that thymol or menthol should be used as the parasiticide, and that chloroform would answer the purpose as the absorbent. But, as the latter was volatile, I added oil to the compound to prevent evaporation. While trying this liniment, of thymol, chloroform, and oil, in a large number of cases, I was struck with the fact that in some of them, in spite of the constant application of the remedy, the disease appeared on other parts of the body, and also on other parts of the head previously free. It seemed difficult to understand that, in a strictly antiseptic medium, spores could be carried from part to part and live; but such seemed to be the case, for in some instances, when the liniment had been used too freely, and had run down the neck, fresh spots of the disease showed themselves in that region. During the time I was considering this difficulty, I found that Koch, in Berlin, had been making experiments on bacillus spores with various antiseptics, and found that these spores lived and developed even after being placed in carbolic oil (one part in twenty) for one hundred and ten days. This, I think, is a very strong argument that neither oil nor fat of any kind should be used when the full action of an antiseptic is required.

Of course I am fully aware that all the best authorities recommend strong ointments, mercurial or otherwise, though for a very different reason from that I have been describing. They care little or nothing about the antiseptic action, so long as inflammation of the follicle, more or less severe, be produced. The spores are said not to live in inflammatory products (Thin). But surely cases are not uncommon in which the disease is transplanted to healthy parts by means of the discharge. I have seen a case in which croton-oil was used to a single patch, and in a short time the head was covered with small centres of infection. In this case, the spores were carried in the discharge.

And, again, have not all the old chronic cases we see in practice—some of them of four or five years' duration—been cases treated by constant attacks of inflammation, and yet with the result that spores have been found with ease? My view is that to produce inflammation of a slight kind is useless; and that a severe kind is unjustifiable, on account of the risk of destroying the follicles altogether, and producing baldness.

To return to the question of fats: if fat of any kind from without protects the spores, as Koch asserts, the natural fat or sebaceous matter must have a similar effect. For this reason, I have tried to remove the fat by means of ether, and have abstained from using ointments or oil in the treatment. I wash, or more strictly dab, the patch each morning with ether, rectified spirits of wine, and thymol, in the following proportions: ether, five drachms; rectified spirits of wine, two drachms and a half; and thymol, half a drachm—applying during the day glycerine with a very small trace of perchloride of mercury. Petroleum may be used in the place of the ether and spirit. One drachm and a half of petroleum-oil takes up five grains of thymol. The ether or petroleum is of greater value than would at first sight appear, and for the following reason. There is a disease of the scalp known as *seborrhoea sicca*, the chief characteristic of which is the falling out of the hair. This is caused by the absence of the natural fat in the sebaceous matter. It is cured by stimulating the glands to action, and by adding fat artificially. In the ringworm patch, we want the diseased hairs to fall out; and, by producing a condition similar to *seborrhoea sicca*—that is, by making the part very dry—we can actually produce this effect. Instead, therefore, of epilating by means of forceps—which is useless, as the hair breaks at the neck of the follicle, leaving the diseased part behind—we can epilate by dissolving the fat, and thus loosening the hair. In this way, we can in a few days remove all the broken and diseased hairs.

LEFT INGUINAL COLOTOMY IN RECTAL STRICTURE.

By H. A. REEVES, F.R.C.S. Ed.,
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THIS preliminary note is published with the view of drawing professional attention to a method of treating rectal stricture which appears, as far as present experience goes, to offer certain advantages. I have already operated on three cases, the last two of which were done non-antiseptically, and all of them have resulted very well. Up to date, I have had occasion to perform forty-six colotomies for rectal or colon obstruction. Most of these have been left lumbar, and the large majority have been in women. Only once have I done the right lumbar operation, and in this case the stricture was high up in the colon. Until lately, my inguinal colotomies were performed on infants for one or other of the forms of improperly developed rectum, and, like the recent ones, were in the left inguinal region. I may add that many other cases suitable for colotomy have come under my care; but, either through the patients declining operation when the object

and result were explained to them, or through their getting tired of waiting for a bed, I lost sight of many of them.

