complained of hæmorrhage and leucorrhœa. When the cervix had been dilated and the polypus removed, the nature of the case was clear.

If cancer beginning within a cervical canal the lower end of which is not open enough to admit the finger is to be diagnosed early, this can only be done by dilating the cervix. If the symptoms suggest cancer, and nothing is perceived by finger and speculum to account for them, the suspicion can be confirmed or verified only by dilatation of the cervix. This done, the finger in the cervix will either feel the firm, smooth ridges of the arbor vitæ, or there will be at some part of the canal a nodule, a warty growth, or a ragged ulcer.

The remarks I have made as to the liability to error of conclusions based on the microscopical examination of broken off bits apply to this form of cancer more strongly than to cancer of the vaginal portion. If we scrape off bits it is not possible to be sure where they come from. There may be cancer at one part of the canal, and a villous erosion, or an ordinary mucous polypus at another. But this form of cancer advances so fast, and its initial symptoms are so slight, that it is seldom we have the opportunity of diagnosing and treating it early.

A NOTE ON AUDITORY VERTIGO.

By **SIR WILLIAM B. DALBY, M.B., F.R.C.S.,**
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If I venture to say that Dr. Stephen Mackenzie's paper on "Aural Vertigo" in the *BRITISH MEDICAL JOURNAL* of May 5th covers the whole area (so far as it has been usefully occupied) of previous observers, whilst it gives his own valuable suggestions, I am sure that he will acquit me of any attempt to pay him a compliment. Both he and the readers of the *JOURNAL* will perhaps, in consideration of the interest which I take in the subject, permit me to offer a few remarks upon his arrangement of the subject and upon some of his observations.

In studying this subject, what we all want and what we must have, if our knowledge of it is to advance or become in any sense accurate, is a determined line of division in these cases. On one side of this line must be placed those cases in which the external and middle ear are healthy. On the other side of the line those cases in which one or both of these two divisions of the ear are unhealthy. Until this is done there will remain, as there now is, endless confusion. The next point is that the term "Ménière's disease" must either be dismissed (it always was indefinite), or, if it is to be retained, it must be clearly understood that it can be only applied to those cases in which there is no disease of the conducting media, and then only used to express a certain train of symptoms, which, beginning by vertigo, nausea, sweating, perhaps vomiting, tinnitus, and deafness on one side, continues by permanent deafness, a long, lasting, and varying tinnitus, a gradual subsidence in frequency, and severity of vertigo and unsteadiness of gait. The very words of Dr. Mackenzie—"In the great majority of cases, in my experience, some disease is found in the middle ear"—show the necessity of this division and exclusion. My own experience not only accords with his remark, but it has become to me an ordinary and daily matter to regard in middle-ear disease vertigo as so common a symptom that it ranks amongst other symptoms, such as pain, deafness, and tinnitus, although it is not so prominent. It is also true that at one time it is of no great importance, whilst at another it is a symptom of the gravest significance. Thus, when it accompanies long-continued and profuse discharge from a perforate membrane, it often marks the advent of cerebral complications. In the course of many affections of the middle ear it is not of great consequence.

Let, then, all cases where the external and middle ear are involved be put on one side in considering the pathology and treatment of aural vertigo. Also let some others be put aside, such as those where the intelligence of the physician at once detects the state of affairs, as when Dr. Mackenzie writes: "I think one of the most practical points in warding off attacks is to keep your finger on the pulse—if one may use the expression—that is, to watch and keep down arterial tension. A dose of calomel, taken in such circumstances, patients have assured me, has averted attacks which they be-

lieve would otherwise have occurred." I shrewdly suspect that Dr. Mackenzie has occasionally, with a very full knowledge of the possible danger, averted an attack of apoplexy. I am reminded at the moment of a man, aged about 60, who, having no disease of his external or middle ear, used to become at times almost completely deaf, with furious tinnitus and considerable vertigo. By my advice he took a strong purge in the shape of calomel and colocynth pills when he had such attacks, and twenty-four hours after always recovered his hearing. The order of events—deafness, pills, and recovery—occurred six or seven times a year for three years, and after then no recovery. I can recall many instances resembling this. The number of persons with obvious arterial tension, consequent vertigo, tinnitus, and deafness that I have placed under physicians is very large indeed. They have not only been relieved by treatment and diet, but, later on, I have known several to illustrate the cause of these symptoms by dying of apoplexy. It is, therefore, also necessary to severely put aside these cases of arterial tension and atheroma as well as the middle-ear cases if we are to get at the root of true auditory vertigo—the vertigo which does not shorten life by a day. We shall then, so to speak, start fair. Persons who suffer from vertigo arising from all sorts of causes are very naturally alarmed, and at the present time they seem to find consolation in the term "Ménière's disease," which they glibly announce they suffer from, so that I cannot but think that this state of things must arise from a somewhat too loose application of a term which, I submit, so far as its accurate pathology is concerned, is almost meaningless.

Under these circumstances, I think the most we can do for it, and possibly the least, will be by common consent to insist upon its being confined to the class of cases I have indicated. All the theories which have been held by various observers at various times have been enumerated by Dr. Mackenzie, and the very variety of theories shows how uncertain is the exact state of the lesion. My own views are referred to by Dr. Mackenzie, so I need not repeat them.

ON CROUPOUS PNEUMONIA IN LONDON DURING 1893.

By **W. P. HERRINGHAM, M.D., F.R.C.P.,**
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THE past year, 1893, was remarkable for the very large number of cases of croupous pneumonia. Wishing to see whether any explanation could be found for this, I tabulated the cases admitted at St. Bartholomew's. The results were so striking that I thought it worth while to test them by larger numbers. I therefore applied to the physicians of Guy's, of the London, and of St. Thomas's Hospitals, who were kind enough to allow me to use their records to the extent required for my purpose. To them, to the physicians of St. Bartholomew's, and to the Registrars, Dr. Box, of St. Thomas's, Dr. Bryant, of Guy's, and Dr. Schorstein, of the London, who have been most courteous in assisting me, I am glad to return my hearty thanks.

I need not discuss in detail the etiology of croupous pneumonia. My purpose was to discover whether its prevalence varied with atmospheric conditions; but whether these are predisposing or exciting causes, and whether they act by weakening men, or by strengthening microbes, are questions beyond the scope of my inquiry.

I will first explain my tables, and then point out what they prove.

I have taken all cases of acute croupous pneumonia admitted during 1893 to the above four great hospitals, except inpatients under 5 years of age. These I have omitted owing to the great difficulty of diagnosis at that age between croupous and catarrhal pneumonia. The cases so obtained, 922 in number, I have divided into fortnightly periods, according to the date of admission. The numbers are not large enough to allow of weekly periods, for such statistics as these are but rough guides after all, and if numbers are small, are not only useless but misleading. The date of onset would have been better than the date of admission, but I could not,