It has been pointed out by several observers that, in almost all chronic scaly affections of the skin, one can, by a diligent examination of the scales under the microscope, find the spores of a vegetable parasite commonly called *Torula vulgaris*. I can quite confirm this fact from my own observations. I would remark, however, that those who are not aware of it are sometimes misled into the belief that they have discovered a parasitic disease, when, in truth, they have only found *Torula vulgaris*, which is quite harmless, and which is a consequence rather than a cause of the disease. An example of this lately came under my observation in the case of a lady about thirty years of age, who had suffered nearly all her life from a well known chronic folliculitis of the eyebrows and scalp depending on constitutional causes; the skin was scaly, and the hairs fell out before they had arrived at maturity. She was told by two medical men abroad, who had examined the scales and hair under the microscope, that the cause of the disease was a vegetable parasite; the result of the treatment was, however, not satisfactory. When she subsequently came under my notice, it was not very difficult to find here and there *Torula vulgaris* in the scales attached to the hairs, but the hairs themselves were quite free; the mistake was thus easily explained. I have met with several other examples of similar mistakes.

With regard to an affection of the skin which I have described as a form of circinate lichen, and which has been supposed by some observers to be pityriasis versicolor, and of course of parasitic origin, I would remark that a very careful series of observations, extending over several years, quite satisfied me that the two diseases are quite distinct. I am quite prepared to admit that, when pityriasis versicolor becomes a little inflamed, as it sometimes does in those who happen to have a tendency to eczema, it bears a close superficial resemblance in appearance to this variety of lichen circinatus; but the microscopical characters of the two are always quite distinct. As to the name circinate lichen, I lay no stress on it whatever; I adopted it to avoid the introduction of a new name; the disease has, however, since been described under a new name.

I hold that it is now quite out of our power to alter to any considerable extent our nomenclature of skin-diseases, however much we may object to some of the terms in use. Many objectionable synonyms will gradually drop out of use; and this is nearly all the improvement we can expect. The most vigorous efforts have been made to get rid of the name typhoid fever; but the word is still as much used as ever. The story of the emperor who failed in an attempt to change a quantity in a Latin word should not be forgotten by the inventors of new names for old diseases.

SEWER-GAS AND PUERPERAL SEPTICÆMIA.

By JOHN C. FERRIER, M.D. Lond.

IN the number of the BRITISH MEDICAL JOURNAL for March 10th, Dr. Playfair refers, in his "Note on the Sanitary Condition of Bagshot Park," to the causation of puerperal septicæmia by sewer-gas. The following cases seem interesting, as showing this connection.

CASE I.—Mrs. S., a multipara, was confined on the morning of February 2nd, 1881. Labour was normal; the child was at full time, and living. A few hours later, I found her feverish, but the temperature was not noted. The next day, she had headache and slight abdominal pains; temperature 102.2° Fahr. She continued ill for more than five weeks (until March 10th), with symptoms of blood-poisoning. The temperature was sometimes very high—over 105° on one occasion. After the illness had lasted a few days, she had pleurisy on the left side; and, towards the end of the attack, abscesses formed in the axilla, groin, labia, and gluteal region. There was no sore-throat and no pelvic inflammation. The lochia were not at any time very offensive. There were only slight rigors, and milk was secreted for some days. She recovered. Two or three weeks before her confinement, the water-pipes being frozen, the trap of the water-closet became blocked; and Mrs. S., while directing the removal of the obstruction, got a strong whiff of sewer-gas, and exclaimed at the time that she was afraid it would give her diphtheria. She was not seen medically before her confinement; but her husband said she had been feverish and ill for a week before it took place, and that she "felt so hot in bed that he was obliged to move away from her." There was no history of exposure to any other poison than sewer-gas. In the same house, two years before, several of her children had diphtheria from defective drains; but these were put to rights, and there was no further trouble until the water-supply was cut off by the frost.

CASE II.—Mrs. H., a multipara, was confined prematurely, at seven months, on July 22nd, 1881. The child lived one day, and died cyanosed. She was ill for several days before confinement, with

pyrexia and abdominal pains. There was no local trouble to account for it. The day before confinement her temperature was 103°. Afterwards, she was better and less feverish for a day or two; but the temperature was never normal. She soon became much worse, and had severe rigors nearly every day; one wrist-joint became red and swollen, also the first metatarso-phalangeal joint of one foot. There was no throat-trouble; the lochia were not offensive. Milk was secreted for some time, and required belladonna to stop it. She died on August 25th, one month and six days after confinement. There were not any cases of infectious disease in the house, nor could any fault be found with the sanitary arrangements. But, a short time before her illness, Mrs. H. had noticed a strong smell from a sewer, while she was out walking.

