of albumen, except when the amount of albumen present had been too small to be detected by the nitric acid test—most of these being the urines of convalescents from acute albuminuria in which, shortly before, the presence of albumen has been indicated by heat and nitric acid. Now since peptone is not coagulable by nitric acid, it is clear that when the urine is found equally coagulable by nitric and by picric acid, the case is not one of peptonuria. And I infer that amongst these numerous cases there has not been one in which the urine has contained peptone.

It would seem *a priori* probable that peptonuria would be as rare a phenomenon as the so-called chyluria. This, however, is certain that, with the modifications of the picric acid test, to which I have referred, there can in future be no difficulty in detecting peptonuria when or if it does occur, or of distinguishing it from the far more common condition, albuminuria.

It has been customary of late to speak of various kinds of albumen, but this surely is not the language of scientific chemistry. There are various albuminoid bodies—such as, for instance, fibrine, casein, etc.—but, of albumen, there is but one kind, whatever may be its source. The albumen which is found in the urine is a derivative of blood-serum, and is always one and the same, although its behaviour with reagents will differ in accordance with the state of combination and of admixture in which it exists. Thus, albumen in alkaline, or in some neutral urines, is not coagulable by heat; and, again, the presence of a small quantity of a mineral acid, or a larger quantity of a vegetable acid, results in the formation of an acid compound of albumen, in which no amount of boiling will cause coagulation. The common practice of adding acetic acid to urine before applying heat, is likely to mislead by the formation of such an acid compound, not coagulable by heat. A small quantity of albumen, therefore, often escapes detection by this fashionable but fallacious method of testing. On the other hand, picric acid has not only the advantage over heat and nitric acid of being so sensitive that it will indicate the presence of albumen in a specimen experimentally diluted beyond the point where the other tests fail to detect it, but it acts equally well in acid, neutral, and even in alkaline urines; for, although the coagulation of albumen by picric acid is prevented by caustic alkalis, I have not once, in examining some hundreds of specimens, found it necessary to acidulate the urine before adding the picric acid. Another advantage of the test is, that it consists of a single cheap substance, which is not liable to undergo chemical change by being kept either in a solid form or in solution; and, without making seemingly invidious comparisons with other tests which have recently been recommended, this, at any rate, may be said of picric acid, that, in its action, it is singularly free from sources of fallacy. In fact, my estimate of the value of picric acid as a simple, certain, and most delicate test for albumen in the urine, has risen in proportion to my increasing experience of its efficacy. I confidently predict that it will soon come into general use; and one good result of the common employment of so trustworthy a test will be, that the next generation of practitioners will see fewer cases of incurable degeneration of the kidneys than daily come under our notice at the present time. For the history of a large proportion of these cases is, that some ten, fifteen, or it may be twenty years ago, there was an acute affection of the kidneys with albuminuria, which was supposed to have passed away; but the complete freedom of the urine from albumen was not ascertained by trustworthy, and frequently repeated, tests. The recovery was incomplete; an unsuspected latent disease has been insidiously making progress, until at length some of the many distressing results of degeneration of the kidneys bring the patient again under medical observation, when it is only too obvious that, not only have the kidneys in the course of years become incurably diseased, but that many other organs and tissues have become involved in the morbid process. There is, then, little more to be done than to watch the progress of the disease to its inevitably fatal result.

The calamitous results to which I have referred may, in a large proportion of cases, be prevented by the careful watching and treatment of recent cases of albuminuria, with a determination on the part of the practitioner that the patient shall not be declared convalescent until the most delicate available test fails to detect the smallest trace of albumen in the urine at any period of the twenty-four hours, and for many successive days.

It cannot, in my opinion, be too emphatically declared or too generally known that, while a fraction of a grain of saccharine matter per ounce is a normal constituent of all urines, the smallest trace of albumen is abnormal and pathological; and, if permanent, it has in it the germ of future trouble, and, it may be, of irreparable disaster.

ERYSIPELAS AND ECZEMA IN A NEW-BORN INFANT.

By HERBERT J. ILOTT, M.D., Bromley, Kent.

Mrs. S., aged 28, was attended by me in her second confinement on December 8th. The labour was natural, and conducted, as far as possible, with antiseptic precautions. The hands were washed before and after each examination with carbolic solution, and the examining finger lubricated with thymol jelly (Richardson's). The placenta was removed by expression, and the vagina syringed out with warm carbolic solution. The external parts were washed with the same, and Southall's absorbent pads applied to receive the discharges. The after-progress of the mother was in every respect satisfactory, the discharge being small in amount, thin and free from odour. The infant (a male) when born was small, but well formed and nourished. Nothing abnormal was noticed with regard to it until the 14th, when it was shown to me by the nurse, and found to have a slight degree of purulent ophthalmia. The nurse was directed to bathe the eyes frequently with tepid water, and to apply at short intervals a tannin lotion. The ophthalmia quickly improved under this treatment. On the 18th, the infant cried a great deal, and a redness of the skin was noticed which, commencing near the umbilicus, spread over the abdomen and thorax. By the next day, nearly the whole surface of the body was covered with a deep redness. On the trunk, especially on the sides of the thorax, were numerous vesicles and bullæ filled with a clear fluid. Several of the bullæ had coalesced. The fluid soon became thick and yellow, and the bullæ, rupturing, left large flakes of epidermis on the skin. The redness subsided, leaving the surface of a yellowish red hue. The epidermis peeled off in large flakes over the body, except on the head and the penis and scrotum, which parts were very slightly affected. The treatment adopted was bran baths, with a lotion of zinc oxide, liquor plumbi, and glycerine. Internally, a saline mixture, with carbonate of magnesium, was given. During desquamation, vaseline was applied with a large camel's hair brush. By December 31st the desquamation had almost ceased, and the surface was healthy, with a few papules here and there. On the evening of the 31st, the infant was taken down stairs, and it is supposed that he caught a chill, for he screamed violently during the night, and next morning the skin was again bright red, the face being much more inflamed than during the first attack. There was soon oozing of fluid from the face, forming yellow crusts and bullæ, and vesicles, discharging a yellow fluid, formed on the body.

