kindly came and performed abdominal section under chloroform. A hard growth (? carcinoma) was found springing from the left ovary, to which the bowel was bound down by numerous dense adhesions, giving rise to the obstruction. The patient's condition was so bad that it was impossible to do more than bring up a loop of bowel into the wound, which was accordingly done. She gradually sank and died the following afternoon.

NOTE ON THE PECULIARITIES OF THE TONGUE IN MONGOLISM AND ON TONGUE-SUCKING IN THEIR CAUSATION.

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NEARLY all the peculiarities which distinguish the so-called "Mongol" baby from other children, and make him look like the young of a different species of man, are obviously developmental in origin and are recognizable from the day of his birth.

The condition of the tongue, however, forms a notable exception to this rule. Its apparent largeness may, indeed, often be noticed soon after birth; but this appearance is probably attributable rather to an abnormal shortness of the mouth than to any real longness of the tongue. The well known characteristics of the mucous membrane—its coarse, raw, sodden appearance, from swollen papillae, and the numerous deep fissures in it—are entirely absent at birth and for long after. They only develop slowly as the child grows. The enlargement of the papillae sometimes begins during the second month, oftenest in my experience between the third and ninth months; and, rarely, not till late in the second year. The fissuring generally begins to appear in the course of the third or fourth year. It may be present in a slight form, however, during the second, and it may not be noticeable till as late as the sixth year.

The slow development of these changes on the tongue's surface may be explained in two ways. On the one hand, it may be supposed that, though the organ looks normal at birth, it is really so abnormally vulnerable as to be unable to carry on for long the common work of an ordinary tongue with impunity. On the other hand, it may be suggested that the various abnormalities of the mucous membrane might be accounted for if it could be shown that the child used the organ in an abnormal way. Neither of these explanations seems quite adequate without the other. It is probable, however, that though the lingual mucous membrane in these children is, like their skin, not quite normally resistant, yet what chiefly determines its swelling and cracking is the way in which it is used.

Tongue-sucking is, of course, a well-recognized characteristic of Mongolism. In studying recently the notes of 92 cases of Mongolism observed during the last twenty years, I have been greatly struck with the extreme frequency of this habit among them, and with the extraordinary energy and persistence with which it is practised by many of the children. In 69 cases in which its presence was inquired into, it was found certainly to exist, or to have existed, in 59. In the other 10 it was said never to have been observed, although at least 2 of them were given to sucking their fingers or hands. Two children who were noticed when in hospital to suck their tongues constantly were stated by their mothers, on admission, never to have practised the habit. Its presence is, indeed, so easy to overlook that it seems allowable to suppose that possibly all Mongols at some period of their childhood may have a period of tongue-sucking, although it may not always be recognized.

In all the cases of older children I remember to have seen, in which the tongue-sucking had been very prolonged and severe, the fissuring and the enlargement of the papillae were particularly marked. In a few in which a reliable history was given of the habit having lasted only for a short time, the surface of the tongue was comparatively little affected.

THE fourth French Congress on Public Assistance and Private Beneficence, which was to have been held this year at Rheims, has been postponed till the spring of 1908 on account of the death of M. Casimir-Perier, Ex-President of the French Republic and President of the National Committee.

THE ACCIDENTAL RASHES OF VARICELLA.

By J. D. ROLLESTON, M.A., M.D. Oxon.,

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THE occurrence of accidental eruptions in varicella receives but scant notice in most of the English and American textbooks. Considerable attention, however, has been given them by French authors, especially during the last fifteen years. Gintrac is usually credited with having first noted a prodromal rash in varicella, but Willan* in 1801 and Bateman† in 1813 had already described such an eruption. Regarded at first as exceptional and prodromal only, they were later shown to be by no means rare, and to be likely to develop at any stage of the disease, being premonitory like the prodromal rashes of small-pox and measles, concurrent with the specific exanthem, post-eruptive, or a combination of two or more of these forms. Cerf, writing in 1900, had collected 45 cases of accidental rashes in varicella. A search through subsequent literature has enabled me to add 14 more, excluding the 6 personal cases recorded below which have come under my own observation at the Grove Hospital in the course of the last two years.

Though accidental rashes in varicella may develop at any stage of the disease, the prodromal and concomitant ones are much more common than the post-eruptive. Examples of the latter are recorded by Charmoy, Chauffard, Comby, Cerf, Galliard, Nissim, Clemmey, Daverède, and Gillet, and below in Cases II and III.

The varieties of the accidental rashes of varicella are in order of frequency—scarlatiniform, purpuric, morbilliform, and mixed. The scarlatiniform variety is the only one represented in the cases below. Purpuric eruptions have been recorded by Bérard and De Lavit, Baader, Andrew, Lannoise, Comby, and Rundle; morbilliform by Revilliod, Chauffard, Désandré, and Heubner; and mixed by Lannoise and Roger.

