the commencement of her ill-health. Two years later, she ceased to menstruate: and for some months previous to this cessation she had considerable losses at her monthly periods.

In May 1873, she first consulted me for the disease from which she is now suffering. Her general appearance caused me to suspect renal mischief; but repeated chemical and microscopical examinations of her urine invariably demonstrated it to be free from albumen, casts of the uriniferous tubes, or renal *débris*. The excretion occasionally was extremely scanty, measuring at times only thirty-three ounces in seventy-two hours; it was of specific gravity 1029, and contained considerable quantities of urates. As a general rule, however, it was in all respects normal. Further, there was an absence of those nervous and dyspeptic phenomena which are characteristic of Bright's disease. The absence of these symptoms, and the presence of others which I am about to detail, caused me to think I had something other than Bright's disease to deal with. Her condition gradually got worse; and in the latter part of the year 1877 she suffered severe family bereavement, which had an evil effect upon her. The following was her state at that time.

Objective Symptoms.—The hair had almost entirely disappeared from her head and axillæ. Her face was swollen, broad, and expressionless. This swelling was most marked above the eyebrows, and around the eyes, where it formed a translucent bag hanging under each eye. There was a bright patch on the cheeks, in marked contrast to the pallor of the rest of the face. There was a discharge of clear fluid from the nose. The lips were swollen; the speech slow, difficult, and interrupted by frequent efforts of deglutition. The saliva trickled down the angles of the mouth while she spoke. The cutaneous surface was absolutely dry, and the hands and chest rough, like sand-paper. Around the middle part of the body were numerous brown warty spots, some of them as large as a sixpence. The posterior triangles of the neck had a swollen appearance, most marked over the supraclavicular triangles, and apparently of the same character as the facial swelling. The thyroid body could not be felt. The hands were swollen, harsh, and lined, and did not pit on pressure. The feet were not much affected. The heart-sounds were soft, slow, and regular. The apex-beat was in its normal position; there was no hardness, twisting, nor evidence of fibrosis or other structural change in the arteries. The pulse was 55 to 60 beats in a minute; the temperature 94.5° to 95.2° Fahr. The lungs were healthy, the breathing normal, and digestion good. The gait was awkward and staggering; and the patient could not walk without the aid of someone's arm, which enabled her to walk fairly well. She answered questions intelligently, but in a slow ponderous manner; and seldom took part in a conversation, unless directly addressed. Her teeth were good, considering her age; but she complained that one of her molars was loose, and she requested me to extract it. This I did, and I feared she would die from the hæmorrhage that followed. Styptics were tried in vain; but ultimately I succeeded by means of a wedge of cork fitted into the cavity, and the opposing tooth kept fastened down on it. An ophthalmoscopic examination of her eyes revealed nothing abnormal.

Subjective Symptoms.—The patient stated that she had a constant trouble at the top of her head, and, if she turned her eyes upwards, she fell down. She had a fear of falling when she walked. Her memory had become bad. Her hands felt stiff; and she could not "fathom" her fingers, which rendered her unable to pick up coins, etc. This caused her to feel quite useless both in her business of grocer and in performing her household duties. Her hearing was normal; but her sight was defective, unless she wore strong convex glasses. She had a good appetite, and slept too soundly, and was liable to fall asleep at any time. She had frequently to shake the old cells of the epidermis from her underclothing. She occasionally was extremely irritable, and at other times felt much depressed. She constantly suffered from a feeling of cold, and her disease invariably became aggravated in winter.

Treatment.—Previously to June 1879, the patient had taken perchloride of iron with quinine, Fowler's solution of arsenic, Parrish's syrup, nux vomica with gentian, and bromide of potassium, but without any benefit. At that date, I prescribed perchloride of iron, strychnia, and dilute phosphoric acid, from which she obtained relief. This treatment, together with warm clothing to head and body, was continued for some months, with marked benefit. Her present condition you have now an opportunity of seeing. All the symptoms I have described are still well marked. The hair, however, has partially regrown. She can use her hands comparatively well, and can walk without assistance, but still staggers. Her temperature is now 95.2°; and her urine is quite normal.

