CASE IX. Eczema.—Hospital patient: While under treatment for tinea barbae, developed a papular and erythematous eczema of flexor surface of both upper arms. Worse on the right, and involving bend of elbow.

CASE X. Eczema.—Hospital patient: While under treatment for a bulla of right forefinger, the cause of which it was impossible to ascertain, developed an attack of eczema of the left arm and left side of face.

CASE XI. Vesicular Eruption.—Private patient: A lady showed me a small "blister" on the right ring-finger, for which a mild boracic ointment was ordered. In a few days she developed a large vesicular eruption on both hands, attended with *malaise*, headache, and gastro-intestinal catarrh.

CASE XII. Erythema Multiforme.—Hospital patient: A girl, aged 12, six or seven weeks before coming under observation, had pediculi capitis and "sores" on the scalp. On January 4th "blisters" first formed round the mouth and nostrils, became purulent and confluent, and now presented the appearance of an ordinary impetiginous eruption. On January 11th a multiform erythema, very extensive and well marked, appeared on both arms; at the same time a bullous erythema appeared on the face and front of neck.

REMARKS.

These twelve cases may be divided into two classes: First, those in which the eruption followed the infliction of an injury; and, secondly, those in which a pre-existing inflammatory condition of the skin, presumably of a non-traumatic origin, being in evidence. A condition common to both was the formation of pus and sepsis. It is interesting to observe the different types of the eruptions and the preponderating number of cases classed as eczematous, six being of this class, three pemphigus or pemphigoid, two erythematous, and one impetiginous.

What are these different pathological conditions due to? Are they caused by one poison or many generated in the process of sepsis? Is it possible that the same poison will induce one type of eruption in one individual and a different one in another. I venture to think that one toxin is capable of causing them all, the difference in type being due to the susceptibility of the tissues of the patients attacked with this modified form of septicæmia. The eruptions were all acute or subacute, and as far as can be ascertained were attended with more or less systemic disturbance.

Do not the foregoing cases suggest to us that many skin affections which have been attributed to vasomotor disturbance and reflex irritation are due to the absorption of micro-organisms or their products either by the skin or alimentary tract? It behoves us, therefore, to pay more attention to wounds of the integument, however trifling, in endeavouring to explain the cause of certain skin diseases.

ANTISTREPTOCOCCUS SERUM IN SEPTIC ABSORPTION.

By G. SCOTT MACGREGOR, M.D.,

Physician to the Glasgow Hospital for Diseases of Women; Examining Medical Officer to the Glasgow Convalescent Home, etc.

RECENTLY much has been said and written concerning serum-therapy. Having read of several successful results following the use of the antistreptococcus serum, I was led to employ it in the treatment of the following case:

L. M., aged 30, admitted to the Glasgow Hospital for Diseases of Women on May 28th, 1897. She was suffering from a bleeding fibroid, and on June 2nd the operation of oöphorectomy was performed. For the week succeeding the operation the temperature never rose above 100° F., the pulse was full and regular, and from 80 to 90 per minute.

On June 10th the temperature was above 100° F., and phenacetin in doses of 10 gr. thrice daily was ordered. In spite of this the temperature stood at 102° F. on June 15th. In addition to the phenacetin, 2 gr. of quinine every two hours were now ordered. This treatment was continued until June 18th, the temperature in the meantime ranging between 101° and 102.4°.

On June 20th, as the temperature showed no signs of rising higher, and as the pulse during the whole course of this increase in temperature never exceeded 95, and the patient looked somewhat better, it was deemed advisable to curtail the antipyretic remedies; accordingly the quinine was reduced to 6 gr. a day.

On the evening of June 21st the temperature was 102.2°; 10 gr. of phenacetin and 5 gr. of quinine were administered. The temperature in the morning was 102.8°, and the pulse for the first time was over 100. The antipyretic remedies were

now pushed, but by the afternoon the temperature had reached 103.8°, and pulse 110. In the evening the temperature was 104.6° and the pulse 120.

On June 23rd the temperature in the morning was 102° F., the pulse 120, small and wiry; the tongue was very foul, the lips quite anæmic; the countenance presented a pale and pinched expression, and the patient, although conscious, lay in a kind of torpor, hardly answering the questions addressed to her. At 1.30 P.M. 5 c.cm. of the antistreptococcus serum was injected into her left arm. At 6 P.M. her temperature was 104.6° F.; after she had had 10 gr. of phenacetin it fell to 101.4° F. in the course of an hour.

