of distinction between the malady in question and common psoriasis. The latter begins as a point, which, spreading at its edge, becomes a papule, which, again enlarged at its border, becomes a patch, possibly a very large one. Thus, psoriasis patches are always almost round, nummular, *i.e.*, like coins or rings, whilst those of lichen ruber are irregular, in lines or particles. In the case in question, most of the eruption was arranged in this manner, but some patches were not. On the elbow-tips and over the ulnæ were patches which, in mode of formation and in accumulation of scales, could not be distinguished from common psoriasis. Our treatment of the case was exactly that of the latter disease—tar externally, and arsenic internally. In nine cases out of ten, these remedies will cure lichen psoriasis pretty quickly. Some of you may remember a man whom we had under care six months, a splendid specimen of the disease. He had been sent to me by Mr. Forshall of Highgate. It was a first attack, and occurred to a healthy young man. I prescribed arsenic and tar. Through Mr. Forshall's kindness, I had an opportunity of seeing this man again last week. He told me that about six weeks' use of the remedies quite cured him, and that he has, during the last four months, remained without treatment quite well. In our last case, however, we have not been so fortunate. Our patient was of very peculiar nervous system, in fact almost insane, and the influence of arsenic appeared to be to excite her. Several times we had to suspend it on account of the irritable condition which it appeared to produce, and finally she was discharged from the hospital uncured, in consequence of the trouble which she gave in the ward. As a rule, I have found lichen psoriasis more easily influenced by treatment than common psoriasis. The cure is also usually more complete. The periods of immunity are also longer, often not less than several years; whereas psoriasis, however good the cure, usually relapses, I think, within the year.

CHRONIC SYNOVITIS, ARTHRITIS, OR STRUMA: IMPORTANCE OF THE DIAGNOSIS.

We have had lately a great many cases of synovitis of the knee-joint. I think you will have observed that, roughly, we may divide all the cases of chronic synovitis into two groups, those which are connected with struma, and those which are of an arthritic nature, in the conventional sense of that term. This division is of considerable practical value. Under the arthritic head, I comprise all that are associated with gout, rheumatism, or rheumatic gout, and all gonorrhœal rheumatism; and of all these, we may say that we expect them to get well. Sometimes there is stiffening, sometimes effusion is very long in disappearing; but still, in nearly all cases, in the end the patient again walks on the limb. It is very different with the strumous group. Here the tendency is to pulpy thickening of the synovial membrane, and to incurable conditions. It may be that destructive changes are ward off by long rest, but the patient is disabled, and the limb useless. We have half a dozen of this kind of knee now in our hands, not bad enough for amputation or excision, but still so bad as to prevent walking. In these cases, we are obliged to forbid walking, whereas in most of the arthritic cases, unless exercise causes pain, it may be permitted with impunity. A considerable variety of conditions is presented in this group, and especially is the arthritic process modified by the age of the patient. The older the patient, the more chronic and the less painful is rheumatism. You know that I am in the habit of insisting upon the importance of the patient's diathesis, even in cases of synovitis which is called traumatic. We admit a great many cases in which free synovial effusion has followed a sprain or contusion. In these cases, if the effusion lasts long, or if it is in excess of what its supposed cause will account for, you must suspect the arthritic diathesis. The patient is rheumatic or gouty. We have had numberless illustrations of this. Sometimes it is difficult to get at the exact facts. In the case of a man who has just left us, the synovitis persisted in spite of treatment, and relapsed after an apparent cure. It appeared likely that the case might end as hydrops articuli. I had repeatedly taxed the man with being gouty, but we could get but little evidence. Last week, his employer called on me; I then learned that the man had been for thirty years employed as a bottler in wine vaults, and that his habits of free wine drinking had often nearly cost him his place. I was told that no objection was made to a bottler drinking as much wine as was good for him, and that complaint only resulted when so much was taken as to interfere with his efficiency as a workman. It is not easy to imagine a position more likely to produce a gouty state of system. We have since let this patient leave the hospital, supplied with a knee-cap. He still has some fluid in the joint, but he can walk without any pain. Exercise, which would of course be most injurious if the disease were strumous, will not hurt him.

