condition as before; the eruption ran the same course; and, with the exception that the attack was less severe, it corresponded in every particular with the former one which I had seen. This was therefore the third such attack from which the patient had suffered. On the first occasion the patient was under the care of Dr. Herbert Osborne, of Vredefort, O.F.S., who has kindly furnished me with the following particulars in regard to it: The eruption then commenced three or four days after the patient began to take a tonic mixture containing iron and liq. arsen. mij thrice daily. The eruption corresponded exactly with my description of the subsequent ones; he had considered it was not due to the drug on account of the local and limited distribution, but was unable to find any adequate local cause.

It appears certain that the eruption was caused by the arsenic prescribed, as on all three occasions the onset occurred from two to four days after commencing to take small doses of that drug.

There are two points in the case which appear specially worthy of note. In the first place, the distribution of the eruption did not vary, and was definitely localised, being limited to the hands in each of the three attacks, and leaving the dorsal surface for the most part unaffected. This striking local distribution of the eruption naturally led us off the scent in coming to a right diagnosis. In the second place, the eruption agrees almost exactly with the rare disease known as "pompholyx." The only point of difference appears to be that in this case many of the bullæ ruptured spontaneously, whereas it is stated that in cases of pompholyx this never happens; but as regards distribution and character of the eruption, the resemblance is otherwise complete and striking. Herpes zoster is known to have been caused by arsenic in numerous instances. This case seems to resemble pompholyx so closely that I would suggest it is to be regarded as a case of that disease caused by arsenic. In this light the case also acquires a further interest, as indicating that pompholyx may, like herpes zoster, be as Crocker suggests, "primarily of neurotic origin, probably a vasomotor neurosis." The intense feelings of irritation felt at the time of the appearance of the eruptions may perhaps be regarded also as favouring this view.

ON MEDIASTINAL FRICTION; WITH NOTES OF A PECULIAR CASE.

By JAMES ADAM, M.A., M.B.,
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THE following remarkable case of mediastinal friction, with peculiar sounds evoked by change of posture, is even more striking than that of Drs. Perez and Harris.¹ The patient, a well-built, somewhat spare, man, aged 26, has always been in good health except as stated below. In October, 1892, while reaching his right hand up to a shelf, he felt sudden pain about the heart. He was laid up four days. In November, 1893, when I first saw him, he suddenly had similar pain, and lay up a week, when it gradually ceased. For the first two days the temperature was about 101° , and respiratory murmur was almost inaudible over the left chest, but no other abnormal sign was found. In a fortnight he returned to work feeling quite well, though the chest condition was the same.

On April 21st, 1895, while dancing, he was suddenly seized with pain, at first along the sternum, but soon passing toward and settling around the left nipple. He at once went to bed, applied a fly blister, and got relief, though slight pain continued for a day, and recurred whenever he lay long on the left side. He had no dyspnoea, cough, or expectoration, and felt well but for the pain. The temperature and pulse were normal. The left chest moved on respiration, but no air seemed to enter; there was no respiratory murmur or vocal fremitus, little vocal resonance, no *râle*, bell sound, or echo. The girth of the chest was the same on each side. Heart dulness was absent, but the sounds distinct and pure.

On the second day of the illness he first noticed an extraordinary symptom. When he lay on the left side severe pain at the left nipple returned, and a double sound accompanying the

systole and diastole of heart was audible to bystanders several feet from him. This sound, he aptly likened to the double sound produced when you quickly dimple a rubber ball and let it rebound, or do the same with a felt hat. It had a loud, hollow ring. Examination in various postures then revealed great variation in physical signs of the left chest; the right remaining normal.

PHYSICAL SIGNS.

I. *Patient Supine.*—A slightly hyper-resonant note was obtained over the front and side right down to the stomach note at the sixth rib. Breath sounds absent; no abnormal sound. Vocal fremitus absent, vocal resonance nearly so. Heart dulness absent, sounds pure.

II. *Lying on Right Side.*—The same as in I; feeble respiratory murmur at left base.

III. *Sitting.*—Lung as in I and II. Cardiac dulness can be detected at fifth rib. When patient leans slightly back a soft blowing murmur follows second heart sound, and sometimes also the first. To this is sometimes added a harsh, rasping, and evidently friction, noise coming after the second sound; occasionally it followed both sounds, being then heard along with the blowing murmur. These murmurs are heard all over the normal cardiac area, but most distinctly along the sternum. They vanish when patient leans forward. They were never heard after the third day of illness.

IV. *Lying on Left Side.*—This position gave surprising results. Air was now heard entering lung freely, with slight prolongation of expiratory murmur below clavicle. Vocal resonance and vocal fremitus became normal. Behind, the physical signs were normal, except for slight diminution of respiratory murmur at apex. Heart dulness could now be percussed of normal size, slightly displaced to left, the apex beat being easily felt an inch outside nipple in fifth space. In this position the rhythmic double sound accompanying the heart beat and audible to bystanders was heard. It was not constant, being most readily evoked when, with the patient semiprone, one's fingers were pressed on the cardiac apex, where it seemed to be produced. It vanished when the patient turned a little off the semiprone position, but air still entered lung freely till he rolled on to his back. This sound was not heard after the tenth day. The pain at the nipple recurred when he lay long on left side or when he exerted himself.

In a few days he went to the country, and returned on May 3rd feeling well. Air then entered the lung freely in all positions; the only abnormal signs were slight hyper-resonance of the percussion note, which was clear down to fourth rib, slightly diminished fremitus, and when he lay on left side the apex beat, previously inside the nipple, fell to one inch outside, and pulsation could be seen in the third and fourth spaces. At the present date no difference from the normal is found, even when arms are raised.

The case excited the interest of several doctors to whom it was shown; none of them had heard such sounds as those described. It is difficult to account for the mobility of the heart on any supposition but that of a slight pneumothorax; yet the patient, till the onset of the illness, had no complaint whatever, and has never had cough or expectoration. Possibly he has an undue tendency to rupture his air vesicles while holding his breath, and thus pneumothorax might be caused. There was no subcutaneous emphysema. In all positions but that on the left side the heart fell back, and the left bronchus was nipped either by the large vessels at the base of the heart passing in front of the bronchus, or by adhesions in the mediastinum. The double borborygmous sound, like magnified heart sounds, was certainly caused by the action of the systole and diastole on an air-containing space, possibly by the heart pulling on adhesions between the pericardium and bronchus, or by the alternate expulsion of air from, and return of it to, the area between the pericardium and the chest wall.

NOTE ON THE THERAPEUTIC USES OF CELLOIDIN.

By R. T. WILLIAMSON, M.D., M.R.C.P.,
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Professor of Medicine Owens College.

Most medical men who work practically at pathological histology will be well acquainted with the value of celloidin as an embedding agent, and many will have been annoyed at the tenacity with which it adheres to the skin, if a few drops of a solution be allowed to dry on the fingers. It was this fact which suggested to me the use of celloidin in medical practice, and for several years I have employed it, and have found it of service in many ways. No doubt others will have employed it also. I recommended it to my friend Dr. Mackenzie some time ago as a permanent dry coating for wounds, when the edges can be brought well together, and I

¹ BRITISH MEDICAL JOURNAL, January 11th and 25th, 1896.

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.,

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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.,
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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