On June 24th, in the arm where she had received the injection the patient complained of pain and swelling; the temperature was 104.6° F., the pulse 112. She again had 5 c.cm. of the serum injected into the right arm; in the afternoon the temperature was 100° F., the pulse 90, but in the evening the temperature was 103.4° F. and the pulse 95.

On June 25th she suffered much from the pain and swelling in both her arms; she was, however, brighter, and answered questions readily; her tongue had begun to clean at the tip and round the edges; the temperature was 100° F., while the pulse was 80.

From this time onwards the patient ceased to give us any concern, and, although the temperature for some days longer went up in the evening to 101° F.—only once to 102° F.—the exhibition of phenacetin in one dose of 10 gr. had the effect of again bringing it down. Ultimately it came down to normal, where it remained, and the patient was dismissed on July 13th, 1897.

REMARKS.

Had I given a larger injection as recommended, a more rapidly favourable issue might have resulted; but the 5 c.cm. plus the 10 gr. of phenacetin had the remarkable effect of controlling the temperature. It was not, however, until another 5 c.cm. of the serum had been injected that a marked change for the better ensued. I am inclined to believe that the recovery which resulted in this case, and with the small quantity of serum used, was due in a great measure to the prompt use of the serum at an early stage of danger.

CHOREA IN RELATION TO SCARLET FEVER.

By JAMES PRIESTLEY, M.D.R.U.I.,

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It would seem doubtful whether chorea should be considered a sequela of scarlet fever or not. Thus, Henoch says: "I have only twice seen chorea during the acute stage of scarlet fever. I have never seen it as a sequela. Considering the very large number of choreic children whom I have had the opportunity of observing this fact seems remarkable, for other authors say they have often seen chorea after scarlet fever." Nor is it mentioned by Goodall and Washbourn,¹ nor by Caiger.² But in the Collective Investigation Committee's report³ scarlet fever is given as the sole antecedent in 6 per cent. Cheadle also recognises it as a sequela, but qualifies the opinion by adding that "scarlet fever chorea is almost certainly a rheumatic chorea." Osler⁴ gives 3 cases in 533.

FREQUENCY.

During the years 1894, 1895, and 1896, 8,360 cases of scarlet fever were under treatment at the North-Eastern Hospital of the Metropolitan Asylums Board, and of these 5,355 were completed there. Thirteen cases of chorea were observed, which gives a proportion of 1 in 412 completed cases. Osler found 1 case of chorea to every 180 patients treated at his infirmary; hence it would appear that chorea is less frequent among scarlet fever patients than among patients in general.

RHEUMATISM.

Five of the 13 cases tabulated on the next page had rheumatic manifestations—that is, 39 per cent. or 9 times the percentage of rheumatism in scarlet fever.⁵ The rheumatism in each instance immediately preceded, or presented itself simultaneously with, the chorea. As is well known, the rheumatism or joint affection which occurs as a complication of scarlet fever sets in towards the end of the first week; but in these cases it was considerably later, indicating a difference in

Thirteen Cases of Chorea following Scarlet Fever.

No.	Initials.	Age.	Sex.	Date of Onset of Scarlet Fever.	Date of Onset of Chorea.	Date of Discharge.	Manifestations of Rheumatism.	Cardiac Complications.	Remarks.
1	A. B.	13	F.	Nov. 13, 1893. Relapse, Dec. 14	Dec. 16	Feb. 13	Joint pains from Dec. 16 to Dec. 24	Systolic apical murmur on Dec. 16, and remained	Had been 5 weeks in bed with rheumatic fever, and only up 2 weeks when attacked with scarlet fever
2	H. B.	7	M.	Jan. 5, 1894	Mar. 5	Mar. 5	None	None	Chorea slight, and only noticed on day of discharge from hospital
3	R. R.	6	F.	Jan. 3, 1894	Jan. 20	Mar. 15	Joint pains with swelling, Jan. 13	Systolic apical murmur, Jan. 20, and remained	—
4	W. F.	8	M.	Mar. 28, 1894	May 11	June 2	Erythematous rash, April 24. Inflammation of ankle-joint, May 10. Erythema nodosum, May 15. Rheumatic nodules, from May 28	Systolic apical murmur, May 11, remained	—
5	R. L.	9	F.	July 27, 1895	Sept. 4	Nov. 4	None	Systolic apical murmur. Sept. 19, which disappeared Oct. 19	—
6	C. S.	8	F.	Sept. 1, 1895	Oct. 28	Dec. 9	None	Systolic apical murmur, Oct. 28, remained	—
7	J. P.	8	M.	Mar. 2, 1896	Mar. 30	May 2	Pain, swelling, and tenderness of joints on Mar. 6 and Mar. 17	Heart sounds normal	—
8	E. S.	11	F.	Desquamating on admission, October 19, 1895	Nov. 7	Jan. 13	None	Systolic pulmonary murmur on admission. Systolic apical murmur, Nov. 17; remained	—
9	M. B.	8	F.	Mar. 7, 1896	April 12	May 29	None	Systolic apical murmur, April 15, and remained	—
10	E. M.	11	F.	Mar. 30, 1896	April 13	May 29	None	Systolic apical murmur on admission, and remained	Had chorea a year previously
11	A. K.	9	M.	June 7, 1896	Aug. 7	Aug. 16	None	Systolic apical murmur, Aug. 7; disappeared	—
12	W. T.	6½	M.	July 25, 1896	Sept. 2	Sept. 30	None	None	Very mild case of chorea
13	A. W.	10	M.	Sept. 3, 1896	Oct. 19	Dec. 22 (died)	Arthritis of wrists, elbow, shoulder, Oct. 14. Arthritis of knee and elbow, Nov. 3	Systolic apical murmur, Oct. 14; the necropsy revealed heart normal	Chorea very severe until Nov. 3. Diphtheria on Nov. 24; tracheotomy, Nov. 27. Death on Dec. 22. His brother was reported to have died from chorea.

