paralysis of the muscles of both upper limbs and of the trunk, and also of the intercostal muscles, thus causing the breathing to be entirely abdominal. There was also partial paralysis of the lower limbs. No loss of sensation could be detected at any place. The temperature was 101° F. pulse 120, and respirations 30. No pain was complained of, but the child was very restless, constantly wanting to be turned from side to side. There was no headache, and the mental powers were perfect; there was no loss of control of the bladder or rectum, no priapism, and no rigidity or twitching of any of the muscles. The pupils were somewhat dilated, and seemed inactive, but equal. There was no squint. Swallowing was not difficult, and the speech was clear.

At 7.30 P.M. of the same day Dr. Barrs of Leeds saw the case with me, when we found that the condition of matters was very similar, except that the paralysis of the legs was more advanced, and the muscles of deglutition seemed somewhat involved, and sensation seemed slightly impaired as regards delicacy of differentiation. The knee-jerks were absent. The spleen was not felt. The respiration had at this time a most marked resemblance to that seen in a frog—that is, on inspiration a peculiar distension of the region below the chin took place. There was not, even at this time, any indication of cyanosis, and the number of respirations was not above 30.

At midnight the facial muscles became involved and speech indistinct, the pulse was falling and becoming rapid (120 per minute and intermittent), but the respirations were not much quickened, and there was no cyanosis.

At 1 A.M. (September 10th) the heart failed very rapidly, slight cyanosis appeared, and he died quietly ten minutes later. He was quite conscious and clear mentally up to 12.30 but after that he seemed to wander.

No post-mortem examination could be obtained.

The diagnosis of Landry's paralysis of a descending form was made from (1) progressive, symmetrical, motor paralysis, affecting first the muscles of the neck—the "stiff neck" complained of—then the arms, forearms, chest, legs, etc.; (2) sensation did not seem at all disturbed until a few hours before death, and even then only slightly; (3) absence of rigidity, twitching, pain, or spasm; (4) mental functions unimpaired, and no loss of control over the emunctories.

It is difficult to see any connection between the slip into the pit and the disease which caused death, as there was no sign whatever of any damage to the spine, and the symptoms do not seem to point to the possibility of the case being one of spinal injury or the results arising therefrom. Nor do I consider it was a case of infantile paralysis, although infantile paralysis has much in common with this disease. The case was an extremely rapid one, as will be seen by noticing the dates.

Little is known as to the pathology of Landry's paralysis, and I would suggest that it is caused by an acute anterior poliomyelitis, somewhat after the nature of that found in infantile paralysis, but instead of the lesions being at spots scattered about the spinal cord, commencing symmetrically at a certain level of the cord, and spreading thence rapidly upwards and downwards. In the case above described the lesion probably commenced in the cord about the level of the second cervical vertebra.

TWO CASES OF SEVERE FRONTAL HERPES.

By C. HIGGENS, F.R.C.S.,
Ophthalmic Surgeon, Guy's Hospital.

THE two following cases are of sufficient interest to merit publication:

CASE I.—In January, 1900, I first saw Mrs. T., aged 45. She was suffering from a severe attack of left frontal herpes. The eyelids were swollen, and together with the forehead and side of nose covered with scabs, the cornea was ulcerated, and there was severe iritis. By the end of March the swelling had nearly subsided, there was much corneal opacity, and opacity in the vitreous. The pupil was dilated and fixed, tension of eyeball + 1, vision $\frac{1}{2}$ and Jaeger 16 C + 2 D. The treatment up to this stage had been hot boracic fomentations, atropine, and attention to general health. She was now ordered solution of pilocarpin nitrate gr. $\frac{1}{4}$ to $\frac{3}{4}$ j, to be dropped into the eye three times a day, and a mixture of mercury perchloride. The treatment was persevered with till the end of May, when there was but little improvement. Galvanism was then tried for a fortnight. By the middle of June the inflammatory symptoms had subsided; there was much corneal and vitreous opacity, the pupil was dilated and irregular; the tension of the eyeball above par, and there were small ciliary staphylomata. Vision = $\frac{1}{2}$ C — 2, J. 14 at 6". I have not seen the patient since, but had a letter from her in February last, and from her description should

say that the eye is in much the same condition as it was in June.

CASE II.—Mrs. H., aged 49, was first seen on March 25th, 1900. She had suffered from frontal herpes ten weeks before. On the left side besides much scarring and cornitis with ulceration, there was complete paralysis of the third, fourth, and sixth, and the ophthalmic division of the fifth nerves. There was ptosis, moderately dilated pupil, complete immobility of the eye, and entire loss of sensation over parts supplied by first division of the fifth nerve. On June 6th I heard from the patient's medical man that she had muscular paresis of the right side of the body (that opposite to the affected eye), but sensation was not impaired. I heard no more of the patient until March 28th, 1901, when she came to see me. The motor paralysis had entirely disappeared, the movements of the eye being perfect; there was some numbness, pain, and itching in the forehead, but the sensation of the eyeball itself was normal; tension of the globe was slightly above par. There was dense partially vascular corneal opacity and some ciliary and conjunctival injection. She could count fingers at 3 feet.

