am glad to find, from his paper in the *BRITISH MEDICAL JOURNAL* of February 1st, that he has found it so useful in the method of wound treatment there described.

Others have not been so favourably impressed with its value in cases of major operations; but possibly they have not applied it properly, or have not used a solution of the right strength. Not being engaged in surgical practice, I cannot speak of its value as a permanent coating over the incision wounds after surgical operations, but in minor surgery and in a number of trivial but troublesome affections of the skin, it is of the greatest service.

In the case of cuts, puncture wounds, excoriations, etc., especially of the hands, it forms a useful, dry, permanent coating and dressing. For the deep cracks and fissures in the skin of the hands, which are sometimes so troublesome in cold weather in persons whose circulation is feeble, celloidin is a most useful remedy. When painted over these fissures, it dries in a few minutes, and forms a coating which adheres for several days. When the celloidin becomes worn off, the fissures are healed.

When a solution of celloidin is painted on the skin it dries quickly, and forms a thin but tough transparent elastic membrane, which adheres very firmly. No dressing is required, and hence, if applied to the hands, the patient is able to write and use the hands freely; also the parts can be washed as usual without the film of celloidin being injured, and sometimes five or six days elapse before a single coating of celloidin wears away from the hands.

Celloidin may be used in all cases in which collodion has been employed. Though the action of the two substances is similar, celloidin is much more reliable; it adheres to the skin more firmly, and forms a more permanent and tenacious coating. The parts to which it is applied ought to be quite dry. If moist they ought to be dried with some antiseptic lint or wool; also the parts ought to be stretched slightly before the celloidin is applied, in order to counteract in some degree the contraction which occurs in the parts after the celloidin has become dry.

The strength of the solution I have employed has been the same as that used in microscopical work—namely, 2 parts of celloidin dissolved in a mixture of 15 parts of absolute alcohol and 15 parts of pure ether (specific gravity, 720). It is important to use pure absolute ether of this specific gravity, and not the sulphuric ether which has a specific gravity of 735. If the latter be used the celloidin does not adhere to the skin so well.

It is to be hoped that celloidin will find a place by the side of collodion in the new *British Pharmacopœia*.

NOTE ON CERTAIN "DERMOID" CYSTS.

By G. A. WRIGHT, M.B., F.R.C.S.,

Senior Assistant-Surgeon, Royal Infirmary; Surgeon, Children's Hospital, Manchester.

AMONG elderly men, and less frequently in young men, a tuft of hair may not very rarely be seen growing from the middle line of the nose, about one-third of the distance from the tip to the root of the nose. In other cases a small pit or scar-like depression is visible in the same position. Not uncommonly the mark is higher up nearer the glabella. Two or three times lately I have met with children in whom a further development is seen: the shallow pit has become a sinus, from which a discharge of pus occurs, or pus mixed with sebaceous material, or, as in two cases, a definite swelling, which, in one instance, was exactly like an ordinary inflamed sebaceous cyst, occupying the middle line of the nose, just at or below the most prominent part of the bridge. On cutting down upon one of these swellings, it will be found that it consists of a well-developed dermoid cyst, from the interior of which hairs grow, and an attempt to dissect out the cyst will lead to the discovery that it extends deeply between the nasal bones or between the lateral cartilages, and it may be difficult or impossible to completely remove the cyst walls without causing more disfigurement than the original disease. The presence of these cysts is to be explained, no doubt, by the upward growth of the bones or cartilages on each side, which leaves a furrow or depression between them, and the

subsequent coalescence of the walls of this furrow over a portion of skin gives rise to a "sequestration dermoid."

A year or two ago a girl aged 8 was brought to me with an ulcer immediately in front of the helix. In the centre of the ulcer was a sinus, and the whole had the appearance of a tuberculous sore. On scraping away the granulation tissue a track was found to run deeply beneath the pinna towards the anterior wall of the auditory meatus. Repeated scrapings and the application of caustics and the cautery failed to procure entire obliteration of the channel, though the condition was much improved.