In both cases, the illness commenced before confinement; local mischief only showed itself after the pyrexia had gone on for some days; and there was nothing in the history, symptoms, or progress of either case to lead me to suspect that any other poison than sewer-gas had been at work.

THE THERAPEUTICAL ACTION OF ACONITE.

By EDWARD J. TILT, M.D.

ACONITINE has attracted so much attention of late, that I will mention how large a dose of tincture of aconite (*B.P.*) was given by me in a very severe case of cerebral neuralgia, to a highly nervous lady, at the change of life. One or two attacks occurred about every week; and the attacks of pain were so severe that she was obliged to stop in bed, and in a dark room, for two or three days—the pain being sometimes accompanied by vomiting, oftener by salivation. There was but little dark-coloured urine passed at the beginning of the attack, and it ended by an abundant flow of limpid urine. The liability to these attacks has now lasted twelve years, and they still occur. What was suggested by Dr. Handfield Jones, Dr. Russell Reynolds, and Dr. Ogle had not the slightest effect on the attacks. The application of six leeches to the temples shortened them; going out of town kept them in abeyance, once for six weeks; and the only medicine that did the same was aconite. The patient took the tincture of aconite, in an aromatic infusion, for sixteen weeks, beginning with five drops, and gradually increasing the dose till she took twenty-five drops, three times a day. That dose caused so great a sense of fulness in the throat, and of tingling and numbness of the tongue, that I lowered it to twenty drops, three times a day, which caused only slight physiological effects. The remedy kept off the attacks for two, three, and once for four weeks; but it did not in the least diminish the intensity of the attacks. I therefore thought a sixteen weeks' trial of a dangerous medicine sufficient, and gave up its use.

As I am not aware that tincture of aconite has ever been given in such large doses, I will add that the prescription was made up at a respectable druggist's in Kensington, and that I am quite sure my patient took the doses I have mentioned. Whether my patient's idiosyncrasy made her able to bear large doses of aconite, or whether there was something wrong in the tincture, I cannot say; but I should follow the same course in a similar case. Dr. Greenhalgh told me he once nearly lost a patient, to whom he had ordered an enema containing nine drops of tincture of aconite.

NEW METHOD OF URETHRAL IRRIGATION.

By WALTER WHITEHEAD, F.R.C.S.E., F.R.S.Ed.,

Surgeon to the Manchester Royal Infirmary.

IRRIGATION, judiciously employed in suitable cases and at a proper stage of the complaint, is unquestionably a valuable adjunct to the treatment of gonorrhœa. In the first place, the prolonged stream of water effectually removes the inflammatory products of the disease, which obstinately and intimately adhere to the surface of the urethra, and protect the mucous membrane from the immediate influence of the remedies we endeavour to bring into action, either through the urine medicated by the administration of balsamic drugs, or by the more direct influence of antiblennorrhagic injections. The tenacity with which the secretions adhere has, no doubt, much to do with the difficulties encountered in the treatment of gonorrhœa. It must be remembered that the urethra in health is an elastic tube tolerant of reasonable dilatation; but when invaded by inflammatory changes, it is converted into a comparatively unyielding tube, intolerant of any force having a tendency to expand its calibre; consequently, irrigation, to be safe and successful, must be conducted on a principle consistent with the laws of hydrostatic pressure; and as we propose to use irrigation in a disease which involves conditions opposed to distension, it is required that the mode of

irrigation, whilst insuring a continuous and copious stream of fluid, should be free from any undue tendency to stretch the walls of the urethra.

These conditions I have obtained by the following apparatus and mode of procedure.

I have had catheters made, some in vulcanite and others in soft India-rubber, by Messrs. J. and W. Wood, of King Street, Manchester, with a deep spiral groove from tip to stem on their outer aspect. The catheter ends, as represented in the accompanying engraving, in a hollow bulb perforated with two large apertures directed backwards. The other extremity of the catheter is adapted for the ready attachment of India-rubber tubing. The groove in the catheter is made with a depth double the capacity of the central tube, so that the facilities for the return of injected fluids are greater than the requirements; and, in consequence, there is no excessive pressure on the urethra, the outflow being more than ample for the inlet of the irrigating fluid.