A few weeks since, some cases of a similar character were shown by Dr. Ord before the Clinical Society of London. To these he gave the

name of "myxœdema", which I have ventured to apply also to this case. He believes that there is a great increase in the interfibrillar mucin-yielding cement of the skin, which, padding the touch-corpuscles and nerve-ends, interferes with the ready reception of peripheral impressions. The brain, thus receiving sensory stimuli slowly and imperfectly, falls into a state of increasing torpor.

EFFECT OF THE RHEUMATIC DIATHESIS UPON THE INITIAL LESION OF SYPHILIS.

By C. B. LOCKWOOD, F.R.C.S., ETC.

MOST observers are agreed that the course of syphilis may be greatly modified by the diathesis of the patient. Reference to the writings of authorities on syphilis, and to their discussion at the International Medical Congress, shows that their observations are extended chiefly to the later stages. I am not aware that anyone has recorded observations showing that the rheumatic diathesis can modify the initial lesion. Primary syphilitic sores come under notice, which at first present ordinary characters. They afterwards become "inflamed and phagedenic" (Hill and Cooper, *Manual of Venereal Diseases*, London, 1881, p. 466) and may cause considerable destruction of tissue. Many attempts have been made to explain this occurrence (*Ibid.*, p. 468); debility, patients' habits, position of the sore, and peculiarities of the virus have all been adduced. In the cases mentioned below, all of these can be eliminated except the last. If the infecting virus in such cases as these be peculiar, it must expend its peculiarities upon the sore, for the other manifestations are not unusual. Moreover, these sores do not cause similar ones when inoculated. It therefore remains to explain what Messrs. Hill and Cooper state, and what personal observation has frequently confirmed, why "patients are met with who, but for the rapidly necrosing chancre itself, present every sign of good health" (*Ibid.*, p. 469). The following cases may suggest a cause. They are not numerous, but seem to be more than coincidences.

A patient, aged 26, came under my care in September 1879. He had what appeared to be an excoriation near the frænum. Ordinary applications had no effect upon it. By the end of September, the sore was larger and considerably indurated; not inflamed or particularly ulcerated. The inguinal glands were indurated. About the beginning of October, the character of the sore changed. It became inflamed, very painful, and excavated. There was a profuse, thin, and slightly sanguineous discharge. Small sloughs occasionally separated, and the ulceration extended until about a quarter of the glans penis was destroyed. The appearance of the disease at this time was quite characteristic. The sore was acutely inflamed and phagedenic. In November, there was acute inflammation of the dorsal lymphatics of the penis, with roseola over the chest and belly. The treatment adopted locally, during the whole course of the disease, was the use of warm baths and the application of iodoform. Constitutionally, two and a half grains of blue pill were administered night and morning. The effect of mercury was to cause the sore to spread, and increase the pain. Iodide of potassium with tartrate of iron was given in increasing doses. Opium was administered to relieve the pain. Improvement was rapid and continuous, and the sore healed. Afterwards, the patient had a slight tubercular syphilide and ulcerated throat. These were relieved by increased doses of iodide of potassium (30 grains) three times a day, and calomel vapour baths (15 grains) every other night. About February 1880, he discontinued the iodide of potassium, and took half a grain of green iodide of mercury each night for a few months. He is at present free from symptoms.

