locomotor ataxia and the other from combined locomotor ataxia and general paralysis, or from general paralysis alone (Lührmann,⁹ Redlich,¹⁰ Mendel⁷). Finally, to complete the series it may also be mentioned that general paralysis has been known to occur in husband and wife (Siemerling, Westphal, Mendel, and others). Of combined general paralysis and locomotor ataxia in both parties I have found no record.

The occurrence of locomotor ataxia in married couples has been looked upon as confirming the current view of the relationship of this disease to syphilis. Erb,¹¹ writing in 1892, goes so far as to say that tabes dorsalis occurring in husband and wife without previous syphilis does not appear to exist. This view is perhaps rather an extreme one. In the case recorded here the history of the offspring gave the clearest possible indication of past syphilis in the parents, but an exhaustive inquiry into the personal history was precluded for obvious reasons in this bedridden couple. A more special interest is perhaps attached to the cases in which an undoubted syphilitic manifestation has been observed in one partner during the course of the locomotor ataxia, such, for instance, as the syphilitic seen in Strümpell's case or the gumma of bone in Lührmann's patient. During the past 20 years and more the evidence in favour of a close relationship between syphilis and tabes dorsalis has been accumulated to an almost overwhelming degree by Fournier, Erb, Grasset, Gowers, Moebius, Oppenheim, and others. It is true that the statistical method has been chiefly relied upon in these researches, but very large numbers have been dealt with, and it seems almost impossible to resist the direct conclusion which these figures naturally lead to. It is certainly a striking fact how rare it is not to obtain a distinct and unmistakable history of syphilis in the very large majority of tabetics presenting themselves in an ordinary out-patient room. Yet obviously only very large figures can be of service in the statistical method, and the percentage of syphilis obtained is then compared with that found in other patients. There are, however, still one or two distinguished authorities, such as Leyden, etc., who deny to syphilis almost any part whatever in the causation of locomotor ataxia. The doctrine is once again attacked by Leyden and Goldscheider¹² in their recent and interesting volume in Nothnagel's *Handbook*, where it is stated that cold is the most important and frequent cause of tabes. Still others are disposed to think that the part attributed to syphilis has been overdone (Carderelli,¹³ Redlich¹⁰). Few, if any, observers believe that syphilis is the sole and only cause of locomotor ataxia, although the renewed statistics published by nearly every author have shown a steadily advancing increase in the percentage of past syphilis among tabetics; thus, for instance, Erb² has reached the formidable figure of over 90 per cent.

It is not proposed here to touch upon other evidence adduced for or against the above-mentioned view—such, for instance, as the nature of the pathological lesions sometimes found, the inefficiency or otherwise of other causes, etc. The relation of syphilis to tabes dorsalis is not of theoretical interest alone, because the question arises as to whether the disease may be benefited in its earlier stages by antisiphilitic treatment. Very divergent views are held upon this subject; but it, may, perhaps, safely be stated with Moebius¹⁴ that an antisiphilitic course judiciously carried out will not harm the individual, and may do good, and this is especially true if there is a comparatively recent history of syphilis, and the more so if some syphilitic manifestation is still present.

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According to *Hinrich's Catalogue*, recently issued at Leipzig, the number of works dealing with medical science which appeared in Germany during 1897 was 1,521. In 1896 the number was 1,545.

A CASE OF CESOPHAGEAL POUCH.

G. A. WRIGHT, BY and REGINALD SMITH,
F.R.C.S., M.R.C.S.,
Manchester. Warrington.

Mr. W., aged 45, stated that when he was 7 years old he swallowed a toy metal disc, but does not remember that he had any serious trouble with his throat till about ten years ago. Since that time he has had difficulty in getting his food down, and after he has finished eating some food lodges in his throat and is regurgitated.

He has for many years observed that he cannot swallow as quickly as other people. He has no pain, and has never brought up any blood. If he holds his head down after eating some of the food returns, and if it has lodged for an hour or two the regurgitated matter is frothy, but it never tastes sour. He can usually take ordinary solids, but sometimes at the beginning of a meal cannot swallow at all. He has had more difficulty since he had influenza in May or June, 1897.