The inguinal operation avoids the risk of unintentionally opening the peritoneal cavity, which has often fatally occurred in the lumbar operation. In fact, the operator deliberately prefers to go through two layers of that membrane, the parietal and that covering the bowel; and the probability of the occurrence of prolapse is, I think, much diminished; but the days are yet early to speak definitely on this point. If the operation be undertaken for innocent stricture, this method of operating offers the advantage that a bougie may be carefully passed through the stricture from above, when it may be impossible or dangerous and difficult to do so from below.

As regards æsthetic considerations, I find that, when the objects and the resulting conditions of the inguinal and lumbar methods are put clearly to the patients, they are usually indifferent, leaving the matter to me; so that it would seem that even married women think more of present relief to pain than of future consequences. I think that the situation of the opening matters little from a sexual point of view, because it is protected by a suitable apparatus, which is not more unsightly than a truss; and because, wherever the incision be, the odour is much the same. This annoyance may be to a great extent kept under by suitably scented compresses.

I make the incision a little higher than that advised in the books—*i. e.*, rather more than an inch above Poupart's ligament, and extending from just external to the internal inguinal ring to a little external to the anterior superior spine of the crest of the ilium. I found that, by doing this, the intestine (sigmoid flexure) was more easily reached at the lower part of its course, and that its tendency to drag away from the stitches to the abdominal wall after operation was diminished. An appendix epiploic will usually be seen; and, if this be steadily drawn out, the bowel will follow.

In my first case, I did not open the bowel at the time of operation, but stitched it to the parietal peritoneum, and not to the skin. The wound was kept open by oiled lint; and, as the patient was a very stout multiparous woman, and had a fat pendulous abdominal wall, this was not a very easy matter. On the third day, it was difficult to recognise the bowel, which was coated over with a thick layer of lymph, and deeply placed at the bottom of the wound. The patient, who was suffering from malignant disease of the rectum, was much relieved by the operation.

In the second case, to avoid difficulty in finding the bowel, I stitched it to the parietal peritoneum and to the skin; but on the fourth or fifth day I found that the stitches had ulcerated through the intestinal coats, and that the bowel was covered with lymph, and deeply placed at the bottom of the wound. At one spot, it seemed as if the serous coats of the abdominal wall and bowel had not united; but the case has done beautifully. This patient is only twenty-five, and has malignant disease of the rectum.

The third patient was a woman aged 50, with extensive disease of the rectum involving the vagina; and in her case I stitched the bowel to the abdominal wall, and opened it at once. She has progressed most favourably.

It is important that the opening in the parietal peritoneum should be sufficiently free, so that, when the bowel is pulled through it, there should be no strangulation on account of its passing along a too small opening. Although the abdominal incision was a little higher up than usual, small intestine did not present, and was not even seen, in any of these cases. I mention this, not so much on account of a possible difficulty in distinguishing a thickened piece of small intestine, but because of the inconvenience which would arise if it bulged at the small opening; as to return it and keep it in place while the operation is being completed is not always an easy matter. All bleeding must be stopped before the peritoneum is opened. I give morphia after, and also a night or two before, the operation, to lessen peristaltic action, and to make the fæces solid, so that no fluid matter may escape along the track of the sutures and set up peritonitis. Should some solid faecal matter be taken up by the needle as it transfixes the bowel (and this may generally be avoided by making sure that the fold of intestine between the fingers does not contain any solid motion), its point will be cleansed by the mucous and muscular coats of the opposite wall before it penetrates the serous coat; but the operator should look to this, and, if necessary, cleanse the needle's point before passing it through the parietal serous membrane. It is advisable to let the patient lie half over on the abdomen, either on the left or the right side, to prevent the dragging on the stitches which occurs in the dorsal position. This tendency to fall back is partly due to the weight of the bowel, and partly to a rather short sigmoid meso-colon. I may here state that the bowel may be reached on its posterior surface, and without opening the peritoneal cavity, by proceeding very nearly as if for tying the external

iliac high up; but, as this involves a larger wound, a longer operation, and as, moreover, we now-a-days know that the peritoneum is no longer to be dreaded, this plan is at a great disadvantage.

