100.2° F. on the 12th. The conditions steadily improved, and by the 14th the temperature was normal and the facial swelling had quite disappeared. The remainder of the puerperium was satisfactory; the patient left her room on the twenty-eighth day.

On February 15th the infant began to be fretful and restless. On February 16th the restlessness was more marked, and there was some vomiting and the bottle was taken badly; the temperature was 99.4° F. On February 17th there was a most typical measles rash, and the temperature reached 101° F., which was the highest point reached. On February 18th the rash was well marked all over the body. On February 19th the rash began to fade on the face, but became distinct again if the child cried. From February 20th onwards the child returned to its usual state, slept well, and took its bottles well; from this date there was some desquamation, most marked on the face and legs, but also present on the abdomen.

The cases present some points of interest:

1. Though exposed at the same time and neither having had a previous attack the symptoms manifested themselves twenty-four hours sooner in the healthy boy than in the pregnant or puerperal woman.

2. The attack was more severe in the case of the boy than in the case of the puerperal patient.

3. The attack was least severe in the case of the fortnight-old infant.

A CASE OF ADHESIVE MEDIASTINO- PERICARDITIS.

By J. M. BENNION, M.A., M.B., B.C. CANTAB.,
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O. B., a girl aged 13, was admitted to the Radcliffe Infirmary on June 20th, 1905, under the care of Dr. Pollier, suffering from pain after food, giddiness, and shortness of breath.

Previous History.

The father, mother, and six other children are all well. The patient had measles when a baby, but has never had rheumatic fever or any other illness of importance.

Present Illness.

She first began to feel ill last April. She states she felt giddy and very tired. She also has suffered from a cough and shortness of breath since about this date. The patient first came to the infirmary on May 6th, 1905, complaining of the above symptoms. It was noted that her skin was somewhat bronzed, that she was slightly anaemic, and that the liver was much enlarged. Nothing abnormal was discovered in the chest. She had no dropsy. On June 20th she was admitted into the female medical ward.

Condition on Admission.

The patient is a fairly well-developed girl of fair height. The expression is not anxious. The eyes are natural. The complexion is sallow, and the skin generally is slightly bronzed. The tongue is moist. The teeth are good. She has a loose cough, but brings up no phlegm. The temperature is 100.6°; the pulse 108, regular, fair volume, low tension; and the respirations are 24 to the minute. The chest is of normal shape, but poorly covered. Both sides expand equally.

The Lungs.—Over the right lung the note is good and the breath sounds vesicular. Anteriorly the percussion note and breath sounds of the left lung appear natural. In the left side below the axilla friction is heard in the fifth, sixth, and seventh intercostal spaces. Posteriorly the vocal fremitus is diminished and the note much impaired over the base of the left lung. The breath sounds are faint and bronchial, and many crackling noises are heard.

The Heart.—The apex beat is in the fourth interspace, just internal to the left nipple line. The impulse is diffuse, and is seen in the third, fourth, and fifth spaces. The area of cardiac dullness is not perceptibly enlarged. Both sounds of the heart are clear and loud. No murmurs are detected.

The Abdomen.—The liver dullness starts at the sixth rib in the right nipple line. There is obviously a great enlargement of the liver. Its definite edge can be readily felt, and palpation leads one to infer that both the right and left lobes share proportionately in the universal enlargement. The margin of the right lobe is 3½ in. below the costal margin in the right nipple line, this being the most dependent point. The spleen is palpable, but not enlarged to any great extent.

The urine is acid. It has a specific gravity of 1018; contains no albumen. There is no oedema.

On June 26th the blood was examined. The number of red blood corpuscles was 4,400,000 per c.mm. The haemoglobin was 75 per cent. Stained blood films show no appreciable changes in the red and white corpuscles.

On June 27th Dr. Gibson, who was examining in medicine for the Oxford M.B., saw the patient and suggested pericardial mediastinitis as the most probable diagnosis.

A sphygmographic tracing of the pulse showed that it was regular, but that the wave became smaller with inspiration.

In fact, the tracings revealed the characters of a "pulsus paradoxus."

On July 7th the patient left the hospital, much against our wishes.

After-history.

On August 25th she was readmitted for "urgent dyspnoea."

The following is a brief abstract of the note of her condition: She is very cyanosed. The lips, tongue, and finger tips are "blue." The pupils are widely dilated. She lies propped up in bed. The pulse is 120 to 130, irregular in rhythm, of small volume, and low tension. The respirations are 60 to 72, shallow, distressed, and the alae nasi are hard at work. The temperature is subnormal. The physical signs in the chest have not altered much. The heart beats are irregular, but no murmur is heard. There is evidence of some fluid over the bases of both lungs. The abdomen is very much distended, the girth at the umbilicus being 35 in. There are all the signs of free fluid and oedema of the abdominal wall. The urine is scanty and contains albumen. There is anasarca. Paracentesis abdominis was performed and eight pints of straw-coloured fluid withdrawn. This relieved patient's condition temporarily. On August 28th, at 2 p.m., she had a very bad attack of dyspnoea, going absolutely blue. At 5 p.m. she had a similar attack and died.