Quite recently a boy has been under my care who appeared to have two exactly symmetrical tuberculous ulcers in front of each pinna. A little closer examination showed the presence on each side of an "auricular fistula" in the helix. On exploration under chloroform, after scraping away the tuberculous granulation tissue on one side, a wire could be passed from the auricular fistula into the depression left by the removal of the granulation tissue. On the other side the communication appeared to be obliterated, but on laying open the "fistula" it was found to run deeply towards the skull beneath the ulcer, and the whole of the track was lined with well-developed skin. The existence of these fistulæ and the occasional occurrence of dermoids in the middle line of the nose is, of course, well known, but I have not met with an account of a condition like these described. In the ear dermoids the ulcers were exactly like tuberculous sores; and though our resident medical officer, Mr. Melland, failed to find bacilli, I cannot altogether get rid of the belief that they were tuberculous.

In both sets of cases it is necessary to be prepared to follow the track deeply to eradicate the cyst, and the possibility of disfigurement must be borne in mind. In the first of the aural cases the child had German measles at the age of 4, and remained delicate. About seven months afterwards the abscess was noticed. In the other child some solid discharge had been noticed to escape from the auricular fistula since his birth, but suppuration on one side had existed for a year, and on the other for only a month or two.

A sketch by Mr. Melland showing the position of the ulcerated area and the orifice of the fistula is appended.

A CASE OF "LANDRY'S PARALYSIS.

By HERBERT ROBSON, M.R.C.S., L.R.C.P.,
Leeds.

W. T., aged 14, a bright, intelligent girl, of tuberculous aspect and with large tonsils, was quite well up to the onset of the present illness, and had not been exposed to any infectious disease. A few years back she had had an attack of follicular tonsillitis and two uncomplicated attacks of measles, but no other illness.

Family History.—Her father and her father's two brothers and sister all died of phthisis. Her mother, aged 59, the subject of chronic rheumatism, had had five children and four miscarriages. Of the children only two survived—namely, the patient and a healthy-looking lad aged 18; the

rest had died—one of convulsions at 1½ year, one of scarlet fever at 8 years, another of meningitis at 5 months. Her mother's sister, aged 51, is an epileptic, and is afflicted with rheumatoid arthritis.

History of Attack.—The patient rode home outside an omnibus after a long walk, and caught a chill on the afternoon of September 14th, 1895. The following morning she shivered and felt ill, and in the afternoon complained of severe pain affecting the top, back, and front of the head, and also of pain in the eyes. The pain continued until the child was seen by me for the first time on September 17th. There was then slight photophobia, but no backache, and no history of any previous backache; nor was there a vestige of paralysis anywhere. The temperature was 101°, the pulse 112, and the respirations 22. A dose (gr. vi) of antifebrin was given, and the natural salicylate of soda in 5-gr. doses every four hours, was prescribed. On September 18th the headache was much better, and no pain was complained of. The temperature was 101°, pulse 104, and respiration 22. Some loss of power in the legs was noticed. In the evening the breathing became somewhat laboured. On September 19th the temperature was 99.6°, the pulse 96, and the respiration 22. There was almost complete paralysis of the lower extremities, though the first and second toes of each foot could be slightly flexed and extended. Sensation over the legs, abdomen, and chest was perfect. The patellar and abdominal reflexes were absent. The diaphragm was acting. The lower intercostal muscles were apparently not working. The upper extremities also were found to lack some power; the patient, for instance, could not feed herself, since she was unable to raise the elbows from the bed. There was perfect control of the bladder and rectum, and all the cranial nerves were acting and unaffected. There was an absence of pain, though the child instinctively shrank at the sight of anyone going near to the bed to disturb her, explaining that "she was afraid any jolting might stop her breathing and kill her." The optic discs were examined and found normal. Dr. Barrs kindly met me in consultation on her case on the afternoon of September 19th, and confirmed my diagnosis of "Landry's paralysis." A mixture containing 3-minim doses of liquor strychninæ was prescribed. On September 20th there was no improvement. The temperature was normal; dysphagia and diplopia were complained of, but no squint was visible. All the facial muscles were acting. Later in the day vision became indistinct, and finally it was obscured altogether. In the afternoon incontinence of urine and faeces set in, and severe backache was complained of. The head had to be supported in one position; her constant fear being that "her neck would break, and that her breathing would stop if her head fell forwards." She was unable to swallow anything. Breathing was irregular and laboured, and there was considerable cyanosis. The temperature was subnormal and the pulse intermittent. Death occurred the same night at 11.30 P.M., the heart as well as the respiration failing only six days after the onset of the illness. Though light-headed towards the end, she was conscious up to the last. Faradism was applied to the muscles of the chest on the afternoon and evening of September 20th, with apparently little or no benefit.