In using the irrigator, it is passed to different lengths of the urethra, after the manner of an ordinary catheter, according to the nature of the case, the aim being to get well behind the furthest limits of the diseased surface. The distance can be roughly estimated by the clinical features of the case, and by testing how far back the discharge can be pressed out of the urethra.

When introduced, a length of India-rubber tubing is attached to the irrigator; and the other end of the tube, passed through a leaden weight, is placed in a vessel containing the fluid to be used, and elevated above the body of the patient. The tube being made to act as a syphon, the strength of the stream can be regulated by the height of the vessel, and by this means a simple and complete control can be exercised over the force brought to bear upon the surface of the urethra and the feelings of the patient. The bulbous extremity of the catheter practically restricts the action of the fluid to the urethra in front, and prevents any of the injection from passing backwards into the bladder. The direction of the stream is also influenced by being diverted forwards within the hollow bulb. The irrigation of the urethra being regarded merely as a measure preliminary to treatment, it remains, after the mucous membrane has been thoroughly cleansed, to apply one or other of the various topical solutions we are in the habit of using; and this can be easily accomplished by connecting a syringe to the irrigator after the rubber tubing has been removed.

ON TAPPING THE BLADDER FROM THE PERINEUM THROUGH THE HYPERTROPHIED PROSTATE.

BY REGINALD HARRISON, F.R.C.S.,
Surgeon to the Liverpool Royal Infirmary.

IN the JOURNAL of December 24th, 1881, I reported a case where I had performed puncture of the bladder for retention of urine from the perineum through an enlarged prostate. I am now enabled to complete the history of that case.

After the bladder was tapped, for about six weeks my patient passed urine through the prostatic cannula. His health rapidly improved, and he was able to go about as if nothing ailed him. Then it was noticed by us that urine in gradually increasing quantities began to flow through the natural passage, so much so as to lead me to infer

that, for some reason or other, the prostate was ceasing to obstruct micturition.

On January 28th, I removed the prostatic cannula; the puncture healed in the course of a few days, and with this the bladder gradually proceeded to recover its natural function and power. It must be remembered that, for over two months, I had resolved the patient's act of micturition into the simple mechanism of turning a tap. During the day-time, he now holds his urine for two or three hours, and at night he gets up twice, and sometimes thrice, to micturate. It may be said that all functional symptoms of enlarged prostate have ceased to exist.

On the day of his admission into the infirmary, when the puncture was performed, rectal examination, made both by my house-surgeon, Mr. Laimbeer, and by myself, left no doubt that the prostate was greatly enlarged. Upon this point, there could be no other conclusion. Now we find that the enlargement has almost disappeared; in fact the finger, by the rectum, discovers but little that may be regarded as abnormal—a strong contrast to what previously existed. Here, then, we have a case where a surgical proceeding on an enlarged prostate was followed by its rapid atrophy, a result which, so far as I know, has not been noted before. It may be urged that rectal examination affords evidence that only one side of the enlarged gland has thus become reduced; it must, however, be remembered that a return of the power and function of micturition warrant a conclusion that a corresponding change has taken place in the vesical aspect of the gland.

Though I am only at present able to narrate one case, it will be taken for what it is worth, and as capable of being imitated.

I desire to record it as bearing upon the radical treatment of an affection for which little has hitherto been done.

Appended is a short description, with an illustration, of the instruments I have devised for this operation, which have been made for me by Messrs. Krohne and Sesemann.

Fig. 1 represents the Trocar with Cannula complete. A piece of India-rubber tubing is to be attached below the collar of the cannula on withdrawal of the trocar, to convey the urine into a receptacle.—Fig. 2. Silver cannula, which is introduced in tube of Fig. 1 to form a probe end, and for retaining it.—Fig. 3. A plain silver tube with which to clear tube (Fig. 2), in case of it being blocked up.

The trocar is hollow, and urine escapes through it as soon as it enters the bladder. The shield on the tube (Fig. 1) is movable, and can be fixed at any desired position to suit the varying thickness of prostate and tissues. The instrument is adapted for other purposes than that referred to in this communication.

POISONING BY PHOSPHORUS BY THE RECTUM.—Landerer relates in the *Archiv der Pharmacie* for the present year a case in which a woman, in order to come into the possession of a large inheritance, poisoned a boy, aged 15, by introducing the ends of phosphorus matches into his rectum. The boy died the same night, with very severe pain and inflammation of the rectum. The murderess committed suicide soon after her apprehension.

Fig 1

Fig 2

Fig 3