the lamp passes through an opening in the blankets at the foot of the tent, and may be covered with asbestos or simply a wet cloth to protect the blanket. It is important that the lamp should be made without solder, because the excessive heat is apt to damage the connections round the wick apertures and to allow of the escape of some of the spirit, which will speedily ignite. A very convenient method is to replace the spirit lamp by a ring bunsen burner attached to a gas bracket by means of a long rubber tubing. This is safer than a lamp, and raises the temperature inside the tent more rapidly. I always use the bunsen burner at the infirmary; but in places where no gas is available a lamp of some kind must be used. Many of the spirit lamps ordinarily employed with this apparatus do not give out sufficient heat, and are therefore useless if a higher temperature than 120° F. is required.

The blanket which has covered the body is removed the last thing to allow of free evaporation from the surface of the skin. The patient, therefore, lies quite nude inside the tent. A small towel can be placed across the hips if desired. The patient is wiped down after the bath, and wrapped in dry blankets for the rest of the day.

The estimation of the temperature inside the bath is not an easy matter. The air in the upper strata near the top of the tent is always much hotter than that of the lower strata in which the patient lies. There may be a difference of 10° F., or even more. It is clear, then, that if a long thermometer be inserted through a hole in the top of the tent its glass is subjected to the heated air of the upper strata as it passes out, and the reading is much higher than the actual temperature near the bulb, and therefore near the patient. The disadvantage of letting down a small thermometer by means of a string, and hauling it up again like a bucket from a well, is that the opening must be made each time, and consequently the temperature may never rise as high as is desired. Perhaps the best way is to insert a long thermometer through a small hole in the blanket near the side of the tent, midway between the head and the foot, so that the bulb is near the patient's body without actually touching it, otherwise the bulb will get wet. The index of the thermometer, being outside the tent, can be watched without displacing the coverings.

As a rule there will be no necessity for making any opening till the patient breaks out in a good perspiration or complains of feeling too hot. If the temperature of the air be taken at this stage it will be found to be from 120° to 130° F. The opening should now be made at the top of the tent. The feeling of excessive heat passes off rapidly, as the hot air saturated with moisture passes away. This is the important point in the treatment, because unless the moisture is got rid of, few patients can be found to stand a temperature beyond 130° F. On the other hand, if this is done periodically, the air in the tent is kept sufficiently dry to allow of the temperature being raised to 200° F. or higher. During the first bath I usually keep the temperature at about 130° F. for twenty minutes, and then take the patient out, subjecting him to a greater heat on the subsequent occasions.

SYNOPSIS OF CASES.

I have full notes of 9 cases treated by this method during the last six months. A brief description of them will be more in keeping with this short paper than a detailed account. Of the 9 cases, 3 were chronic rheumatism, 2 chronic gout, 2 sub-acute rheumatism, 1 chronic arthritis of a doubtful nature, probably due to an old injury, and 1 arthritis associated with osteitis.

The last case was not relieved by the baths. I thought that if anything he was made worse, and after a week's treatment they were discontinued. One case was slightly relieved. He left the hospital suddenly after nine baths. It was a case of chronic rheumatism of the hands. When he came in he could not button his trousers on account of the pain and stiffness in his hands. On leaving he was sufficiently improved to accomplish this.

Two cases were distinctly relieved. One of these is still under treatment and will, I think, derive considerable benefit eventually. The remaining five were greatly relieved.

INDICATIONS.

There appear to be four classes of cases to which this method seems especially suitable:

1. Subacute attacks of rheumatic arthritis.
2. Subacute arthritis following an acute attack of either rheumatism or gout, or consequent on a pyæmic condition such as gonorrhœal arthritis.
3. Cases of chronic thickening remaining as a consequence of gout, rheumatism, or rheumatoid arthritis, associated with pain and stiffness on movement, with continual aching pains in the neighbourhood of the joints.
4. Cases of impaired mobility following injuries to joints or to muscles in their neighbourhood; and cases of joint trouble from trophic causes or disuse.

There is no claim to anything new in the above method or in the apparatus by which it is carried out. It simply has this advantage that, by removing the excessive moisture from time to time in the manner indicated, a high temperature can be borne in an ordinary blanket tent. It can, therefore be given in any hospital or private house, and is applicable to any class of patient, whether bedridden or not.

NOTE ON MULTIPLE FAMILY CANCER.