AN UNUSUAL SYMPTOM IN SECONDARY SYPHILIS.

By A. A. SCOT SKIRVING, F.R.C.S. EDIN.,
Assistant-Surgeon, Leith Hospital.

DURING the last few years several cases of secondary syphilis of the throat have come under my observation in which itchiness of the fauces has been present. This was not a mere tickling, but a definite itchiness in every way comparable to the ordinary feeling experienced in the skin, and accompanied by a similar desire for counter-irritation by scratching. In two cases this symptom was most marked, and I was greatly struck with the fact that though both patients admitted that there was some pain in the throat, especially on swallowing, it was the *itchiness* that they complained of most.

In these two cases the desire to scratch the part was most urgent. One of them, who was at that time under treatment at Wiesbaden, used to scratch his throat—and obtain temporary relief—in an ingenious manner by swallowing entire portions of the crust of the "brodchen" supplied by the Badhaus in which he was taking his "cure." The other, a working man, said he sometimes felt "inclined to tear the throat out." Until relieved by local treatment he used to scratch his tonsils with his finger. In these cases the itchiness was felt most over the tonsils, but also over the pillars of the fauces and posterior part of the side of the tongue. The other parts of the mouth and throat were unaffected. In the Wiesbaden case, in addition to congestion, some ulceration was present on one of the tonsils, and this tonsil was the more itchy of the two. In both cases the itchiness had appeared very shortly after the onset of the sore throat, namely, about eight weeks after the appearance of the chancre. Marked cutaneous manifestations were present in the one, none in the other, nor did he afterwards develop any. The latter patient, it may be remarked, had been vigorously treated ever since the primary lesion, the former only on the appearance of the sore throat.

Marked itchiness of the mucous membrane is an interesting symptom, and, so far as I am aware, has not been referred to in connection with the interior of a cavity. It is of course of common occurrence at the margins of the various openings of the body where skin and mucous membrane meet, as at the urinary meatus, the anus, and vulva. The tongue and the larger part of the buccal cavity are lined with epithelium of the same character as that of the skin. Sensory nerves are abundant, and convey the normal cutaneous impressions of contact, pain, heat and cold, etc., in addition to others of a more special nature which the skin does not possess. In other words, the lining membrane of this cavity is practically moistened skin in some places of a specialised nature. The wonder, then, seems to be that an abnormal cutaneous sensation, such as itchiness, is not more often met with in connection with mucous surfaces. Probably it is present in a fair number of cases, but is either very slightly marked or is so masked by more urgent symptoms that it fails to attract the patient's attention.

That itchiness should occasionally be a fairly marked symptom in syphilitic affections of the mucous membrane is the more remarkable, since, with the exception of small papular syphilides, specific cutaneous eruptions seldom itch much, often indeed not at all.

WHOOPIING-COUGH CURED BY IRRIGATION OF THE NARES.

By ED. MARTEN PAYNE, M.B., C.M.ABERD.,
Cricklewood.

It is admitted by all authorities that the mortality due to pertussis is very great, while it is at the same time confessed that "the treatment of whooping-cough is one of the opprobria of medicine," and that, "notwithstanding the claims of many to the contrary, it remains a fact that we possess no means of cutting it short" (Tyson).

In view of the above facts, having been consulted with reference to a boy, aged 9, who was suffering from a very severe attack of the disease, and having in vain had recourse to the usual remedies, I determined to work on the theory that the disease was due to the irritation of the Schneiderian membrane by a specific organism. What the specific organism was, whether it was the larva of an insect according to Linnæus or the bacillus of Koplik did not much matter as far as treatment was concerned. Acting on this hypothesis, 10 to 20 ounces of carbolic lotion (1 in 40) were injected by a syringe through the nostrils, being allowed to go up one and down the other, the operation being repeated three times a day. At first the irrigation caused a good deal of sneezing and coughing, and a considerable amount of gelatinous mucus, some of which was of a greenish colour, was ejected. After a few times the operation caused less discomfort, and the patient, who was at first rather refractory, at last began to look forward to it as a relief to his sufferings. The cure was complete in about a week, but the treatment was continued a few days more to prevent recurrence. The following diary shows the progress made from day to day.

March 4th. The child was kept away from school, and rapidly developed all the symptoms of whooping-cough, which were at first treated by various domestic remedies.

March 12th. I commenced treatment on the ordinary lines with belladonna, the bromides, cannabis indica, etc., but with no satisfactory results, the paroxysms becoming more numerous and distressing.

March 26th. I determined to institute a systematic and thorough irrigation of the nares. I myself on this day commenced the treatment as described above, and instructed the mother to repeat it at noon and at night.