The cases mentioned have all recovered, and were operated on during the last three months at the Hospital for Women; and, since writing the above, I have operated on a fourth case at the London Hospital. In this case, omentum presented when the peritoneum was opened. In this last case I had, two years ago, excised four inches of her rectum, giving her eighteen months of comfort; but the return of the disease, and the pain caused by the growth, induced me to offer her the few months' comfort which this operation, if successful, will give her.

CLINICAL MEMORANDA.

MEASLES WITH MARKED THROAT COMPLICATION.

E.T., aged 6, who was stated to have been more or less ailing for ten days, was first seen on April 10th. He then had a very distressing cough, croup-like in character, and unaccompanied by any expectoration. Slight aphonia was also present. The larynx was tender on pressure, and the fauces acutely inflamed; there was no enlargement of the tonsils. Inspiration was whistling, the origin of the sound being referable to the larynx. He had occasional sickness, and was extremely prostrated. Temperature 102°; respirations 36; very small pulse. There had been several cases of acutely inflamed and ulcerated throats in the house quite recently, their cause having been traced to imperfection in drainage. On April 12th, the patient being still without any coryza, and with the cough retaining the same character as before, a slight rash appeared on the forehead, which on the next day presented the characteristic aspect of measles, and spread rapidly over the back, arms, and legs. There was also busy delirium at night, and the temperature reached in the evening 104°. The glands of the neck became much enlarged, and cough continued, still dry and barking. On April 15th, the rash was fading on the legs, but very deeply pigmented on the arms and hands. There still was delirium. Temperature 104°; respirations 60; pulse 130. The patient continued in the same state until April 18th, when there were physical signs of pneumonia at the base of the left lung. The cough was more loose. The sputum was swallowed by the child, and therefore could not be noticed. He had diarrhoea, with yellow foul-smelling stools. The rash was very deeply pigmented, and almost everywhere on the body and extremities. Delirium was not constant. Temperature in the evening 104.4°; respirations 62; pulse 130. Brandy was freely ordered, and the diarrhoea checked by astringents. The patient gradually improved under treatment, but it was not until the 1st of May that the rash entirely disappeared. This was the boy's first attack of measles. The mother of the patient, who had had measles when young, and who had been constant in attendance on her boy, began to show symptoms of illness on May 10th. No previous feeling of illness could be elicited. On May 10th, she complained much of her throat. The fauces were very acutely inflamed, the tonsils not enlarged, the larynx tender; there was slight aphonia; the cough was dry and barking. The glands of the neck were swollen. On May 13th, she had slight coryza. Temperature 100°. On May 14th, a very well-marked morbillous rash appeared on the face, and spread the succeeding day over the body. With the exception of slight prostration, she progressed favourably, and on May 18th had lost all appearance of rash.

H. G. ORLEBAR, M.D.

THERAPEUTIC MEMORANDA.

ON THE TREATMENT OF ECZEMA BY DIET.

MR. B. SQUIRE entirely fails to comprehend my remarks on the above subject, and his criticisms show a complete misconception of my meaning. A few words, however, will make this clear.

As to the use of cod-liver oil, I did not say that the efficacy of the Banting diet was "very much enhanced by the addition of a little cod-liver oil." On the contrary, I agree with Mr. Squire that the oil is inconsistent with Bantingism. What I did say was this—and here is the exception to the rule—that in some children the use of oil is indicated, and may be given after the diet has been used for some weeks. There is no inconsistency here; if there be, then modern therapeutics is full of such inconsistencies. Sudden change of treatment, medicinal or dietetic, or both, is of every-day occurrence, as, for example, in pneumonia. May not the same principles be applied to the treatment of cutaneous disorders? I may add, that I usually prescribe the oil in small doses, and in the etherised form, five minims of ether to one drachm of oil.