Urticaria, which, as I have shown elsewhere, not infrequently precedes the characteristic eruption of measles, is rarely met with in varicella. In MacCombie's case a bright erythema with numerous urticarial wheals preceded and accompanied the specific exanthem. Varicella being mainly a disease of childhood, it is obvious that most of the cases will be found in children. Cases in older patients, however, have been published by Alméras in a female of 16, by Lorrain in a male of 19, by Nissim in a female of 24, and by Metcalfe in a male of 39. The trunk is most frequently affected, but there is no site of predilection, like the abdomino-femoral region in the prodromal rashes of small-pox. Like the prodromal rashes of measles, the accidental rashes of varicella are usually of short duration, and are not accompanied by any cutaneous irritation nor followed by desquamation. These facts sufficiently explain how it is that the accidental rashes of these two diseases have not received a wide recognition in the profession. With the following exceptions there is nothing noteworthy in the previous history of the recorded cases. In a few there had been a recent pre-existent eruption. Thus one of Chauffard's patients had had measles a fortnight before. Oeconomon's case had recently had scarlet fever. One of Daverède's cases showed the eruption of hereditary syphilis. Four cases reported by Sabathé, Charmoy, Bourdineau, and Cruet respectively were convalescent from broncho-pneumonia; and two cases reported by Nissim and Lannoise respectively were suffering from pulmonary tuberculosis. Alezais's case was a weakly child prematurely weaned. One of Daverède's cases was delicate and rickety.

From a diagnostic standpoint varicella rashes are of considerable interest. The scarlatiniform variety is most likely to cause difficulty in diagnosis. Since 1899 a total of 94 cases, or an annual average of 15.6 cases, of varicella has been admitted to the Metropolitan Asylums Board hospitals, which had been certified to be suffering from scarlet fever, probably on account of the prodromal scarlatiniform rash.

With the important exception that the scarlatiniform

* "The varicella, or chicken-pox, has been very prevalent during the summer (1797). The eruption was generally preceded by a strong fever; and in three cases, by a vivid universal rash, similar to that which often attends the eruption of the small-pox." Loc. cit., p. 120.

† "The eruption is sometimes preceded, for a few hours, by a general erythematous rash." Loc. cit., p. 208.

rash of varicella is not followed by desquamation (vide Cases v and vi), there is no definite pathognomonic feature to distinguish it from the eruption of scarlet fever. The triad of symptoms supposed to be characteristic of scarlet fever—namely, headache, vomiting, and sore throat—may also occur in varicella. Saint Paul records two cases in which a scarlatiniform rash with faucial symptoms shortly preceded the vesicular eruption. Injection of the fauces was a noticeable feature in Case vi. The temperature may not be raised, or only slightly (Case ii), or be high, as in Cases i, iii, and iv. In Thomas's and Baader's cases the temperature was 106.8° and 104.6° respectively.

Can varicella exist without a vesicular eruption? In other words, is there a varicella sine varicellis analogous to variola sine variolis, and morbilli sine morbillis?

French writers¹ have recorded cases where the prodromal rash formed the entire eruption in small-pox. I have elsewhere² published a case in which the prodromal rashes constituted the sole cutaneous evidence of measles. Revilliod is the only writer who relates a similar abortive form of varicella.

Out of nine children suffering from varicella three presented at the onset a morbilliform rash on the trunk and limbs. In one patient this eruption appeared to replace the vesicles of varicella, although the other symptoms appeared sufficiently clear to justify the diagnosis of varicella sine varicellis.

The accidental rashes of varicella do not appear to have much prognostic value. It is true that they have been found in varicella gangraenosa, as in the cases reported by Staniforth, Charmoy, Augier, and Beaudoin. Of these Beaudoin's was the only fatal case. Unless accompanied by haemorrhages from the mucous membranes, as in Comby's and Rundle's cases, both of which died, the existence of purpura does not justify a sombre prognosis. In the cases of Alméras, Lorrain, and Nissim, the prodromal, and in Metcalfe's case the concomitant, symptoms were severe. It must be noted, however, that these four cases were in adults, in whom the constitutional disturbance produced by varicella is often more severe than in children. Albuminuria may sometimes be present, as in Cases iii and v. In one of Daverède's cases it was considerable, and was accompanied by much oedema of the legs.

PATHOGENY.