March 27th. The report was that there had been fourteen paroxysms, but the mother thought that they had been not so severe in character. On the following days during which the treatment was continued the progress of the improvement is shown below:

March 28th, 7 paroxysms; March 29th, 5 paroxysms; March 30th, 5 paroxysms, but character not so severe; March 31st, 5 whoops, no paroxysms; April 1st, 5 whoops; April 2nd, 3 coughs, no whoops; April 3rd, 3 coughs, no whoops; April 4th, 3 coughs, no whoops; April 5th, 3 coughs, no whoops; April 6th, 4 coughs, no whoops.

Although carbolic lotion was used in this case, doubtless any other antiseptic would have done equally as well.

I consider that it is essential to the success of the treatment that the irrigations should be thorough, and for that reason they should be carried out by the medical man himself at least once a day.

No doubt the reason why the insufflations and sprays which have been in times past tried in whooping-cough have met with so little success, is that the nares cannot thus be cleansed of the micro-organisms which swarm in the complicated cavities of the nose, and are thus effectually covered against such modes of attack. On the other hand, by the irrigating they are overwhelmed by the deluge of antiseptic fluid and all perish. Although insufflations and sprays have before this been recommended for whooping-cough, I believe the method of thorough irrigation of the nares is original, and it was in the above case attended by such marked success that I have ventured to place it before the medical world, in the hope that it may be tested by others, and be of some service in arresting the rather serious epidemic now in progress.

The first woman medical graduate of Peru is said by the *Cronica Medica*, of Lima, to be Señorita Laura Rodriguez, who graduated in 1900.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

VELD SORE.

My experience of nearly eighteen months in South Africa differs somewhat from that of Mr. Pridmore as recorded in the *BRITISH MEDICAL JOURNAL* of January 26th:

1. It is prevalent all the year round.
2. I have treated many cases in Johannesburg 5,880 feet, and at Koomati Poort 2,000 feet, above sea level.
3. The horse or ox tick only indirectly helps in its formation, acting as an exciting cause.
4. It has been quite as noticeable among officers as among men, and in this battalion (1st Scots Guards) we have never been entirely free from this complaint.
5. An abraded surface appears to be a necessity for its production, whether it be due to a sun blister, the bite of an insect and subsequent scratching, or an abrasion consequent on "fatigues," such as digging etc.
6. Of its specific bacterial origin there is no doubt. The micro-organism, I believe, to be present in water, and washing secures its entrance. The fact of its presence on the hands, and next in frequency the face and feet, tends to this view. It is autoinoculable.
7. The ulcer usually commences as a blister with serous contents; this becomes pustular almost immediately, and at the same time the superficial layers of skin covering the ulcer become flattened, then burst, leaving a red, irritable-looking, depressed surface, which extends marginally until treatment stays its progress.
8. I have seen no cases amongst natives of South Africa. Boers, most of whom have some "black blood" in their veins, are exempt. Dark-complexioned Europeans rarely contract the "sore," the fair coming in for more than their share; in fact, these ulcers are seldom absent from those who are auburn or red-haired. If neglected scabs form over the ulcer as it extends at its periphery, and the lymphatics extending to the nearest glands become affected. Pigmentation often is an after-result.

In persons with a history of constitutional syphilis the "sores" may "take on" the characters of that disease. Calomel dusted on the ulcer and mercury internally is the only treatment. The treatment most useful is a primary application of strong carbolic acid, followed by the application of a wet dressing of lotio hydrarg. perchlor., 1 in 3,000, to be applied twice daily. Lotio rubra hastens the healing once the margins of the ulcer have ceased to extend.

S. GUISE-MOORES,

Captain R.A.M.C., M.R.C.S.Eng., L.R.C.P.Lond., D.P.H.Lond.
Piet Retief, Transvaal Colony.

FORMALIN IN THE TREATMENT OF LUPUS.

MUCH has recently been written concerning the treatment of lupus by means of chemical rays, hot air, steam, etc. I should like to call attention to the use of formalin in this disease. I have just had under my care a case of lupus on the nose of from four to five years' standing, in which the local application of formalin caused marked improvement, if not cure.

The patient objected to scraping, and seemed inclined to allow the disease to run its course until about eighteen months since. An attack of bronchitis at this time caused the lupus to spread so rapidly that the increasing disfigurement caused an increased desire to try something to stop the trouble. Accordingly, after carefully removing all crusts by means of poultices and fomentations, I painted the parts with a solution of formalin (formic aldehyde 40 per cent.) and glycerine in equal parts, having previously dusted the parts with orthoform to lessen the pain.

I must confess that I did not place much confidence in this treatment, but thought that perhaps the antiseptic qualities of the solution might lessen the energy of the bacilli, and thus to some extent stop the spread of the disease until the patient could submit to more radical treatment. At the end of a fortnight I was much surprised to find that the ulcers had