With regard to the case I mentioned, I am perfectly well aware of the good results of the pitch treatment in chronic eczema. But here is a little patient, who, for more than eight years, has been under active treatment with ointments of all kinds, including pitch, and no improvement is noted. He is put on the Banting diet, the pitch being continued because it appeared to relieve the intense irritation; and he recovers. Surely the logical inference is, that the dieting has been productive of this happy result.

In conclusion, let me add that in my article I did not explain the Banting diet, or attempt any definition of it; that I strictly follow the diet laid down by Mr. Banting in his pamphlet on *Corpulence*; and that the patient, whose case I quoted, was under my personal observation during the whole course of his hospital treatment.

A. CRESWELL RICH, Liverpool.

REPORTS

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN AND IRELAND.

UNIVERSITY COLLEGE HOSPITAL.

FOUR CASES IN WHICH IODOFORM, USED AS A LOCAL APPLICATION, APPEARED TO EXERT A POISONOUS INFLUENCE ON THE ECONOMY.

(For the notes of these cases, we are indebted to Mr. STANLEY BOYD, Surgical Registrar.)

CASE 1. *Strangulated Femoral Hernia: Iodoform Dressings: Drowsiness, Hebetude: Recovery when the Iodoform was removed.* (Under the care of Mr. MARCUS BECK.)—G. F., aged 61, a barber, was admitted on August 13th, 1881. During the previous eleven years, he had occasionally noticed a swelling in the right groin; it gave him no inconvenience. He was subject to sudden attacks of acute pain in the epigastrium, which were accompanied by vomiting of "black stuff", but had always ceased spontaneously. On August 10th, at 9 P.M., he was suddenly seized with an acute pain in the hypogastrium, and he passed a small motion. Two hours later, he began to vomit dark green, bitter-tasting material. On the morning of August 13th, the vomiting became stercoraceous. When admitted, a strangulated femoral hernia about the size of a turkey's egg was found on the right side. Mr. Beck performed herniotomy. The gut was returned, and the sac was found to be lined by uniformly adherent omentum. The carbolic spray was used; and the wound was dressed with carbolised gauze, etc. For four days, all went well; but on August 18th the wound was found to be suppurating, and there was some cellulitis extending from the iliac crest to the last rib on the right side. The carbolic dressings were persevered in; but on August 20th the discharge was offensive. Fomentations and boracic acid dressings were now used, and the cellulitis began to diminish. On August 23rd, a counteropening was made above the crista ili, and a drainage-tube was passed through to the groin.

On September 3rd, iodoform was used for the first time. A piece of lint, sprinkled with the drug, was passed through the whole length of the sinus above described. On September 7th, it was noted that the iodoform was then being puffed into the sinus through a bougie, and that the patient was emaciating somewhat rapidly. On September 20th, he complained that he felt "generally low", and could eat no solid food. The structures over the sinus were a good deal inflamed. His general condition continued to be very unsatisfactory; he was dull heavy, and exceedingly drowsy; he was disinclined for food or to make any exertion, wandered a little at night, and was losing flesh. On September 26th and 27th, the temperature reached 101.6°; and on the following day it was thought that pericardial friction could be heard at the inner end of the sixth rib. The tongue was dry and brown. The pain was relieved by poultices; but the appetite remained bad, and the pulse high (130). He continued to waste, and was apparently passing into a hopeless condition of hebetude, and exhaustion. The sinus had not contracted much, and still discharged freely.

He left the hospital on October 1st. On October 20th, Mr. Beck saw him at his own home, and the following note was made. The patient was very much better. The improvement was said to have begun about three days after he was discharged from the hospital; that is, when all the iodoform had been washed out of the wound by the red wash which had been ordered him on discharge. The great drowsiness and slight wandering at night then disappeared, and he had been getting better ever since.

Soon after he got about again, the hernia again became strangulated. He again waited two or three days before seeking advice. Mr. Beck