The same treatment as before was ordered, with the addition of small doses of quinine; as this, however, caused vomiting, and the child cried very much, a mixture of bismuth and soda, with aromatics, was substituted. On January 8th, the surface was in a general state of desquamation, the scales of a yellowish white, colour, resembling bran. The eyes were quite clear and bright; the child slept well, and took nourishment freely. The mother's milk being very scanty, he was given in addition Swiss milk and white wine whey, which was taken freely.

On the 10th the face was clear, but desquamation was going on over the scalp and back. The bowels were regular, motions healthy. The surface, from which scales had separated, was of a bright pink hue.

On inquiry I found that the mother who, as a rule, enjoys good health, but is not strong, had suffered during pregnancy from leucorrhœa with a yellowish white discharge. She had never had any skin-disease; nor had the father. The father's aunt, who was staying in the house, told me this history. About thirty years ago, while standing at a cottage-door in June, the weather being cold and snow falling, she felt a sense of swelling and irritation of face and head. After reaching home she was laid up with erysipelas of the head and face, extending to the arms and trunk. The attack was very severe, and she was ill from it for ten months. About two years after this she again got a chill, and was laid up with a similar attack for a like period. Although she has never had a recurrence of erysipelas, she is very subject to irritation of the skin from the effects of extreme heat or cold. She is also subject to urticaria, more especially if she venture to eat salmon. As a child, she suffered from redness and oozing of watery fluid from the bends of the joints.

The infant's grandmother, on the mother's side, has had more than one attack of facial erysipelas, the first occurring at the age of 52. His aunt (mother's sister) has had several attacks of eczema, which seems to be provoked by the effects of heat or cold winds.

I may add that I attended the eldest child, a boy, in August, 1860, when eighteen months old, for erythema of the fugacious type,

chiefly appearing on the trunk and upper extremities, which seemed to be connected with gastric derangement, and which rather abruptly disappeared on the child being taken to the seaside. It was rather fortunate, especially viewed in the light of the family history, that no ill-result followed on vaccination, which was successfully done. This case seems worthy of record, as illustrating the strong tendency to skin-inflammations existing in the relatives of these children on both sides, though it is curious that neither father nor mother have hitherto suffered. They are both individuals of slight physique, nervous temperaments, with remarkably clear, red-and-white complexions. The attack that I have described was evidently related to both erysipelas and eczema, the first phase more resembling the former in its characters, the second the latter.

OBSTETRIC MEMORANDA.

CASE OF HYDRAMNIOS.

ON February 7th, 1883, I was called in consultation to see a patient said to be pregnant. She was the mother of several children, all her labours being natural. I noticed her peculiarly anxious countenance, and she was evidently suffering from extreme dyspnoea. I found the abdomen enormously distended and tense, dullness on percussion, and well marked impulse on palpation; the lower extremities were highly oedematous. Fetus-like movements could be detected through the thinned abdominal walls. I found the os dilated, and the membranes protruding and tense, these were ruptured, and sixteen quarts of glairy yellow fluid drawn off; subsequently, a full-grown foetus was expelled, the occipital bone and part of the cerebellum being absent. The patient made a rapid and perfect recovery without any untoward symptoms.

Kidderminster.

SAMUEL STRETTON.

THE PREVENTION OF LACERATION OF THE PERINEUM.

IN a paper read before the Obstetrical Society of London in 1876, entitled "The Treatment of Rigid Perineum and the Avoidance of its Rupture," published in their *Transactions* for that year, page 61, and also in the *BRITISH MEDICAL JOURNAL*, I recommended what Dr. Alexander Duke now suggests. The following is a quotation from my paper. "We meet with ample instructions in many of our standard works for the dilatation of the os uteri; but, so far as I am aware, the same line of treatment has not been applied to the perineum, to which, however, I find it peculiarly applicable. This probably arises from the long-established idea that the perineum needs support."

