at the end of six weeks a plaster-of-paris jacket was applied, and the boy allowed to move about by the aid of crutches.

I showed the case before the Hull Medical Society on November 16th, 1894, and then he was quite recovered, and able to walk about without the help of crutches or any aid whatever, and indeed a few days ago I saw him running and flying a kite.

ON DELIVERY IN CERTAIN CASES OF IMPACTION OF THE TRUNK OF THE FŒTUS.¹

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In the present paper I purpose speaking briefly of some practical points in connection with the method of delivery in a class of obstructed labour which has received very inadequate treatment in the ordinary textbooks of midwifery, namely, those in which the obstruction caused by the trunk of the fœtus is an indication for embryotomy. I shall omit the consideration of cases in which with a large child or a small pelvis craniotomy alone is sufficient to remove the obstruction, and also those in which obstruction occurs in breech presentation, as embryotomy is rarely required and easily performed in such cases. My remarks will be limited to those cases of head presentation in which, after delivery of the head, it is found that the child's body will not pass through the pelvis without reducing its size and to those cases of presentation of the trunk in which embryotomy is called for on account of the impossibility of performing version or decapitation. Of the first class of cases I have met with several instances, of the second class only two.

In cases of head presentation it is sometimes found that it is impossible to deliver the child's body unutilated after the head has been born, especially through a contracted pelvis. Apart from the rare cases of double monster and of tumours external to the child's trunk, the difficulty may be due to the large size of the child. The largest fœtus I have ever seen weighed 13½ lbs., and required mutilation on account of its great size. But through a small pelvis a child of half this weight may be unable to pass.

With a normal pelvis the obstruction formed by the child's trunk may be due to pathological conditions either in the serous cavities or the viscera. Disease enlarging the thorax to any considerable extent is very rare. A slight serous or bloody effusion in the pleura is very common, and I have once met with acute pericarditis in a newborn child; but these effusions very rarely enlarge the thorax sufficiently to cause obstruction in labour. The trouble will almost always be found in the abdomen.

One of the most common causes of obstruction is distension of the child's belly with the gases of putrefaction—a somewhat rare occurrence even in fetuses which have been dead some time. It is, however, a good rule in all cases of obstructed labour to percuss the uterine tumour; a tympanitic note will indicate the cause of the obstruction. Another not infrequent source of distension is ascites or peritonitis, by which sometimes the belly is distended to an enormous size. I have seen the vagina distended sufficiently to form an abdominal tumour, and great distension of the bladder and uterus has been met with by other observers; but the only other causes of obstruction which I have personally met with have been distension of the colon by meconium in cases of imperforate anus, cystic kidneys, hydronephrosis, and distended ureters, and enlargement of the liver and spleen in syphilitic children. The diagnosis of the cause of the obstruction can usually only be made by careful exploration under anaesthesia. The question of treatment then arises. Traction upon the child's head in order to deliver the trunk should be made with caution and judgment; the employment of great force has caused rupture of the uterus.

If judicious traction fails to bring down the trunk it may be necessary to reduce the width of the child's shoulders.

With this object I have found it a useful plan to snip through the clavicles with scissors, then, if necessary, to pass a blunt hook into the axilla and thus to bring down the arms. If delivery is still impossible it may be necessary to remove the head in order to gain room for further manipulations; but before decapitating it is advisable to seize the neck with a strong volsella furnished with interlocking teeth which will prevent the trunk from receding out of reach. Usually not much advantage is gained by opening the thorax, and the broken ribs are troublesome. The hand should be passed up to the abdomen, which should be opened with the scissors or the perforator, if the obstruction is due to gas or liquid effusion, the obstruction is immediately relieved and delivery effected; in other cases it may be necessary to remove the abdominal viscera.