Dr. BEAMISH, late medical officer of the City Prisons, Cork, has been granted a retiring allowance of £110 *per annum*.

A FEW REMARKS ON YELLOW FEVER, AND ON THE MOVEMENT OF TROOPS.

BY SURGEON-MAJOR J. P. H. BOILEAU, B.A., M.D.,
Diplomate in State Medicine, University, Dublin, etc.

THE return of the 1st Royal Lancaster Regiment (1st 4th Foot) from the West Indies, has recently been made the subject of a short paragraph in a contemporary. The regiment arrived in England in November last, having been ordered home from Barbadoes, on account of the prevalence of yellow fever at that station, and in consequence of the officers and men of the corps having suffered very severely from the disease. The paragraph states, that it was anticipated that a regiment from Malta would be ordered to Barbadoes as soon as the local authorities considered the epidemic to have passed off, and after the barracks had been thoroughly disinfected.

It seems to me, judging from the lessons of the past, that the authorities will not hastily order a regiment from Malta to Barbadoes under present circumstances. I will narrate a few cases which seem to justify me in forming this opinion; and first, that of the 84th foot, in 1867.

I served in the Malta command during the years the 84th was stationed in the island—1865-67. The first year was that of the great cholera epidemic there, and in that year sickness and mortality were very high in the 84th; during the year 1866 continued fevers were much more prevalent and fatal than usual in the command. The 84th left Malta early in 1867, and landed in Jamaica in April; it was immediately marched up to the hill station of Newcastle; in May, 18 cases of fever were admitted to hospital; in June suspicion arose as to the true nature of the disease, and before the end of the month a case proved fatal. The disease—yellow fever—spread, and the regiment lost 13 men in July, 13 in August, and subsequently 5 more. Further particulars will be found in the 9th Volume of the *Army Medical Department Reports*.

The 1st-4th Foot, which has returned from Barbadoes, arrived there in January, 1879, and like the 84th, it came from the Mediterranean, from Gibraltar, where it had been stationed upwards of four years. The sad experience of this regiment in Barbadoes is too fresh in the minds of your readers, to need dwelling on here.

The 2nd-3rd Foot arrived in the West Indies in July 1864, also from Gibraltar. Soon after its arrival it suffered from an epidemic of remittent fever, which was the cause of 182 admissions into hospital in November, and 133 in December. Officers, men, women, and children were alike subject to it. The Royal Artillery also were affected by the epidemic, "but by no means to so great an extent" as the 3rd regiment.—*Vide Army Medical Department Reports*, Volume 6.

The 1st-21st Foot went from Malta to the West Indies in April, 1860. During the nine months of 1860 that it was in Barbadoes, 84 cases of remittent fever were admitted, and two died; and it is worthy of notice that the year before the regiment left Malta, it was exceptionally healthy; for whilst the admissions for fever were "exceedingly numerous" in other regiments, the 1-21st was "the only corps which appeared to have enjoyed a marked exemption from the disease."

Now, contrast the above cases with that of the 29th Foot, which after two years in Malta, went to Canada in July, 1867, and thence, in December, 1869, to the West Indies, (relieving the 84th). I was then the assistant-surgeon of the 29th, and served with it continuously for more than three years in Jamaica and in Barbadoes. I well remember that, as we lay off Port Royal, in view of the dreaded palisades, we contemplated our future abode on the distant hills, between three and four thousand feet above us, with many and with mingled feelings, for *inter alia*, had we not the unfortunate experience of the regiment we were about to relieve as a subject for our reflections? Yet, as the sequel proved, we need not have troubled ourselves with a single gloomy foreboding; for the fates were singularly propitious to us. During the three years and three months that I served with the 29th in the West Indies, I attended altogether but two fatal cases (mitral valve disease, the sequel of rheumatic fever, and a case of acute hæmorrhagic phthisis in a young recruit). We lost not a single man, woman, or child from any endemic or epidemic disease; nor indeed from any zymotic disease whatever, either at Newcastle, Jamaica, or at Barbadoes, nor did we invalid any, to the best of my recollection.