After describing a case in which this treatment was most successful, I proceeded: "In my way of thinking, the only justifiable course was first to remove the obstacle, and then to arouse and assist the uterus. With this view, I hitched three fingers into the posterior commissure, and kept up pretty firm continuous extension, first with one hand and then with the other; in less than half an hour, the outlet was very considerably dilated. I then gave a dose of ergot, applied a bandage firmly around the abdomen, and assisted by pressing the hand over the uterus, and in a short time had the pleasure of seeing a fine boy, and of knowing that my patient was in no way lacerated."

I must add that, since recommending this treatment, I have applied it in about a thousand labours; nor do I now confine it to cases of rigid perineum, for I find that, first, it not only avoids any rupture of the perineum, but, secondly, it materially shortens labour by performing the dilatation usually done by the child's head; thirdly, it stimulates the uterus to action; and, fourthly, it very frequently terminates a labour which would otherwise have necessitated the use of the forceps, with the probability of a ruptured perineum.

My object in this communication is not so much to claim originality as to insist upon dilatation of the perineum being made a rule of practice, instead of the mischievous and useless support of that part so frequently practised. Any aid which facilitates and shortens labour, and at the same time renders it more safe, is worthy of our attention; and every obstetric physician must have seen cases where the surfaces of a lacerated perineum appeared to have been the place of septic absorption.

The dilatation during a pain is not noticed by the patient; but, in urgent cases, continuous steady traction is far more expeditious. In cases where forceps have to be used for obstruction at the brim

of the pelvis, dilatation not only prevents laceration, but saves much time, and the delivery is far less painful.

H. ERNEST TRESTRAIL, M.R.C.P., F.R.C.S., Aldershot.

IN the *BRITISH MEDICAL JOURNAL* of March 10th, page 454, Dr. Duke brings out some interesting and original facts with regard to the prevention of laceration of the female perineum. His plan, however, of pushing the head forward with the finger in the rectum seems to me to be of questionable value. Before the head has descended low down to the outlet of the pelvis, in cases where the pubic arch is narrow, no amount of pressure from behind will make the head travel forwards, for the simple reason that the arch presents a barrier to such a movement. In occipito-anterior cases, when the head is low down, and the occiput has become as much fixed as it can under the pubic arch, the movement of "extension" takes place. When this has begun, any pressure from behind the rectum at once favours the movement, because the force is applied at the end of the lever, represented by the head; this lever's fulcrum being at the occiput, fixed under the pubic arch. And, further, the same amount of force will have a proportionally greater effect according as the movement of "extension" has taken place in a lesser or greater degree.

Thus, the uterine contraction, acting through the child on the base of the skull, at the point where the spinal column joins the foramen magnum, would be reinforced by another (though a much smaller) force, acting further away from the fulcrum, both tending to produce "extension" of the head, and consequent stretching of the perineum. Now, it must be remembered that, where there is a rigid perineum, this small increment of force may produce the results we wish to avoid. In cases where the perineum is much stretched, and is in danger of being ruptured, counterpressure on the presenting part of the head will prevent the movement of "extension" taking place too rapidly; and thus give the time, Dr. Duke aptly remarks, ought to be given for dilatation of the perineum.

Probably, in cases of occipito-posterior presentation, the finger in the rectum would be of great service; for the ruptured perineum is often the result of insufficient "over-flexion" of the head, the uterine contractions forcing the head itself on to the perineum, the element of rapidity of delivery of the head being generally subordinate.

ALFRED CARR, M.R.C.S., late Obstetric Assistant,
University College Hospital.

FACE PRESENTATION.

A. W., AGED 22, primipara, at full period, was first seen after slight dilatation of the os had taken place, the face having barely engaged the pelvis, although the membranes were ruptured, and the liquor amnii was escaping. The finger touched the right malar bone and orbit. The pains were frequent but not strong, and the patient was hysterical. I gave opium, and left her, and was sent for twelve hours later, when the os was fully dilated, and the face, which had now descended to about the middle plane of the pelvis, was found presenting, in the first position, the right oblique diameter, with the chin backwards towards right sacro-iliac-synchondrosis. As the forehead seemed decidedly to take precedence, I tried gently to make the head rotate on its transverse axis into the first cranial position, with the occiput towards the left ilio-pectineal eminence, but did not succeed. This method was recommended by the late Dr. J. Clark, but is now abandoned. Next, introducing my finger into the mouth, I endeavoured to bring down the chin—the proper analogue of the occiput; at the same time assisting the natural rotation into the fourth facial position—the left oblique diameter, with the chin forwards. But all my efforts seemed fruitless to move the head in any way, especially as the pains were weak. Therefore, after waiting two or three hours longer to see what course nature intended to adopt, and as the fronto-mental diameter still remained impacted in the same position, I gave chloroform, and applied the long forceps with double curve; the upper blade, which had to be introduced first, being rather difficult of introduction between the prominences of the face and the maternal parts, so as to avoid injuring either. The long straight forceps is recommended in these cases with the view of better assisting rotation, but in this instance the double-curved one answered remarkably well, as, under rather powerful traction, accompanied by a gentle twist in the desired direction, rotation took place into the fourth position, and the face was born chin forwards, the hollow of the forceps pointing backwards. Had rotation not taken place, the case would most likely have ended in craniotomy. The child was born alive, and, although slightly disfigured at the time, with the caput succedaneum