And now to speak of the second class of cases. In transverse presentations it is rarely that version cannot be performed, and in impacted transverse presentation it is very rarely that decapitation is impossible. It has twice happened to me to meet with cases in which neither operation was possible. In both instances the pelvis was contracted and the soft parts oedematous, and in one there was the complication of placenta prævia. The uterus was retracted and as hard as a board; the back of the child presented; it was impossible to introduce the hand far enough to perform version or decapitation. I have never in midwifery met with such an *impasse* as these two cases presented, and the fact that Caesarean section has more than once been performed for this state of affairs² is an indication of the difficulty that has been experienced by others. It is in the belief that the method which I successfully adopted in these two cases meets the difficulty that I place before you the following method of treatment:

Make an incision through the skin of the child's back, and cut through its spine with scissors, then apply Braxton-Hicks's cephalotribe (the points of which meet when the instrument is closed) to the sides of the trunk of the child and screw up the instrument. By making traction with the cephalotribe the soft parts are brought down, and may be cut through with scissors. The delivery of the two halves of the child's body then presents no special difficulty.

A CASE OF BILATERAL HERPES ZOSTER OF THE FIFTH PAIR.

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On January 5th I was asked to see N. M., aged 18, a Highland ploughman, supposed to have an infectious disorder. Three days before, he had been attacked by headache and vomiting, and on the morning of my visit a rash had developed on the head and face. I found him in bed, still complaining of pain in the head, but as he did not speak English fluently, it was impossible to determine the exact seat and nature of the pain. The pulse and temperature were normal. I found the alleged "rash" to consist of patches having an inflamed well-circumscribed base, upon which numerous clear vesicles were implanted. They were most marked on the left side of the face, picking out very neatly the sensory distribution of the fifth pair. There was a patch near the root of the nose on the supraorbital ridge, another just below the orbit, another on the left side of the nose, and one or two spots in the moustache of the left upper lip. On the upper part of the helix of the left ear there was a small patch, and, curiously enough, upon the lower and back part of the neck, between the contours of sterno-mastoid and trapezius, was an oval patch of the same nature. On the right side of the face there were patches in the supraorbital region, on the chin, a large one on the cheek just beneath the outer end of the zygomatic arch, and one on the right temple. The development of the eruption had a good effect upon the pain, which, except for a little in the supraorbital region, very soon left for good, and by January 12th the dried-up crusts were separating.

¹ Read before the West Sussex District of the South-Eastern Branch of the British Medical Association.

² As by Professor Hubert, of Louvain, *Rev. Méd.*, Louvain, 1892-1893, xi, 385-388.

The case is worth recording on account of the great rarity of bilateral herpes zoster. Hebra,¹ in his definition of this disease, emphasises its unilateral tendency, and says: "It is only in rare and exceptional cases that herpes zoster attacks both sides simultaneously." Trousseau² says: "In all cases, however, there is only one side of the body affected." And Dr. Allan Jamieson³ says: "It is very rare for nerves on both sides of the body to be simultaneously or consecutively affected, and still more rare for corresponding nerves on both sides."

REMARKS ON A CASE OF HERPES OF UNUSUAL DISTRIBUTION.

By H. DRINKWATER, M.D.,
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THE following case, which recently occurred in my practice, presents some features which may help to throw a little further light on the pathology of this disease. The herpes was not confined to the area of distribution of one nerve, but of a set of nerves, namely, those of the superficial cervical plexus together with some others.

The patient is a young lady, aged 22. On April 9th, 1894, she came to me complaining of severe pain in the neck just over the occipital attachment of the trapezius on the left side. Nothing abnormal was discovered by sight or touch. Two days afterwards (April 11th) she presented several groups of herpetic vesicles on the left side of the neck (all those shown in the sketch with the exception of the groups near

the figure 3). One of her brothers had herpes some years ago, but she had never had it before. There was phthisis in the family, and the patient was rather anæmic.

I could assign no immediate exciting cause of the attack. She had not been taking arsenic; the last medicine she had contained principally hypophosphites.