The 98th Foot relieved the 29th in the West Indies, in March 1873. It came from Bermuda, and its medical history, in the West Indian command may be found in the *Army Medical Department Reports*, volume 15, page 77, and volume 16 page 75, etc. Suffice it to say here, that the sun of health which had shone so brightly over the 29th, with

the departure of the latter from the island, became shorn of its beams, and Hygeia was overshadowed by a cloud. Before the end of the year "fever of a severe bilious remittent type became prevalent," and three cases proved fatal. In 1874, there were 221 cases admitted under the head of fevers, and "most of these cases were complicated with enteric symptoms, in many cases severe."

Now, *why was the 29th regiment so exceptionally fortunate?* I think that anyone who has studied the medical history of European regiments in the West Indies, will admit that this question deserves to be italicised. For a more or less complete answer to it I must refer to papers of mine in the *Lancet* for 1880, volume 1, page 560 and 599. Here, I will notice only one point. Whilst other regiments had been sent to the West Indies from more or less debilitating climates, such as Gibraltar, Malta, or Bermuda, the 29th was sent from a very healthy and invigorating command, from Canada, where, for nearly two years and a half, it had been laying in a stock of disease-repelling vigour. Two years in such a climate must impart to the human economy a resisting power against morbid forces, very different from that to be gained by a residence of the same period in Malta.

I do not, of course, mean for a moment to insist that a regiment sent from Malta to the West Indies must suffer; or that a regiment sent from such a climate as Canada cannot suffer; but, I desire to strengthen the idea that a very important factor in estimating the effects of deteriorating or of lethal influences on any regiment, is a consideration of the hygienic characters of the place from which it comes; and, believing this, I hold there is much to be thought of before sending a regiment from Malta to Barbadoes to take the place of one removed therefrom in consequence of an outbreak of yellow fever.

Whether the few facts I have brought together, and the remarks which I have made, will convey to other minds the impression produced on my own, I cannot say; but the end which I have in view will certainly not be attained, if they are found wanting in suggestiveness.

POISONING BY CHROMATE OF LEAD IN WEAVERS.

By ROBERT C. SMITH, M.D.,

Bachelor of Science in Public Health, Univ. Edin., Manchester.

ON February 12th, 1881, Mrs. B., aged 30, a weaver in a cotton-mill, came to me for advice and treatment. She had been unable to follow her work for the previous six weeks, and was suffering from great weakness, wandering pains in her limbs, and anæmia. Her gums showed well-marked signs of lead-poisoning. There was no albumen in her urine. She attributed her illness to the inhalation of a yellow dust that was given up from the yarn in the process of weaving an orange-coloured cloth. She had always enjoyed good health before being employed at this class of goods. She gave, as a reason, that it was the coloured dust (lead dichromate) which had made her ill; that her fellow-workers, when engaged at the same kind of work, sooner or later sickened; and that there were many others at home ill from the same cause.

Mary C., also a weaver at the same mill, applied for advice a few days after Mrs. B.; and had, like her, been engaged as a weaver of orange yarn. The blue line was very distinct. Her breath was offensive, and the skin and conjunctivæ were of a distinctly yellow colour. There was no albumen nor bile in the urine; nor had she any tenderness over the liver. She suffered from tormina and wandering pains over the body, and was very costive. Under treatment, the yellowness of skin passed away; but the blue line remained long after other symptoms of lead-poisoning had disappeared.

Jane C., sister of the above, was visited by me at her own home on the same day. I found her also affected with lead-poisoning. She appeared at first sight to be suffering from an acute attack of jaundice: her skin and conjunctivæ were intensely yellow in colour. There was obstinate sickness, and purging of dark sap-green motions (probably stained with chromium oxide). The urine contained albumen and a trace of chromium, but no bile nor lead. This patient recovered with great difficulty—the staining of the tissues, sickness, and purging ceasing first, but the blue line is still yet present.