By W. ROGER WILLIAMS, F.R.C.S.,
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SUCH instances of multiple family cancer as that recorded by Mr. Power in this JOURNAL of July 16th, are of great interest in view of their bearing on the *questio vevata* of the hereditability of cancer. I know of many family histories quite as remarkable as Mr. Power's. I will briefly mention a few:—

1. I have seen a woman, aged 53, with uterine cancer, whose maternal grandmother, mother (aged 45), mother's sister, and the patient's two sisters (aged 32 and 36) had all died of cancer of the uterus. She was one of a family of eleven; of her other brothers and sisters, 3 died in infancy, and five were still alive and well.

2. Atthill mentions the case of a woman, aged 28, with uterine cancer, whose mother and two sisters died of cancer of the same organ.

3. In a family known to Sibley, the mother and her 5 daughters all died of cancer of the left breast.

4. Of the celebrated Bonaparte family, Napoleon I, his father, his brother Lucien, and two of his sisters (Pauline and Caroline) all died of cancer of the stomach.

5. It is very rare to find, in the same family, such a large number of members affected as in the following case mentioned by Broca:—

Madame Z. died of cancer of the breast, aged 60. Of her 4 daughters, 2 died of cancer of the breast and 2 of cancer of the liver.

The first daughter's offspring comprised 3 females, who were still alive and well, aged 68, 72 and 78 years.

The second daughter had 2 sons and 5 daughters. The eldest son died aged 28, not cancerous, and the youngest daughter died aged 60, not cancerous; all the rest died cancerous—the son died of cancer of the stomach, 3 of the daughters of cancer of the breast, and the other daughter of cancer of the liver.

The third daughter had 5 daughters and 2 sons; all the daughters died of cancer, 3 of the breast, 1 of the uterus, and 1 of the liver. Of the sons, 1 died in early manhood without issue, not cancerous, and the other was alive and well, aged 72.

The fourth daughter had only 1 son, who was alive and well, aged 70.

6. Otto cites an instance of 4 brothers and sisters who all died of malignant disease of the eye.

7. Silcock has reported the occurrence of melanotic sarcoma of the left eyeball in three generations of the same family.

8. Six cases of cancer in the same family were known to Catani; the parts affected being the rectum in 2, the lungs in 2, and the bladder and rectum.

9. Of a family of 7, under Roper's observation, 6 died of cancer; in the females the breast being the part affected.

10. Strümpell reports the death in early infancy of 2 brothers, each with sarcoma of the left kidney.

11. Manichow reports that 23 families known to him in "la Soissonnais" had between them 69 cancerous members, and of these the stomach was the part affected in no fewer than 57.

12. Some remarkable examples of the hereditary transmission of melanosis in horses are cited by Virchow. One of these a young white stallion, with melanosis of the anus, transmitted this disease to all its white descendants, whereas those of a darker colour escaped. From horses thus bred the disease became widely diffused throughout the neighbouring country.

Such instances as the foregoing seem to me to prove the hereditability of the disease. It is obviously impossible in most of them that the malady could have been acquired from a common source of infection, and no fortuitous circumstances will explain such concurrences.

A remarkable feature about many cases of inherited cancer is that like normal structure it is homotopic in its transmission; that is, it attacks the corresponding organ in each of the related individuals. This is especially noticeable in Sibley's case, where the mother and her 5 daughters all had cancer of the left breast.

Although this form of transmission often defaults, it is, nevertheless, noteworthy that on the average—taking all the seats of inherited cancer into consideration—homotopic transmission preponderates. Thus my analysis of the family history of 136 women with mammary cancer shows that of the 48 seats of inherited cancer the breast was the part affected in 19.

EXTRAUTERINE PREGNANCY: FIVE MONTHS FETUS: PLACENTA IMPLANTED ON ANTERIOR ABDOMINAL WALL: OPERATION: RECOVERY.

By JAMES OLIVER, M.D., F.R.S. EDIN.,
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History.—A. K., aged 28, and married three years and a half, had had no child and no miscarriage. She began to menstruate at the age of 17, and the discharge thereafter recurred regularly until March, 1898, during which month and the four succeeding months (April, May, June, and July) it did not appear. A hæmorrhagic discharge from the vagina was observed on August 8th and 9th, from August 24th until August 31st, and again from September 5th until September 24th, when the fœtus and placenta were removed by abdominal section. Menstruation had always been accompanied by pain, and in March, when the menstrual discharge should have made its appearance, pain similar to that usually experienced during menstruation, but more severe, was then complained of. Little or no pain was complained of during April, May, June, July, or August. On September 2nd patient was suddenly seized with severe pain in the left iliac region, but she has been, comparatively speaking, free of pain since this date. Almost immediately after the menstrual period was missed in March patient began to be sick in the morning, and this symptom persisted until the end of April only. During March and April pain was experienced in the hypogastrium during micturition. The abdomen has increased in size since April.