There did not appear to be anything to account for the course of this patient's disease. He had not taken mercury before the inflammation began. He appeared strong and healthy. His circumstances were comfortable, and his life regular. The following case seemed to throw some light upon it. About December 1880, W. H., aged 25, a book-binder, came under observation in St. Bartholomew's Hospital. He had an inflamed and phagedenic chancre, which resembled in all its characters that of the first patient. He also had lymphatic engorgement and roseola. His throat was ulcerated. Mercury increased the ulceration, which had destroyed about a quarter of the glans penis. Iodoform was therefore applied to the sore, and iodide of potassium and tartrate of iron were administered internally. By the end of January 1881, the sore was healed, the patient left the hospital, and has not been seen since. There was nothing about this patient which would account for the inflammation and phagedæna. He, like the other, appeared strong and healthy. However, I remember that the first patient was very rheumatic. He had suffered from rheumatic fever twice, and from one or

two slighter attacks. He had had endocarditis and iritis. Upon inquiry, it was found that W. H. had been laid up in the London Hospital seven years before, suffering from rheumatic fever. He said his heart had been affected, but no murmur could be detected. There was no family history of rheumatism. Two other cases, in which hard sores became inflamed and phagedænic, have come under notice. In one, there was a clear history of previous rheumatism. The other had never had rheumatism; but his father had had rheumatic fever, and his mother suffered from chronic rheumatism. This case is progressing favourably, iodine being applied to the sore, and $\frac{1}{2}$ grain of bichloride of mercury given three times a day. It may be mentioned that he had inflammation of the dorsal lymphatics of the penis. This occurring in two cases denotes the intensity of the inflammation. Mr. Hutchinson, in the *Medical Times and Gazette* (quoted by Hill and Cooper, page 469), has attempted to account for the origin of phagedæna. "He considers the patient's temperament. Certain persons have special proclivities to acute inflammation; and such a patient, if attacked by a chancre, would be more likely to have a phagedænic form of chancre." Bearing this in mind, and remembering how prone rheumatic patients are to inflammations, it might be anticipated that in them chancres would become inflamed. Four cases form insufficient materials from which to draw sound conclusions. But these are suggestive, and serve to bear out theoretical considerations.

As regards the treatment of these cases, in two mercury certainly did harm. The third was not under observation a sufficient time to form any conclusion. The last is improving under very small doses of a mild preparation. He had never had rheumatism himself, and his predisposition was probably least. Experience teaches not only that phagedæna is seldom benefited by mercury, but also that iodide of potassium is good for rheumatism. It can, therefore, be understood why these cases were so amenable to treatment by the latter. Therefore, in cases of syphilis, in which the initial lesion is inflamed and phagedænic, and in which there is a history of rheumatism, it is probable that iodides will be of service at an earlier stage than usual. Mercury should be administered with the greatest caution, if at all.

SURGICAL MEMORANDA.

A NEW METHOD OF PERFORMING INCISION OF THE CHEST.

As the treatment of empyema is now receiving prominent attention, I beg to submit to the notice of the profession a safe and easy method of incising the chest.

At the point selected for the operation, I introduce my No. 2 antiseptic trocar (see *BRITISH MEDICAL JOURNAL*, February 25th, 1882), which serves the purpose of an exploring instrument, and then forms the sheath of a probe-pointed knife. Under Listerian precautions, the India-rubber case is removed, and the inner tube withdrawn; then in its place the knife is introduced, which accurately fits the trocar, and projects a cutting edge of one inch and a quarter in length. The trocar is thus converted within the chest into a probe-pointed bistoury, and with it the required incision can be safely and rapidly made. This modification renders the performance of the operation very easy; on the other hand, an incision from without inwards is often delayed by the dense layer of lymph lining the costal pleura.

JOHN WARD COUSINS, M.D. Lond., F.R.C.S.,
Surgeon to the Royal Portsmouth Hospital.

ATTACHMENT OF PENIS AND SCROTUM.

In the *JOURNAL* of May 10th, reference is made in the report of a case of this kind to its infrequency. I met with a case some time ago. The penis was closely adherent by its under surface to the anterior part of the *raphé* of the scrotum in the same way as described by Mr. McDougall. The mother refused to have anything done for it, on the assurance that there was no immediate interference with the health of the child. In Bryant's *Surgery* (1879) no case of the kind is mentioned.

JOHN DOUGALL, M.B., C.M., York.