The above are types of cases that were of constant occurrence, about nine months ago, in the practices of medical men in the neighbourhood of the mill in question. I had eight patients at once from the same mill under treatment for this form of lead-poisoning. Another medical man has had twenty, and a third has had from thirty to forty similar cases in all under observation. One of the mill-hands, under the care of a fourth medical man, dying from lead-poisoning, an inquest was held, when, at the *post mortem* examination, this gentleman found distinct traces of lead in the liver. Public opinion having been drawn

to the dangerous nature of the work, pressure was brought to bear on the employers, who have since then caused the yarn to be more carefully dyed and prepared before being woven. They have also insisted on the winders and weavers wearing a muslin respirator over the mouth and nose, when at work; and the use of hooks to thread the shuttle, instead of sucking the web through its eye with the mouth, under a penalty. By these precautions having been rigorously carried out, the operatives, though still weaving chromes, no longer suffer from lead-poisoning.

In the cases which I have observed, the yellowness of the skin is the first symptom to disappear, and the blue gums the last; and chromium is found in the urine, and probably in the feces. I therefore conclude that, after absorption, the dichromate undergoes decomposition within the blood; the lead being fixed in the tissue, whilst the chromic acid combines most probably with soda—a compound which is intensely yellow, and stains the liquor sanguinis and skin for a time; and, finally, leaves the body by the liver and kidneys.

OVARIOTOMY IN GENERAL HOSPITALS.

By JAMES E. ADAMS, F.R.C.S.,

Surgeon to the London Hospital.

THE desirability of performing ovariectomy in general hospitals must be admitted to be a matter requiring some consideration, seeing that there are some surgeons, my colleague Mr. Hutchinson in particular, who think it better to send all patients requiring this operation to special hospitals; and this opinion is mainly based on the improving statistics of the practice of those who have made this operation a specialty, and through whose praiseworthy efforts the operation has become one of the most brilliant in surgery. There are, however, many reasons against declining to do this operation in ordinary hospitals, especially where there are large schools; and I hope to be able to show that patients operated on by us do just as well, and show as good an average as those dealt with by others. What reasons are there against it? Is it because we cannot have a sufficiently pure air, pure dressers, nurses, and materials? I aver that—by complete disinfection, isolation, Listerian methods of operating, careful selection of specially trained nurses, rigorous exclusion of all sponges and dressings not absolutely new and carbolicised—we can place our patients in conditions just as favourable as in any special hospital. If we could not, we ought to abstain from opening the peritoneal cavity at all, and decline all kinds of abdominal section. Do we lack the necessary manipulative skill or knowledge in dealing with difficulties? As to the former, the hands of any skilled operating surgeon should be good enough for the work; and to assume that we lack the latter, is paying a poor compliment to the lucidity of the various writers who have so carefully recorded and published such large masses of evidence as are now before us. My view is, that the specialists have given us the means of learning, and that it is the duty of surgeons in large hospital practice to acquire knowledge and to diffuse it. Nevertheless, I would not advise any patient to undergo any operation in my wards, if I thought it could be done with less risk in a special hospital; but this is the very thing which I do not believe; and I undertook my ovariectomies with the firm conviction that the preventable causes of danger or death could be as thoroughly eliminated in the London Hospital as elsewhere. I can only adduce the facts that occur in my own practice, and they are very few in number; but, so long as the belief holds that ovariectomy is not safe in a general hospital, the opportunities for extending our experience and enlarging our statistical tables are not likely to be frequent. Of five ovariectomies (properly so-called), including one woman aged sixty-one, where there were numerous adhesions, all recovered. There were two cases, besides, in which an operation was undertaken with a full knowledge of the probable difficulties and dangers, which terminated fatally; one being a soft solid malignant tumour involving the peritoneum, and the other a large succulent fibroid attached to the fundus of the uterus. The statistics, including the cases of my colleagues, extend back as far as 1878, and show a mortality of 23 per cent.; and even this, though including one or two very unfavourable cases, will bear comparison with some of the numerous series lately published. No one is more gratefully appreciative of the results obtained by, and the means of acquiring information given by, the masters and pioneers in this branch than myself, and I have no desire to acquire a special reputation as an ovariectomist; but I should like to show, if possible, that it is not only justifiable, but desirable, to perform these operations in those hospitals where patients seek relief in the first instance, instead of having to banish them to a distant institution. My argument, if I have made myself clear, is not in the direction of bold-