taining the same percentage of combined silver is closely similar, and it is practically impossible to place them in any order of activity which would be true under all circumstances.

As argyrol and collargol are not bactericidal, it is evident that the amount of silver which a compound may contain is no criterion of its bactericidal power. Moreover, in view of the results obtained with argyrol, it seems impossible to attribute the good effects which many clinicians have obtained with it to its bactericidal action.

THE RELATION BETWEEN A CUTANEOUS NAEVUS AND A SEGMENTAL NERVE AREA.

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THE original observation which pointed out the fact that naevi sometimes occupy nerve areas I have failed to trace. But it is mentioned in some of the textbooks which deal with the matter, and in a few an example is illustrated. The illustrations are those which relate to the areas of the fifth cranial nerve; and I cannot discover any recorded case which describes the distribution of a naevus that corresponds to the area of a segmental nerve.

Fig. 1.

For such a case I have been looking for four years, and at last I have found one among the out-patients of King's College Hospital. It is the first case of naevus which I have seen or heard of which corresponds to the complete area of distribution of one segmental nerve area.

This naevus occupies the area of distribution of the third cervical nerve. (See Figs. 1 and 2.) Fig. 3, with Dr. Head's kind permission, is taken from his article in *Brain*, vol. xvii, on The Disturbances of Sensation with Especial Reference to the Pain of Visceral Disease, and shows the corresponding part mapped out in the sterno-mastoid area, which is the area of the third cervical nerve. The curious notch in the lower border of the naevus corresponds to the same interruption in the line of the inferior border to the sterno-mastoid area. In my case the actual naevus is difficult to reproduce in a photograph, but clinically it is linear and less continuous in arrangement towards the angle of the jaw where the lines are vertical. In fact the whole manner of its formation resembles an eruption of herpes zoster in this area.

In my collection I have naevi which occupy the following areas:

1. The first division of the fifth cranial nerve.
2. The second division of the fifth cranial nerve.
3. The first and second divisions of the fifth cranial nerve.
4. Dr. A. H. Lister of Aberdeen has kindly sent me a cutaneous and subcutaneous naevus which occupies the areas of the fifth cranial nerve, the second cervical nerve, and part of the third cervical nerve. But the case I now publish is the first and only one that corresponds to a

Fig. 2.

single segmental nerve distribution. It is not one case out of many, but the only case of a widespread naevus I have seen on the neck or trunk.

I have published three cases of rodent ulcer which are of interest in considering the areas occupied by naevi.

1. Occupied the area of the first division of the fifth cranial nerve (BRITISH MEDICAL JOURNAL, April 18th, 1903, which also contained the next case).
2. Occupied the second division of the fifth cranial nerve.
3. Occupied the first and second divisions of the fifth cranial nerve (BRITISH MEDICAL JOURNAL, December 12th, 1903).

Fig. 3.

So far as the head is concerned, these rodent ulcers correspond in distributions to the naevi and eruptions of herpes on the face; but on the body I have never seen any case of widespread rodent ulcer which marked out a segmented nerve area, and in this respect the distribution

of rodent ulcers on the body differs from the distributions of herpes zoster and this one case of naevus. The distribution of rodent ulcers on the body and face resembles the areas occupied by leucoderma and scleroderma. In the early stages rodent ulcers on the trunk appear oblong, with their longitudinal axis in the direction of the segments, but the form is soon lost, and the eventual sites occupied are peripheral areas rather than those which are segmental. It must be borne in mind that cutaneous naevi may spread during life and they may atrophy, the recognition of which form data of importance in considering their relation to the nervous system.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL.

DOUBLE UTERUS AND DOUBLE VAGINA.

In June, 1904, I was consulted by a young woman, aged 25, who had been married seven weeks. She complained of very severe pain during coitus, and this instead of improving became gradually worse, and latterly had been accompanied by haemorrhage more or less profuse. She was a well-developed young woman, of an extremely dark type. The external genitals were well formed, and menstruation, which began at 13, was regular though painful. Since her marriage she had been coactive. I found she had a double vagina with a thick fleshy septum between the two orifices, the right being more anterior and the edge of the septum raw, exquisitely sensitive, and bleeding freely when touched.

When slight tension was put on the perineum the vaginal orifices became quite parallel, the right being the less sensitive. The septum extended the whole length of the vagina; there was no visible perforation in it, and it seemed to be thicker above than below. A cervix and os uteri were found in each vagina. Two uterine sounds were passed, one into either uterus; they passed to a normal depth, and could not be made to touch each other internally. Examined per rectum, the right uterus seemed the larger and the adnexa on that side more easily palpable. Examined with a speculum, the os and cervix of the right uterus were, if anything, better developed than the left. She was ordered some vaginal pessaries containing cocaine to be used before coitus, and was next seen in July, 1905, when she came to tell me she thought she was pregnant. This was found to be the case. The left vagina was much more patent, and the septum was pushed over so as to completely occlude the right passage. Impregnation had apparently taken place on the left side, and she was about three months pregnant, the tumour being markedly left-sided. When eight months pregnant she was again seen; the tumour then occupied the normal central position.