Necropsy.

This was made on August 29th by Professor Ritchie, to whom I am indebted for the following notes:

Body poorly-nourished, very cyanotic. Chest: Right side, 1½ pints of slightly blood-stained fluid; right lung has some degree of consolidation (no tubercles); a few ounces of clear fluid at left base shut off by firm old pleuritic adhesions; collapse of lower lobe of lung and some consolidation, no evidence of tubercle. Pericardial sac quite obliterated, two layers of sac being firmly united, no fluid between them; large calcareous deposits in the pericardium, all round the base of pericardium, especially well-marked over the inferior vena cava. The valves of heart all competent; heart muscle is hypertrophied. Some enlarged glands at the root of the lungs. Abdomen: Six pints of turbid, straw-coloured fluid. Liver very large, weight 4 lb., advanced nutmeg, lobulated. Spleen 7 oz., congested. Kidneys congested.

REMARKS.

Professor Ritchie regarded the pericarditis as probably rheumatic in origin. This case, I think, is very instructive and rare. On these grounds it seems to me worthy of publication. The fact that the diagnosis was confirmed by an autopsy renders the case complete, and adds value to the symptoms and physical signs which were noted during the life of the patient.

In conclusion, I would refer any one interested in this subject to the *Practitioner* of February, 1903, where they will find an excellent article by Dr. Gibson.

My thanks for permission to publish this case are due to Dr. Collier, under whose care the patient was in the hospital.

SOME UNUSUAL VARIATIONS OF THE ERYTHEMATOUS SYPHILIDE.

By ARTHUR COOPER,

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In acquired syphilis the erythematous syphilide (syphilitic roseola) usually appears first on the sides and front of the abdomen, soon spreading in most cases to the chest and back, and not infrequently to the upper portions of the limbs also. The face, hands, and feet generally escape. As a rule the rash comes out gradually, new spots appearing day by day for about a week or ten days, and the whole duration being roughly from two to four weeks, but varying in different cases according to treatment and other circumstances. The typical rash consists of red spots, irregular in shape, varying in size from a millet seed to a sixpence, the average being fairly well indicated by Kaposi's term finger-nail-sized. But to these rules there are exceptions, and it is important to remember that the erythematous syphilide is liable to vary considerably both in its course, distribution, and aspect. Sometimes the rash instead of appearing gradually spreads rapidly and widely and profusely, and in such cases may disappear as quickly as it came as in the following instance:

CASE I.

S., aged 24, when first seen by me on July 31st, had a venereal sore of doubtful nature on the penis. By August 14th the sore had become indurated and the inguinal glands enlarged and multiple. Mercury was given. On August 21st the skin remained free from rash. On August 28th an erythematous rash, which the patient said had appeared the day before,

covered the whole body except the palms and soles. The cervical, axillary and cubital glands were also enlarged. On August 30th the rash was fading, and next day had nearly disappeared.

These cases of profuse rash are generally said to be connected with something causing general congestion of the skin, such as violent exertion, alcoholic or other excess, or exposure to a high temperature, but sometimes no cause can be discovered. Local congestion also favours the development of the rash in certain regions. In women, for example, it is very common to find the spots most numerous about the waist where the clothing fits closely to the skin.

It has just been mentioned that the rash usually appears first on the abdomen, and this no doubt is the case in those who are going about in the ordinary way. But when for any reason the patient happens to be lying in bed I have noticed that the rash may affect first and chiefly, and sometimes almost exclusively, the parts on which he habitually lies, and which are thus kept warmest. For example :

CASE II.

L., aged 23, was laid up on his back on account of inflammation of the primary lesion, with phimosis, at the time his first syphilide appeared. The rash came out first and profusely on the back, and to a less extent on the sides of the thorax. Only two days later did spots appear, and then but scantily, on the abdomen.

CASE III.

B., aged 52, had a sloughing primary sore, with phimosis, which required circumcision. Whilst he was in bed on this account the erythematous syphilide appeared profusely on the back only, and although it lasted for about three weeks it did not extend to other parts.

The following case shows the influence of another form of local congestion :

CASE IV.

I., aged 60, who was liable to suffer severely from colds in the head, happened to have an acute catarrh at the time his first syphilitic rash broke out. The erythematous spots were limited to the face and scalp, except a few on one buttock and one forearm. The coincidence of catarrhal symptoms with the rash on the face in this case presented at first a certain resemblance to measles. A severe attack of syphilis followed.

The next case is an example of the effect of solar heat :

CASE V.

A., aged 43. The erythematous syphilide showed itself whilst he was rowing with bare arms and legs in a hot sun. The spots at first were present only on the exposed parts of the limbs. When I saw him, later on, there were spots on the abdomen also, but I was told that the limitation of the rash to the limbs at first had led to temporary doubt concerning the real nature of the eruption. This patient also suffered severely from syphilis.

It has been remarked in connexion with Case I that when the erythematous syphilide spreads widely it may come and go rapidly. The next three cases are examples of short duration, although the rash was only of average or less than average extent :

CASE VI.