The accidental rashes of varicella, like those met with in the other acute exanthemata, are probably septic or toxic in character, and are independent of the varicellar infection itself. Drugs and gastro-intestinal disturbance can usually be excluded from the etiology. Secondary infection may find entrance through any part of the mucocutaneous surface. The rashes are especially liable to develop when the skin is in a condition of diminished resistance owing to a pre-existing eruption. This fact accounts for the frequency of rashes that occurred in my own cases, most of which were convalescent from scarlet fever. The greater frequency of these rashes in childhood is to be explained not only by the predilection of varicella for young persons, but also by the greater sensitiveness of the nervous system and more active capillary circulation in the child. Certain individuals, too, from the mere fact of their idiosyncrasy are more likely than others to develop rashes. Authorities are agreed that the character of the eruption is determined by the degree in which the cutaneous capillaries are affected. If the paralysis is small, and is in discrete areas, a morbilliform rash results. If the vascular paralysis extends over a more considerable area a scarlatiniform rash is produced. After an extreme degree of dilatation, capillary ruptures occur, represented by the purpuric type of rash.

CASE I.

Boy, aged 8, admitted November 28th, 1904, with mild scarlet fever. Typical desquamation followed.

December 14th. Varicella. Bright scarlatiniform rash on trunk, most marked on back. Fauces normal. Morning temperature, 98°; evening temperature, 99°.

December 15th. 11 a.m. Erythema faded, vesicles semi-confluent on back, where there is a faint diffuse erythema. Still fainter erythema on chest. Morning temperature, 99.4°; evening temperature, 102°.

December 16th. Erythema faded. Morning temperature, 99.8°; evening temperature, 100.2°.

December 18th. Temperature normal.

CASE II.

Boy, aged 2, whose brother had developed chicken-pox on January 26th, was admitted with scarlatina anginosa on February 1st, 1905.

February 6th. Varicella. Morning temperature, 98.6°; evening temperature, 99.6°.

February 7th to 9th. Fresh vesicles. Temperature, 98° to 101°.

February 10th. General desiccation. Faint generalized erythema of trunk and limbs. Morning temperature, 100°; evening temperature, 99°.

February 11th. Erythema still present on trunk, but faded on limbs. Morning temperature, 99°; in the evening and subsequently the temperature was normal.

February 12th to 13th. Erythema still present.

February 14th. Erythema faded.

The autonomous existence of scarlet fever in this case is proved by the character of the onset, characteristic desquamation, and the supervention of otorrhoea.

CASE III.

Boy, aged 3, admitted February 28th, 1905, with scarlatinal nephritis. The rash had occurred a fortnight before.

March 11th. Varicella.

March 12th to 14th. Fresh vesicles. Temperature 98° to 105.2°.

March 15th. Punctate erythema of trunk and limbs. Morning temperature, 98.2°; evening temperature, 101.4°.

March 16th. Erythema still present. Morning temperature, 99°; evening temperature, 100°.

March 17th. Erythema faded. Morning temperature, 99°; evening temperature, 98°.

CASE IV.

Girl, aged 5, admitted March 29th, 1905, with mild scarlet fever. Characteristic desquamation followed.

April 8th. Varicella. Morning and evening temperatures, 98°.

April 10th. Numerous fresh vesicles. Faint punctate erythema on trunk; most marked in hypogastrium. Morning temperature, 100.2°; evening temperature, 104.2°.

April 11th to 12th. Erythema still present. Temperature, 100° to 102°.

April 13th. Erythema faded. Morning temperature, 100°; evening temperature, 102.4°.

April 14th. Temperature normal.

CASE V.

A girl, aged 3, was admitted November 3rd, 1905, certified to be suffering from scarlet fever. She had had a sore throat on November 2nd, and a rash had appeared the same day. On admission there was an indefinite erythema on the back. Fauces normal. Vesicles of chicken-pox on body and limbs. Trace of albumen in urine. Temperature 101.6°.

November 4th. Temperature normal. Erythema faded. No subsequent desquamation.

CASE VI.

A boy, aged 9 months, was admitted December 18th, 1905, certified to be suffering from scarlet fever, on the first day of disease. On admission there was a punctate erythema of trunk and limbs. Fauces injected. Temperature 101°.

December 19th. Varicella on face and trunk. Erythema still on chest and limbs. Fauces still injected. Morning temperature 98.8°; evening temperature 99.2°.

December 20th. Erythema fading. Morning temperature 97°; evening temperature 99.2°.

December 21st. Erythema gone. More vesicles on trunk. Morning temperature 100.4°; evening temperature 99.8°.

December 24th. Temperature normal. No desquamation occurred.

I am indebted to Dr. J. E. Beggs, Medical Superintendent of the Grove Hospital, for permission to publish these cases.

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MERYCISM OR RUMINATION IN MAN.

