boiled the heated upper layer became denser. Under the microscope no blood corpuscles were found. Sediment consisted of quantities of granular material, some of it in form of casts, and great numbers of crystals of triple phosphates. No epithelial cells, no leucocytes. Numbers of long rod-like bacteria, some in couples. At 11 a.m. patient got a very violent rigor after a stage of extreme restlessness and severe abdominal pain; he became almost pulseless; blue round lips and finger-tips; shook violently; rigor lasted three-quarters of an hour. He had hot flannels applied to his heart, which as it recovered itself, began to beat with great violence. Complained much of cardiac pain and distress, and also pain in splenic region. Temperature rose to 102°. He drank freely, but vomited everything at once. At 4 p.m. he was given 10 gr. of quinine, but failed to retain it. Specimen of urine passed at 5 p.m. lighter in colour than that examined in morning—clearer, one or two red blood corpuscles, but otherwise sediment like that examined in the morning. At 8 p.m. he had another rigor, attended with severe shivering and collapse, lasting ten minutes; lips quite bloodless.

November 11th. During the night the patient passed a considerable quantity more dark, porter-like urine. First half of night was very restless and could not sleep; talkative but sensible. Was given pil. opii gr. ss at 10 p.m., repeated at 2 a.m., after which he slept. 7 a.m.: seemed better. B.O. this morning. Urine passed this morning acid, 1013, quite clear, dark red, with transmitted light, no sediment, no albumen. At 11.15 a.m. the patient got another severe rigor with great cardiac distress; relieved by hot flannels; repeated severe vomiting, at first yellow but later bright green. No urine till 1.30 p.m., when he passed a quantity of dark, porter-like urine; this specimen was dark-red in colour, but not quite so dark as that first examined; the specific gravity was 1025, and the precipitate under the microscope showed numerous granular and a few epithelial casts and triple phosphate crystals. 2.30 p.m.: The patient seemed very ill indeed, almost bloodless in appearance, the lips being as pale as face; jaundice deeper than on admission; perspiring freely; vomited yellow water, about 4 oz., and passed 6 oz. deep-red urine. 4 p.m.: Temperature 102°; he vomited at 3.30 and again at 4 (2 oz.). 4.30 p.m.: Vomited again, brownish colour; a little more urine. 5.45: Vomited again, bright green, with a small streak of blood. Temperature 99.6°; pulse 124, weak, and a little intermittent. 10 p.m.: Has vomited at intervals all the evening; passed 19 oz. of urine at 9 p.m., a rather lighter red. Examined acid: specific gravity 1020; albumen on boiling, granular casts and triple phosphates as before. Temperature 103.2°. Seems very exhausted; pulse 172, thready.

November 12th. From this he was given champagne every hour, and milk occasionally; he continued to have attacks of vomiting up to 2 a.m., when he had another slight rigor. At 3 p.m. he had general convulsions, and at 4 p.m. a severe vomiting of very bright-green material, and unilateral convulsions, involving the right arm and leg. His brother, who had been with him all night, thinking him *in extremis*, decided to take him home, and removed him in a stretcher to his house near at hand.

RESULT.

At 8.15 a.m. I was called to see him in consultation with two other doctors whom the friends had called in. He was collapsed and dying, only the faintest pulse being perceptible at the wrist. He was noticeably more jaundiced than the previous evening, and the saliva wiped from his mouth was of a deep yellow colour.

He had had no vomiting, nor had he passed any urine since he had been taken from the hospital, nor had any more convulsions. He was unconscious, and in no way responded to the energetic treatment of my colleague's hypodermics of quinine, ergotine, ether, and artificial serum. He died, after I had left, about 10 a.m. No *post-mortem* examination was permitted.

The treatment of the case was on general principles. Quinine, which was at first used, was stopped as soon as the nature of the case was clear. When vomiting became constant, nutrient enemata and champagne were given.

I examined the blood microscopically on November 11th. There was considerable leucocytosis, but the red corpuscles were not markedly altered; they readily formed rouleaux. A few microcytes were noticed. A few red corpuscles contained malarial plasmodia.

A CASE OF MEASLES IN THE PUERPERIUM.

By MALCOLM CAMPBELL, M.B., Ch.B.,
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THE following case of rise of temperature during the puerperium is of interest for two reasons. In the first place, it was due to a definite known cause, and, secondly, it has the very unusual advantage of having a very satisfactory "control."

The patient, a young primipara, and her brother, a boy 6 years of age, were at a place of public amusement on January 28th, 1905—a time when measles was rather prevalent. The following day both showed signs of having caught cold, but as the symptoms completely disappeared in about thirty-six hours nothing further was thought of the matter. Both were out as usual on January 30th and 31st.

On February 1st the lady had a perfectly normal labour, and gave birth to a living healthy son. The infant was nursed, and the puerperium till February 9th was perfectly normal; the temperature never exceeded 98.8° F.; the mammary secretion was slightly diminished after February 5th.

On February 8th the patient's young brother showed marked catarrhal symptoms; by 8 p.m. his temperature rose to 102° F.

On the morning of February 9th the lady's temperature was almost 100° F. The lochial discharge was not offensive in character, nor was it increased in amount; there was no uterine tenderness, nor any other sign of any local cause for the rise in temperature. Having in view the typical condition of the patient's brother, it was concluded that the patient's temperature might be due to the onset of measles—a disease from which she had, so far, escaped. The infant was accordingly weaned, a second nurse was got, and she and the infant were isolated.

Regarding the patient's brother's case, which was practically a "control case," nothing need be said beyond stating that it was a severe case with some ear complications. It ran a normal course; the temperature reached 104.2° F. the day the rash appeared and then fell.

On February 9th the patient's temperature reached 101.2° F. On February 10th the temperature continued to rise, and at 11 p.m. reached 102° F.; the rash now began to appear. On February 11th the rash became general, the temperature was 103.2° in the morning, and by 8 p.m., reached its maximum, 105.2° F., in the mouth; it remained at this point till midnight, when it began to fall. On February 12th the patient had some ear symptoms, and there was a general facial oedema, causing excessive swelling round the mouth and under the eyes. In spite of this the temperature fell to

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,