Remarks.—This case is interesting on account of its rarity, its sudden onset, and its rapid and fatal progress. Then, too, the affection of the eye is worthy of note, because I believe the disease rarely reaches the bulb before proving fatal. The case is also of particular import as regards diagnosis and prognosis.

POOR-LAW MEDICAL OFFICERS AND THEIR SUBSTITUTES.—Dr. Moorhead, of Cootehill, has brought an action against the guardians for £12, for four weeks' service as *locum tenens* during the illness of Dr. McQuaid. The guardians have resolved to take defence. The Committee, it appears, fixed upon two guineas as the remuneration, but that decision was never communicated to Dr. Moorhead.

PRESENTATION.—Dr. Wilson, the Medical Superintendent of the Croydon Infirmary, Thornton Heath, has been presented with a gold watch, suitably inscribed, from the united staff of past and present officers at the infirmary, as a token of respect and esteem.

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

THYROID CYST IN A CHILD ELEVEN MONTHS OLD : OPERATION : RECOVERY.

THE patient, A. B., aged 11 months, was a female, very small and puny.

The mother noticed the enlargement when the child was 4 months old. From that time the growth increased rapidly, and latterly caused much difficulty in swallowing and occasional attacks of urgent dyspnoea, and violent fits of screaming, during which the child "went black in the face." These symptoms, I imagine, were due to pressure on the recurrent laryngeal nerve.

The cyst, about the size of a small chestnut, was easily removed. After the cyst wall was exposed by a vertical incision over its most prominent part, I dropped the scalpel and used two pairs of dressing forceps to strip off the adhesions right down to the sheath of the vessels. Here the adhesions were so intimate that I had to tie with fine catgut and divide with scissors. This was accomplished without opening the cyst. The little growth was completely enveloped in a thin covering of thyroid structure.

Subsequent to the operation everything has gone on well, and the child is now in much better health. The rarity of thyroid cysts in young subjects has induced me to report the case.

J. T. WILLIAMS.
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DIABETES MELLITUS AND ANTIPYRIN.

MRS. B., aged 42, who had had several children, was found in an epileptoid condition, foaming, and convulsed; this was followed by maniacal raving and struggling. Soon the patient became calmer, complaining of tremendous thirst and loss of sight. After a return of the epileptoid fit she gradually became comatose. Early in the evening she had complained of headache and severe pain in the eyes, and fell suddenly in convulsions. She remained somewhat comatose for about thirty-six hours; sometimes rambling faintly. The tongue was red, dry, and clammy. The temperature was 103°. She had had much trouble, and two severe shocks. She had not noticed herself passing much water until some days previously; she had suffered from persistent and aggravated eczema and boils. The catamenia had not ceased. Nothing had pointed specially to glycosuria beyond growing weakness and the above, and no trace of sugar was found, although on two occasions, when treating the eczema, I examined the urine. She was somewhat gouty, and crystals of urate of sodium were abundant. Eleven months previously I removed a large spindle-celled sarcoma from the thigh.

The Urine.—About 360 ounces of pale urine were drawn off the following day; specific gravity 1035; and by Fehling's method the sugar was estimated at about 32 grs. per ounce. Albumen appeared only as a trace. Urea was increased; further on repeated examinations with ferric chloride acetone appeared to be abundant, giving the dark red colour—the acetonæmia of diabetes mellitus. Nitro-prusside of sodium gave a red, fading to straw colour, and no change on addition of acid, as would happen in the presence of kreatin, aldehyde, or ethyl-diacetic acid. This was at first; subsequently the ferric chloride reactions pointed to diacetic acid rather than acetone. This test failed after about three days—diacetic acid being, perhaps, the source of acetone, as suggested. I found no evidence of pancreatic abnormality.

Treatment.—Pilocarpin ½ gr. was injected, and a small dose of morphine afterwards. Compound jalap powder was used, and chloroform inhalation once with marked benefit. Next morning the patient was semicomatose, and the temperature 102. The pilocarpin and morphine were repeated. Thirty-six hours from the onset the temperature was 101°, and the patient was sensible, complaining only of headache, great prostration, and inordinate thirst. The urine fell to about 290 to 300 ounces, but the specific gravity was 1033, and the glucose about 29 grs. per ounce. She was fed on milk