She was confined in January, 1906. Presentation: occipito-posterior. Labour was naturally slow and tedious. During the progress of the head the septum was torn nearly its whole length, the external portion slipping like a band over the advancing head as it came through the vulvae. Labour was terminated by forceps, and there was pretty smart *post-partum* haemorrhage. She did not menstruate during pregnancy.

Remarks.—Her future fate is very uncertain. While the septum remained intact, and practically occluded the right vagina and uterus, there was little or no chance of superfetation. But in her present condition, with her cervix presenting into one common vagina, such a calamity comes within the range of possibility; unless the unimpregnated uterus and its appendages have undergone some form of atrophy, or in some other manner become a mere appendix to the active one.

Wigan.

JOHN BLAIR, M.D.

EPIPHYSIECTOMY OF THE FIFTH METATARSAL BONE IN THE CURE OF CLUB-FOOT.

DISEASE or injury of an epiphysis of a bone may lead to arrest of its growth; and where there are two parallel long bones, as in the forearm, if one is damaged and its growth stopped while the other continues to grow, the result is that the hand is pushed to one side. This fact induced me to try what would be the effect of arresting the growth of the fifth metatarsal bone in talipes varus. Here, no

doubt, in many cases which have been neglected a great deal of deformity exists in the bones of the tarsus, long-neglected malposition of the foot interfering with their development. In the following case—one of talipes equinovarus in a child aged 4—treatment was begun early. By strapping and plaster-of-paris the foot could be almost straightened, but whenever the restraint was removed the forepart rotated and inverted to a considerable degree. Instead of doing a tarsotomy, for which the patient was sent into hospital, it occurred to me that a portion of the fifth metatarsal bone might be excised and the ends wired together. The result at first was excellent, but did not last, as the wire cut through the soft bone. It then occurred to me that if the proximal epiphysis were thoroughly removed and growth arrested the traction of the stunted bone would pull the foot out of its inverted position automatically.

This operation I subsequently performed on May 29th. An incision was made on the side of the foot and the epiphysis removed. The soft parts were approximated by strong silk sutures, and a back splint with foot pieces and side splints were applied. On June 21st, the child was sent home with measles, the limb being encased in plaster-of-paris. The inversion of the foot was considerably reduced.

Whether the arrest of one metatarsal bone will be sufficient it is impossible as yet to say, but there is no reason why the fourth should not be treated in a similar manner; then I have no doubt the foot ought to be pushed by the uninterrupted growth of the other three into its normal position. Possibly the operation would find its greatest utility in cases where the parents have not the tenacity of purpose necessary for prolonged treatment by splints.

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TRICHOCEPHALUS AND APPENDICITIS.

I SEE in the BRITISH MEDICAL JOURNAL of August 4th, page 265, a case of appendicitis reported from abroad in which two specimens of *Trichocephalus dispar* were found in the mucous membrane of the appendix. On May 28th this year a potman, aged 23, was admitted to this hospital, under the care of Mr. D'Arcy Power, suffering from what appeared to be an ordinary attack of appendicitis of three days' duration. There was marked rigidity and tenderness in the region of the appendix, and the original attack of pain, he said, doubled him up. On June 28th Mr. D'Arcy Power operated and removed what was to all appearance a normal appendix. Upon splitting the organ open, however, after removal, a small worm was found inside, and was identified by Dr. Thursfield as *Trichocephalus dispar*.

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ACUTE COLITIS.

I HAVE recently had several cases of acute colitis following the ingestion of tinned or potted meat. In all there was severe pain along the course of the colon, with raised temperature, diarrhoea, and little or no vomiting. (1) The first case followed the consumption of some tinned meat, the patient having a temperature of over 106°. (2) In the second case, a young lady had suffered from constipation and colicky pains some days before eating tinned salmon; having done so, severe pains and fever (102°) set in, attended by the passage of copious motions, resembling red-currant jelly, and containing much blood and very offensive. The illness was very acute and lasted a week. (3) The third case followed the eating of potted salmon. In this the diarrhoea and tenesmus were most frequent and distressing; large flakes of mucus as well as extremely offensive jelly-like material were passed. In this case the treatment commenced with calomel, which was followed by salol and bismuth salicylate, and starch and opium enema and pil. plumbi & opio for the frequent diarrhoea. The severe haemorrhage in the second case was promptly arrested by calcium chloride and hamamelis. The food was chiefly peptonized milk. The jelly-like material in the third case showed plasma cells like those in the plate illustrating Dr. Saundby's recent paper, and there were abundant bacteria, which when stained superficially resembled the bacilli in his case; no cultivations were made.

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