DR. MCDUGALL'S communication regarding the above malformation recalls to me a somewhat similar case, which I have seen lately in a child eight months old. In my little patient the penis is tied down in the greater part of its length, but it is bent not directly downwards, but considerably towards the left, while it is also turned a quarter

round on its own axis, so that the slit-like orifice of the glands looks right across, and the urine is passed straight to the left. The preputial orifice is unusually large, and the amount of loose bulging foreskin on the upper and right aspects much in excess of the normal. The child's health is not such as to warrant interference at present.

D. MITCHELL, M.B., C.M., Renton, N.B.

THE PLASTER-OF-PARIS JACKET FOR SPINAL DISEASE.

THE series of interesting papers published in the *JOURNAL* of May 13th, induces me briefly to state that I have found no reason to modify my opinion as to the advantages of applying the plaster-of-Paris jacket for spinal disease, in the recumbent posture, by the method which I suggested some years since, which was demonstrated at the Association meetings at Bath and Cambridge, and which I fully described in the *JOURNAL* of March 1st, 1879.

Many surgeons who have adopted my method complain of the weakness behind of the jackets thus applied. To obviate this Dr. B. Lee, of Philadelphia, has suggested that, after one layer of bandage has been applied, the patient should be turned to the prone position for the application of the second, the third being applied in the dorsal position. This modification of the steps described in the paper referred to I have adopted, and recommend to others.

THOMAS JAMES WALKER, Surgeon to the Peterboro' Infirmary.

THE code of directions which Mr. Golding-Bird gives in the *JOURNAL* of the 13th instant as a guide in the treatment of spinal disease appears to me to require some slight modification.

With regard to disease of a chronic or subacute character affecting the spine between the third cervical and the sixth dorsal vertebra, it is stated that "the deformity being mostly from the weight of the head support must be given to it"—it refers, I conclude, to the head, not to the deformity. Now certainly deformity in such cases, as in all other cases of Pott's disease, is directly dependent upon destruction of bone, and the only means by which deformity can be prevented is by arresting the existing disease. It is universally acknowledged that treatment in such cases must be to place the affected vertebra in a condition of complete rest. The term rest includes not only absence of movement, but also relief from pressure. Mr. Golding-Bird rules that treatment should consist in supporting the head, which object is to be "attained (1) by a chin and occiput rest, acting crutch-like from a suitable leather corset below; (2) by a chin and occiput band, acting as a suspender from a steel spring rod arched over the head, and rising from a plaster-of-Paris corset (this is Sayre's jury-mast)." Mr. Golding-Bird prefers the latter appliance "because it permits rotation," a quality which should rather condemn its employment, for, if the vertebrae be not prevented from rotating, they are not placed in a condition of rest. A further distinction is drawn between the two appliances in reference to their mechanical action. The first is described as a "dead push up;" the second as giving "constant elastic extension." Practically, they act in the same way, since in each case the fulcrum is the same the extending force must necessarily be the same.

Disease of the spine as high as the third dorsal vertebra, it is ruled, may be treated by means of the plaster jacket alone; "the downward weight of the head is not obviated, but the spine is kept still by the fixation of the upper ribs." Even supposing that the upper ribs can be fixed by the jacket, which is very doubtful, it must be remembered that they are not immovably connected to the vertebrae, whilst relief from pressure is as necessary here as in the case of disease of any other portion of the column.

I regret to find that Mr. Golding-Bird so completely condemns the curative power of the poroplastic felt jacket, because I am strongly of opinion that the success of the jacket treatment of Pott's disease of the spine depends upon our finding a suitable appliance that can be removed when necessary, for examination of the seat of disease. I can only add that my own experience is directly opposed to that of Mr. Golding-Bird.

FREDERIC R. FISHER.

TOXICOLOGICAL MEMORANDA.

POISONING BY BELLADONNA AND ACONITE.

ON April 27th, I was called in great haste to see a man who was stated to have taken some poisonous lotion by mistake. On arriving, I found that he was an out-patient at the Infirmary, suffering from rheumatism, and had been prescribed a lotion containing compound liniment of belladonna and aconite liniment, together with a mixture. When I