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I WAS much interested in reading the article by Dr. Brockbank under the above title in the *BRITISH MEDICAL JOURNAL* of February 23rd, as when in England I had a case in many respects similar to that related by a "professional gentleman" in Dr. Brockbank's paper. The patient in my case also was a young professional man of about 28 years of age, and rumination had first occurred some ten years ago when he was studying at college. As in a majority of the cases cited by Dr. Brockbank, the rumination occurred most frequently after dinner, and it was mostly meat that was regurgitated, though other substances—such as bits of vegetable, etc.—also came up. It was only very rarely that fluids were regurgitated. The process would start a short time after the completion of the meal, usually within a quarter of an hour, and a mouthful or two would come up at a time without any voluntary effort on his part, and quite unaccompanied by any acid eructations or pyrosis. The patient seldom brought up more than eight or ten mouthfuls altogether, and never went so far as to rechew a whole meal. At first he used to spit out the mouthfuls as they were regurgitated, but by-and-by, as there was no disagreeable taste accompanying them, he got into the habit of chewing them over again and reswallowing them, finally reaching the stage of quite enjoying the process of rumination, more especially if the food regurgitated were anything he particularly liked.

When I saw him this curious idiosyncrasy had been in existence for some ten years. The habit did not seem to worry him at all, and, as a matter of fact, I only came to know about it accidentally. In his case there was no family history of such a habit; his father and mother both had good digestions, and, of several brothers and sisters, none were affected. At the time I set it down to a somewhat anomalous form of atonic dyspepsia, although at a loss to account for the rumination of food without any other unpleasant symptoms. The regurgitation in this case, however, was not constant, and the patient himself said it varied largely with his general health, being much worse and more frequent when he was

working hard at college and feeling "run down" than during the vacation, when he was taking plenty of exercise and feeling in "good form." Unlike a number of Dr. Brockbank's cases, he at no time suffered from constipation. On the other hand, he had occasional bad attacks of flatulence, accompanied by pain; these, however, were very infrequent, though, generally speaking, he appeared to have a "weak" digestion. His stomach was particularly intolerant of fat, and, as in a number of Dr. Brockbank's cases, bits of bacon used to come up, a mouthful at a time, after breakfast. He also illustrated in a marked degree what one might almost call a "selective" action of the stomach in regurgitating certain articles of food and not others (see Dr. Brockbank's paper, p. 425). In the case of my patient the regurgitation was certain to occur after eating fat, even if swallowed unconsciously—for example, if he had partaken of a stew or curry in which small pieces of fat were mixed up with meat, etc., whether anything else were regurgitated or not, these bits of fat were certain to be returned shortly after the meal was concluded. Even when his general health was at its best and he was not bringing up his food as a rule, if he inadvertently swallowed a bit of fat it was absolutely certain to be regurgitated. The fat he did not re chew but always spat out, as he did not like it. In the case of the food he did re chew—meat, etc., but principally meat—he had no more trouble with it after he had reswallowed it.

It is a very curious thing that when he was ruminating little the food returned would usually be of an indigestible nature—for example, bits of gristle, skin, etc., as if his stomach were pointing out that these bits needed more mastication than the rest, if that organ were not to be overtaxed. In the case under notice smoking had no effect in preventing the rumination.

Another point of interest is that the actual rechewing and reswallowing of food was distinctly secondary to the regurgitation and might be spoken of as an "acquired" habit, as the patient had been regurgitating and spitting out his food for some time before he began to re chew and reswallow it.

Except for this peculiarity of merycismus the patient was in good health—in fact, of very active habits, going in for gymnastics, golf, cycling, swimming, etc.—and, although not fat, had not lost weight during the ten years he had been ruminating.

I should be inclined to class this case in subdivision (6) of the varieties of merycism as classified by Lemoine and Linossier and quoted in Dr. Brockbank's paper.

In conclusion, I may state that I had this patient for a long time under observation, and was enabled to verify personally all the facts stated.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL.

TWO CASES OF DIAPHRAGMATIC HERNIA.

SUCH anomalies are uncommon. During the four years that I have been in charge of the public mortuary at Hong Kong, only these two cases have been found.

CASE I.—The child was stillborn. The defect in the diaphragm was on the right side. Through this, part of the stomach, the greater part of the small intestines, the omentum, and a fold of the large gut had passed. The heart was displaced to the left. The left lung was fully developed, the right being only about one-third of its normal size, and lying posteriorly. The serous membranes of the peritoneal and right pleural cavity were continuous through the cleft in the diaphragm. The other organs were normal.

CASE II.—The child was stillborn. The defect in the diaphragm was on the left side. Through this the entire stomach, the majority of the folds of the small intestine, a large loop of the large intestine, the omentum, and the spleen had passed into the left pleural cavity. The other organs were normal.

According to Arnheim, about 400 cases had been reported up to 1896. The condition is also found in animals. They are not true hernias, in that there is no sac. Most authorities are agreed that the left side of the diaphragm is the seat of predilection for such a condition. In my own cases, however, one existed on the right, the other on the left side of the diaphragm.

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