine

has its fibres arranged circularly—the external longitudinally. We must remember also that stitches which are inserted into muscle must, if they are to hold, run transverse to the fibres, and therefore the inner portion of a stitch taking up both muscular coats should run across the circular fibres. As to 2, the broader the surface of union, the stronger and more reliable the union—that goes without saying; but it needs just a little inspection to see which are broad surfaces and which are narrow; 3 and 4 need no comment.

Now let us take from the latest edition of one of our most popular textbooks three standard methods described and figured therein:

Continuous Lembert:

Here we have a simple method giving a broad surface of union, but principles 1 and 3 are not fulfilled, for the inner or deep part of the stitch does not cross the circular fibres, and so cannot hold them; and again, we either have an exposed stitch or a puckered surface of union, because the point B has to be drawn over either to A or to C. If the stitch be drawn tight, then B goes to A, and we have a puckered union; whereas if B goes to C, then the portion of the stitch A B will lie exposed between A C, and the union will be loose.

Cushing's:

Here principle 2 is not fulfilled, because on tightening the stitch there is only a narrow line of union, the line B being rolled over upon the line A.

Halstead's:

Here every principle is violated; the stitches ought to cut through, the surface of union is only a line, the stitches are exposed, and the application is complicated.

The conclusion, therefore, is that *theoretically* these three standard methods are at fault. Experience teaches that they will each make a good union, but that is not the point. Our textbooks ought to be theoretically correct, and therefore these faulty methods should be banished from them or else put quietly into the background, and some stitch more nearly approaching the ideal given the place of honour. And I submit the following stitch as one worthy to hold the place of honour until supplanted by a better. Here all four principles are complied with.

This stitch may be as old as the hills, and may have been described and figured before, but that should in no way discount the fact that it is the only theoretically correct stitch of the four, and therefore the one that should be given the place of honour in the textbooks.

At a meeting of the Berwick Board of Guardians, held on February 14th, Dr. MacLagan requested the guardians to take over the cost of the medicines, which at the present time he had to supply out of his own pocket. After some discussion it was agreed by a majority to grant the request of the medical officer.