Physical Signs.—The abdomen below the level of the umbilicus is prominent; the left half is markedly more prominent than the right. Palpation reveals the presence of a somewhat pyriform tumour, which extends from the left anterior superior spine of the ilium to within 2 inches of the same anatomical mark on the right side. The larger end of the tumour is located in the left abdomen, and its upper border here reaches to the level of the umbilicus, whilst the upper border on the right side falls short of this level by 2 inches. The left portion of the tumour is smooth and appears to be solid, whilst the right half is slightly irregular and appears to be cystic. No sounds are heard on auscultating the tumour. Colostrum is obtained readily from both breasts. The cervix uteri is located far back towards the hollow of the sacrum; it is not enlarged and the os is not open. The vaginal roof anteriorly and on the left side is pushed down by a swelling which is a portion of the abdominal tumour. The body of the uterus is incorporated with the abdomino-pelvic tumour posteriorly. The pulse is 72 a minute and the temperature normal.

Operation.—The abdominal wall was incised mesially from $1\frac{1}{2}$ in. below the umbilicus to within 1 in. of the pubes. The upper portion of this incision opened the peritoneal cavity to the extent of about 1 in. The tumour was carefully incised below the peritoneal reflection. It was then observed that the placenta was implanted on the anterior abdominal wall and extended some inches to the right and left of the abdominal incision. I separated the placenta extensively from the abdominal wall, but as I failed to reach satisfactorily the

free margin of the placenta and feared I might injure the bladder by persisting, I broke through the placenta at a spot opposite the abdominal incision and delivered the fœtus, head first, through this breach. The remaining portion of the placenta was thereafter separated and removed. The fœtus, 5 months old, which had probably been dead 6 or 7 weeks, had been lodged in the substance of the left broad ligament, and had separated the bladder from the uterus. The cavity in the broad ligament was plugged with cyanide gauze, which was removed twenty-four hours after the operation. Convalescence proceeded uninterruptedly.

Remarks.—It is highly probable that by rupture of the Fallopian tube the ovum escaped into the substance of the broad ligament during the fourth week after conception, or at least some days before the placenta had begun to be differentiated. No hæmorrhage from the uterus occurred until the fœtus was dead and no decidual shreds were ever observed. No spurious labour pains were experienced, and in none of the full-time extrauterine pregnancies which have come under my care have pains of a labour-like character been complained of.¹ Although the fœtus had been dead 6 or 7 weeks before it was removed there was no evidence of any constitutional disturbance, the pulse and temperature even were normal. Morning sickness was a troublesome symptom for about 7 weeks, and was noted first soon after the menstrual period was missed in March. The implantation of the placenta on the anterior abdominal wall centrally proved a troublesome complication at the time of operation.

REFERENCE.

¹ See A Study of Four Cases of Full-time Extrauterine Pregnancy. *Edin. Med. Journal*, August, 1898.

MEMORANDA:

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

THE TREATMENT OF ECZEMA.

FROM time to time one sees in the BRITISH MEDICAL JOURNAL and in other papers references to special treatment of eczema. In the EPITOME of November 12th, for instance, occurs a paragraph on the treatment of chronic eczema by iodine. The time seems opportune for me to emphasise what is practically the essence of treatment for this disease.

Antiseptic Remedies.—Silver nitrate I discarded for iodine nearly ten years ago, but for the time I used it I must speak favourably of its efficacy. The solution of iodine which I adopted and have since used is one of 100 gr. of the metal dissolved in 1 fluid ounce of spirit, with potassium iodide and ether. This solution may be used in most stages of the disease, even when the skin is much fissured and inflamed, especially if its application is preceded by brushing the part to be treated with a solution of cocaine hydrochlorate (4 per cent.). Thickening of the skin I soften by strapping with "infirmity strapping" previous to applying the iodine, but this proceeding is not often necessary. More often I apply the iodine solution and over the painted part apply the strapping. By this means an iodine vapour bath is ensured. Copper sulphate is a good remedy when used over small areas, such as the fingers. After smoothing the fingers with soap and pumice-stone, I rub on the blue-stone. The immediate effect is painful, but the resulting cure is rapid. When eczema has almost recovered there are often foci of inflammation left, which seem to reinfect the recovering surface. These must be cauterised, and for that purpose I prefer strong carbolic acid lightly applied.

Exclusion of Air.—When the skin is healing is the time to dust over the surface with calomel or cover over with some air-excluding medium. For the horny eczema which occurs readily on the hands and forearm a frequent application of common paraffin oil is very useful. It is to be washed off by means of soap and warm water shortly after each application. On some large surfaces I have begun with a spray of ethyl chloride, followed by painting with collodion flexile. By excluding air some cases have recovered without further application.