After a meal overnight he can always bring up some of his food the next morning. By pressure on the right side of the neck above the sternoclavicular joint he can force the food up into the mouth, and such pressure causes air to escape with a squeaking noise. At times air escapes with a clicking sound without any pressure. Certain twisting movements of the head cause pain and a feeling of wanting to swallow. After drinking, which he does with an effort, pressure on the side of the neck causes escape of fluid and gas into the mouth. There is no history of any injury or of abscess in the neck. He believes that his mother suffers from the same condition. Mr. W. is a great oboe player, and has been in the habit of holding air in the throat to keep up a continuous blast.

The above notes were taken by one of us on December 9th, 1897. There seemed no doubt that the case was one of cesophageal pouch, and he was advised to empty the pouch by pressure after each meal and to try the effect of wearing a sort of truss to press upon and obliterate the sac.

Shortly after this patient was seen Mr. Butlin's interesting paper was published.¹ In our case we did not think any operation was required, and by later accounts, though he is unable to bear the pressure of the truss, he is quite comfortable now that he empties the pouch each time after he eats or drinks anything.

ACUTE RHEUMATISM: HYPERPYREXIA: TREATMENT BY COLD BATHS: RECOVERY.

J. SHELDON WITHERS, BY and OLIVER WITHERS,
M.R.C.S., L.R.C.P., M.D., M.R.C.S., L.R.C.P.
Sole, near Manchester.

The following case seems to us to be worth recording, as it shows very clearly the value of the cold-water treatment in the hyperpyrexial state, when, as in private practice, the patient cannot be under constant supervision, and may not be seen until he is in almost a moribund condition.

At the end of May and early in June, A. A., aged 28 years, was suffering from apparently an ordinary attack of acute rheumatism, without cardiac complication, but his condition had latterly given rise to some uneasiness, as his temperature was rather erratic, and showed little disposition to fall even when the swelling and pain had disappeared from the joints under the influence of large doses of sodium salicylate. On the evening of June 5th the patient was quite comfortable; joints free from pain; temperature 103°.

On the morning of June 6th we were summoned hurriedly as the patient had been unconscious for some time, and his appearance had much alarmed his friends. He was found to be very deeply comatose, with reddish-purple countenance, convulsive twitchings of the limbs and face, and he had a petechial rash scattered over the body. The fæces were passed involuntarily. As hyperpyrexia was expected to account for the condition the temperature was taken, and in a few moments the thermometer had reached 110° in the

¹ BRITISH MEDICAL JOURNAL, January 1st, 1898.

axilla. The patient was quickly placed in a large bath of cold water, which was kept reinforced by buckets of cold water from the cellar as the warmed water was allowed to escape. The temperature gradually fell, and after being in the bath for nearly a quarter of an hour he was carried to bed, and wrapped in blankets, with hot bottles to the sides and feet, and ether was injected subcutaneously. He gradually recovered consciousness, and took a little warm milk and chicken broth.

One of us remained with him during the night, as it seemed very probable that the temperature would rise again when the effect of the bath had passed away. About 1 A.M. on the following morning it had already reached 105°. The patient was carried on a blanket to the bath and immersed again. He was quite conscious, free from shivering, and much enjoyed the coldness of the water. When the temperature fell he was removed to bed again, and was extremely comfortable for several hours.

On June 7th he became very delirious, though he answered quite rationally when spoken to. During the night the temperature reached 103°, but was kept under control by frequently-applied wet packs to the trunk. As the delirium increased and coma vigil came on, his head was shaved and a blister applied to the scalp.

On June 8th, as he was still somewhat delirious, an icebag was applied to the head, and he became quiet, and slept at intervals. In the evening the temperature was 102°. Food was taken well.

On June 9th his right ankle was red and swollen; he was quite free from delirium and the skin was moist.

On June 11th he was aphasic though quite rational, and had a free and constant action of the skin.

On June 16th it was noted that for some days he had been quite comfortable, though the temperature had occasionally reached 103°, and required frequent application of the pack. He gradually from this time recovered strength and vigour. The speech difficulty and defect of memory, of which he much complained, were, as one might expect, the last effects of the hot blood on the cerebral centres to disappear.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

A CASE OF PLACENTA PRÆVIA.

MRS. A. B., a married woman 28 years old, had had two children, with both of whom she had trouble with "false pains" at six months. She was suddenly seized with flooding, and I found that she had lost much blood. The external os was slightly open, admitting the point of the forefinger, but the cervix and the internal os were firmly closed and could only be very slightly dilated with force. A mixture containing iron and ergot was given and the hæmorrhage stopped.