the nature of the joint affections which go with chorea ("the choreic arthropathies") and those which go with scarlet fever, though both are classed in statistics under the expansive term "rheumatism."

CARDIAC IMPLICATION.

The proportion of heart affection in first attacks of chorea is given as 30 per cent.¹ It will be seen that 7 out of the 13 developed murmurs which remained till the date of discharge. If we leave out of consideration cases (2) and (10) as evidently not valid, this gives 7 in 11, or over 60 per cent., which is in harmony with the statement in the Collective Investigation report that "scarlet fever would seem to predispose to the occurrence of heart affection in chorea." The average interval between the scarlet fever onset and that of the chorea was over 35 days.

REFERENCES.

- ¹ *Manual of Infectious Diseases*. ² *System of Medicine* (Allbutt), vol. ii. ³ *BRITISH MEDICAL JOURNAL*, 1887, vol. i. ⁴ *Chorea* (published 1896). ⁵ See Report of Statistical Committee of Metropolitan Asylums Board, 1896, p. 156. ⁶ Collective Investigation Committee's Report; Osler On Chorea.

A CASE OF RAYNAUD'S DISEASE.

By ALBERT MOUILLOT, M.D.,
Harrogate.

Miss N. H. consulted me in March, when she told me that she was 15 years of age, and up to November, 1896, had enjoyed fair health, though always a sufferer from cold hands and feet. This coldness of the extremities became worse, and in November her left hand began to swell, became painful, and looked quite black. The hand got extremely tender—so tender, indeed, that she could not bear even to have her nails cut. This swelling, pain, and tenderness rendered the hand so useless that she was unable to pick anything up with it. This state of things continued in spite

of care until her visit to Harrogate in March, but, except that menstruation had ceased, there was no sign of impairment of the general health.

When I saw Miss H. her condition was very striking. The hands and feet were deadly cold, as also was the tip of the nose; the ears were quite warm. The extremities were of a bluish-black colour when cold and of a deep red when warm. The left hand was greatly swollen and the fingers were kept fully extended; she was quite unable to flex them herself, and any attempt to do so caused extreme pain. The coldness and black colour extended half way up the left forearm. The condition of the nails was very peculiar; they were snow-white in colour, and very long owing to the pain on cutting them. Miss H. said that sometimes her hands and feet got hot, and when they did the pain was much worse. There was no albuminuria nor any history of hæmoglobinuria.

Miss H. was in this condition when she accompanied me to the meeting of the Leeds Medico-Chirurgical Society on March 19th, at which she was carefully examined by many of the leading Leeds physicians, who concurred in the diagnosis, though one physician suggested that the case came nearer to the disease known as erythromelalgia than to what is usually called Raynaud's disease. It seems safer, however, to retain the more general name.

It appeared to me that the only chance of improving a condition like that described was to keep the patient in an equable temperature and endeavour to improve the nutrition of the body by frequent feeding with nutritious food, at the same time treating the local and general conditions by careful and skilful massage. The Weir-Mitchell treatment, the great value of which I have so often proved, met all the indications, and accordingly I sent my patient to the Victoria Nursing Home, Harrogate, on March 24th.

The improvement under this treatment was uninterrupted. At first the manipulations had to be very gentle, but gradually more and more could be borne, so that at the end of seven weeks my patient left the home practically well. All