F., aged 23, first seen by me on June 15th; he had then an indurated sore on the penis and enlarged multiple inguinal glands; the skin was clear. Mercury was given. The rash, consisting of erythematous spots of the usual form, began to appear on June 20th, and next day had become distributed over the abdomen, chest, and back. By June 25th the rash had gone completely without extending further.

CASE VII.

R., aged 22, consulted me on November 30th for an indurated sore on the penis and enlarged multiple glands; there was no rash. Mercury was prescribed. December 7th: Erythematous spots on the abdomen, chest, and back. December 14th: No trace of eruption.

CASE VIII.

This case, which has been reported elsewhere,¹ was that of a girl, aged 10, in whom the primary lesion of syphilis was on the nose. On August 28th the skin was free from rash. On September 1st erythematous spots were present on the upper abdomen and chest only. On September 8th only a single spot remained.

On the other hand, the erythematous syphilide sometimes lasts for many weeks, and even for months, especially if untreated by mercury. For instance :

CASE IX.

A male patient, who did not know that he had syphilis, and consequently had had no specific treatment, came to me on account of discomfort about the anus. The trouble proved to be due to mucous patches, and he had also a well-marked erythematous syphilide. The spots still faded on pressure,

although they were said to have been present for four months. The rash slowly disappeared under mercury.

CASE X.

A man, suffering from late secondary syphilis, who had the remains of an erythematous syphilide, which he said had been there for eighteen months.

Another thing to be kept in mind in connexion with this subject is that a rash on a syphilitic person is not necessarily a syphilide, even though it be present at a time when such a rash might be expected. The following is an instructive illustration of this :

CASE XI.

M., aged 19, came under observation on July 24th with a general erythema of scarlatiniform type so profuse that even the palms and soles were involved. He said the rash began four days before, and that it itched a little at first but not afterwards. There had been more than one exposure to risk of venereal infection, and two days after the last occasion, a fortnight ago, he noticed a sore on the glans penis, and since then had been unable to retract the prepuce. When first seen, besides the rash on the skin, there was a discharge from beneath the prepuce, which was hard and swollen, and there was complete phimosis. There were also multiple enlarged glands in both groins. The rash looked most like that of scarlet fever, but the tongue and throat did not correspond. The temperature was 98.6° and the pulse 74, and the patient did not feel ill. Consideration of the circumstances led to the inference that the rash was a syphilide, and mercury was prescribed. On July 26th the rash had almost gone, and there was some desquamation on the abdomen. On July 28th there was more desquamation on the abdomen and only slight mottling elsewhere. After about a week's treatment of the phimosis it became evident that there was a purulent urethritis as well as an indurated sore on the penis. Copaiba was now given, and next day a rash similar to the first appeared chiefly on the thighs, but also to some extent on the backs of the hands, where the patient said he had first noticed the earlier eruption. Unfortunately he disappeared after this and I saw him no more. But although my notes of the case—which occurred a good many years ago—say nothing about the taking of copaiba previously, and although the man had early syphilis, yet it seems clear that the first rash, like the second, was a drug rash and not a syphilide.

Again, a drug rash and a syphilide may be present together, as in a case published by me some years ago.² In that instance the erythematous syphilide appeared as the copaiba rash was fading.

From a diagnostic point of view the importance of variations of the erythematous syphilide lies mainly in the danger lest the rash be either mistaken for something else or overlooked altogether. The unusually widespread syphilides are most likely to be mistaken, for they may simulate other rashes, and notably those of measles, German measles, and scarlet fever, as well as some drug eruptions, especially, perhaps, that due to copaiba. In such cases the history, the presence or absence of primary lesion, the state of the lymphatic glands, the temperature, the pulse, and the condition of the tongue and throat will usually lead to a correct diagnosis.

It is, of course, when the syphilide is scanty, or when it comes and goes rapidly, that it is most likely to be overlooked. When a diagnosis of syphilis has already been made and acted on, the overlooking of the rash is not a matter of very great moment, but when the history and primary signs are insufficient for diagnosis, the patient ought always to be carefully watched for signs on the skin and mucous membrane. The occurrence of these scanty and ephemeral syphilides should more especially be borne in mind by those who make it a rule to wait for the skin eruption before beginning specific treatment.

REFERENCES.

- ¹ On Extra-genital Syphilitic Contagion, *Lancet*, 1890, vol. ii, p. 866.
- ² Roseola Balsamica and Roseola Syphilitica, *BRITISH MEDICAL JOURNAL*, 1891, vol. i, p. 904.

PSYCHOLOGICAL MEDICINE IN GERMANY.—The German Psychiatric Association will hold its annual meeting this year at Munich on April 20th and 21st. Professor Heilbronner, of Utrecht, will present a report on disorders of speech in functional psychoses, excluding aphasia. Among other communications promised are the following: Dr. Gudden, of Munich, on heredity; Dr. Nitsche, of Munich, perception and observation in alcoholic subjects; Dr. Plaut, of Munich, psychological investigation on sufferers from the consequences of accidents; and Dr. Weiler, of Munich, observations of the pupil in subjects of mental disease.