The patient complained of very severe pain shooting up to the vertex behind the ear, in the district supplied by the small occipital nerve, but there was no rash to be discovered in this part. I infer from this that the nerve was affected as much as the nerves lower down were, but that owing to the

density of the skin no vesicles were formed. In the lower portion of the ear, where the skin is intermediate in density between that of the scalp and the neck, there was an intermediate stage of the eruption.

Dr. Head, in the autumn number of *Brain* of 1893, showed that "herpetic eruptions on the head and neck.....correspond fairly with areas of tenderness produced by visceral disease" (p. 341); and, further, that these tender areas do not represent the supply of posterior roots of spinal nerves, but "correspond to the distribution of segments of the cords." He gives particulars of many cases, but there is none resembling mine in distribution (Case No. 22 approaches most nearly to it). The pain kept my patient awake.

On April 11th all the groups of vesicles were developed except those near figure 3, and these came out on April 14th. The groups of vesicles were distributed over the entire region supplied by the branches of the superficial cervical plexus, the main branches of which are the superficialis colli coming from the posterior border of the sterno-mastoid to the middle line anteriorly, and extending just to the chin and margin of the jaw. The descending branches extend just beyond the clavicle. The great auricular or auriculo-parotidean (Turner) is of great interest; it supplies the skin over the parotid and the lower two-fifths of the ear exactly—that is, the portion of skin seen to be affected with the patches in this patient. The late Mr. Hilton laid great stress on the distribution of this nerve, and gives an illustrative figure in his work on *Rest and Pain*. The distribution of the skin lesions in this case corresponded exactly to that of the nerves mentioned; but posteriorly they were found in portions of skin not supplied by the cervical plexus, for it does not supply branches posteriorly, at least not further back than the acromion. Viewed from behind, it was seen that the lowest spots were in the region supplied by the posterior division of the fourth cervical nerve—that is, all the nerves were affected from the first to the fourth inclusive posteriorly, and the same was true anteriorly, for the cervical plexus is formed by the anterior divisions of the fourth upper cervical nerves.

The explanation I would suggest is that the disease was due to some pathological process occurring in the superior cervical ganglion which distributes vasomotor nerves to the upper four cervical nerves. I cannot imagine any other explanation why all these nerves, and only these, should be affected simultaneously with the same morbid process. I did not form the opinion until the groups marked 3 came out on April 14th: for up to then I rather wondered why there were no spots visible on the parotid region.

The pain now became very severe, and the patient begged of me to do something to relieve it, as she could not get any sleep at night. I had given her opiates without any relief. Dr. Edward Woakes, in one of his works, says that tobacco has a paralytic action on the superior cervical ganglion, and that camphor has an antagonistic action. I assumed this case to be due to a paralytic action of this ganglion, and that the vasomotor paresis extended to the vessels supplied to the branches of the upper four cervical nerves, the dilated blood vessels exerting pressure on the nerve fibres, and thus causing pain and some trophic change resulting in vesical formation. If such were the case the camphor internally should afford some relief. Accordingly, on April 14th, I gave her five minims of spirits of camphor three times a day on loaf sugar. Up to this date the spots were spreading and the pain was getting worse daily. There was a remarkable improvement almost immediately; the night of April 14th she slept well; on April 15th she was quite free from pain, and it never recurred at all, but what struck me as most remarkable of all was that the group of vesicles that had come out last were all retrogressive, and those over the parotid were gone, leaving no sign of their former presence. That is they had not gone through the usual course of crust formation by evaporation of the contents; the contents had been reabsorbed.

I did not see her again until April 19th (she had gone up to town on business on April 16th). On this day there were only very slight remains visible, most of the vesicles having entirely disappeared; only a few dry thin crusts remained. Crust formation occurred in those that had been allowed to develop fully, whereas those that came out the day before

¹ *Dis. of Skin*, New Sydenham Society, vol. i, p. 372.

² *Clin. Med.*, New Sydenham Society, vol. ii, p. 291.

³ *Dis. of Skin*, 2nd edition, p. 143.