Next day the bleeding recurred slightly, but on the succeeding day she had none. On the fourth day from the onset it came on again, but stopped in a short time. No recurrence took place for two days, but then it came on more severely than ever.

It was evident, in order to save the mother's life, that the child must be delivered as speedily as possible; but with the os in the condition stated and the whole organ high up above the brim the case was an awkward and difficult one. By means of bimanual manipulation I was able to reach the os, and could insinuate one finger into the cavity, where it touched what I took to be placental tissue on the left side and extending over the os. I was able to separate the attachment as far as the finger could reach. The cervix and internal os gradually dilated with the movement of the finger, so that I was able to pass two fingers, but was unable to reach the further edge of the placenta. I therefore kept up a steady and increasing pressure from the cervix outwards. This process is slow and severe, but as the pressure is kept up the parts are felt to dilate. I felt sure that if I had taken away my hand the hæmorrhage would have come on again, and most likely have proved fatal. All the time this pressure was

kept on I was doing what I could to get more fingers past the internal os, and in the course of an hour I got four in, but the thumb was the greatest difficulty; ultimately it was got in, and shortly after the knuckles followed, with the whole hand, I was then able to separate the placental attachment in the whole of its extent. The membranes were punctured, and the placenta had to be taken away, the amniotic fluid escaping, and the membranes remaining *in utero*. The child was in transverse position, dorso-posterior. The uterus at this time began contracting periodically; I tried to turn and deliver either as a facial or cranial, but found it impossible to get the head through the os. The uterine contractions seemed to be stronger than ever, and my hand was rendered almost useless by the pressure against the head of the child. I then made a search for the feet, and with difficulty in partially turning again brought them down, but the head struck firmly in the cervix, and had to be relieved with ordinary forceps. The membranes were expelled immediately thereafter. The mother was very weak and almost pulseless, and during the progress of the manipulations was given small quantities of water frequently repeated. She made an excellent recovery, with a slight elevation of the temperature for a few days.

The following points seem to me to be of importance:

1. The dilating power of the fingers if pressure be kept up in a steady manner with increasing force.
2. The turning of the child after the escape of the amniotic fluid.
3. The influence of small quantities of cold water often repeated in averting collapse.
4. The influence of iron and ergot in stopping unavoidable hæmorrhage, although only temporarily, but thus giving time.
5. The fact that the uterus did not contract until after the amniotic fluid and placenta were away.
6. The fact that no hæmorrhage took place from beginning to end of the operation.

Johnstone, N.B.

W. WESTWOOD FYFE, M.B., C.M.

A CASE OF ATRESIA ANI VAGINALIS.

B. A., who will be 3 years of age in May, came under my notice a few weeks ago. Her mother gave the following history. Until the child was two months old nothing abnormal was observed. A slight relaxation of the bowels then necessitated more careful attention to the parts, and the mother then discovered that there was no anus. The child, who is well nourished and in good health, suffered very little inconvenience. On examining the parts the normal anal depression was found to be absent, and nothing to indicate the normal situation of the anus was observed. Situated just within the entrance to the vagina could easily be seen the fistulous opening, and except that the vulva was slightly swollen and excoriated, the surrounding parts were normal. As the little patient objected to much manipulation I did not feel justified in making a closer examination, if, indeed, anything further could be made out.

I find from Starr's *Diseases of Children*, 1895, that congenital malformation of the rectum and anus occur in the proportion of 1 in 10,000 births. Bodenhamer classifies these under eight headings, the above case coming under No. 6. Treves, in his *System of Surgery*, gives no proportion, but states they are of extreme rarity, and divides them into three classes, according to developmental errors; this one comes under his heading No. 2.

I have advised the mother of the child to wait until she is older before submitting her to any operative treatment and hope for a very successful result. Rizzoli's suggests itself as being a very suitable operation.

Dublin.

F. CHARLES FITZGERALD, L.R.C.S.I.

PUERPERAL VOMITING.

DR. BUXTON'S case of puerperal vomiting recorded in the BRITISH MEDICAL JOURNAL of February 5th recalls to me a somewhat similar case.

On February 21st, 1897, Dr. S. Bridger, who was then assisting me, was called to see Mrs. S., a 3-para, at full term. Her former confinements were normal. She had no labour pains, but complained of great sickness, being unable to retain anything. The temperature was normal. She was ordered sinapisms and a bismuth mixture.

On February 22nd I received an urgent message at 1 P.M.