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.,
Wrexham.

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.

the camphor was administered died away without forming scabs or even any visible scales.

To sum up, the two points upon which I wish to lay stress are:

1. The distribution showing that the disease was of sympathetic origin.

2. The effect of camphor. The improvement occurred so suddenly after its administration that I feel very much inclined to attribute the amelioration to its action, and would recommend its trial in herpes.

I am sorry that the illustration is not better. The lady would not consent to be photographed.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

INTUBATION IN DIPHTHERIA.

In the *BRITISH MEDICAL JOURNAL* of March 23rd Mr. Guest Gornall records a fatal case of diphtheria treated with antitoxin in a girl aged 4 years, in which he says that "the child was already much exhausted by difficulty of respiration when the injection of antitoxin was made, but tracheotomy was refused by the parents." As some time ago I had a somewhat similar experience—minus the fatal result, however—it may not be amiss to record it also.

On April 18th, 1894, a boy, aged 7 years, who had been under my care for a few days with well-marked diphtheria of the pharynx, presented symptoms of invasion of the larynx by the disease. Early on the morning of April 19th these became so alarming as to clearly indicate the opening of the windpipe, and I suggested this to the child's father, who at once said that that he would not under any circumstances allow the patient to be operated on. I thereupon sent for Dr. Hunter Mackenzie, who I knew had had an extensive experience of intubation in children. The father agreed to permit intubation, and this was accordingly performed by Dr. Mackenzie, who during the operation detached thick shreds of membrane from the larynx. For several days the child swam for his life, and it was only on the fifteenth day that the tube was permanently removed. On two or three occasions it was coughed up, and allowed to remain out for a few hours, until, in fact, the recurrence of laryngeal dyspnoea compelled its reinsertion. The urine, I may add, was laden with albumen. The child slowly recovered, with post diphtherial paralytic manifestations. Antitoxic treatment and bacteriological examination were not in vogue in this country when this case was under treatment.

My object in briefly recording this case is to direct attention to intubation, which seems to me a most valuable auxiliary to the treatment of diphtheria by antitoxin not only in such cases as Mr. Gornall's and my own, where the parents will not consent to tracheotomy, but in all cases in which, at or before the commencement of the treatment by antitoxin, laryngeal obstruction is present.

Edinburgh.

T. J. THYNE, M.B., F.R.C.P. Edin.

SCARLATINIFORM RASH IN INFLUENZA.

In the *BRITISH MEDICAL JOURNAL* of March 9th, p. 563, Dr. Ashby asked for observations of scarlatiniform eruptions in influenza.

On March 5th I saw a lady, aged 39, who had had influenza, with slight bronchitis, for three days. Some years ago she had an eruption diagnosed as acute eczema by her former medical attendant, and at the beginning of this year I had treated her for muscular rheumatism. When seen her temperature was 101.6°; the bowels had been constipated for three days, but the tongue was clean. There was a slight redness over the upper part of the chest, in front.

At 11 o'clock the same night I was sent for as the patient thought she had "erysipelas." I found the arms and legs and front of the neck almost covered with urticaria, and a few plaques over the lower ribs on the right side. There was a thick scarlatiniform rash all over the face, sides and back of

neck, chest, and upper part of abdomen; it also covered the lumbar region thickly, but faded away on the shoulders. The temperature was 103°; there was slight congestion of the fauces, but the tongue was clean.

The bowels acted freely and spontaneously in a few hours, and in twelve hours the urticaria had almost disappeared without spreading to the trunk. The scarlatiniform rash was also fading, and there was no trace of it on the second day. No desquamation occurred.

The patient said she had had facial erysipelas, but never remembered a previous attack of urticaria. The slight constipation and febrile disturbance of the alimentary tract may explain the appearance of urticaria, but the other eruption would seem to be of the class referred to by Dr. Ashby.

The only other case in which I have seen it was in a girl of 20, and I have since examined twenty or thirty cases for this symptom with negative results.

Bristol.

C. W. J. BRASHER, M.R.C.S., L.R.C.P.

RAILWAY SERVANTS' EYESIGHT.

THE two following cases may serve as supplementary to those recorded by Mr. Lawford in the *BRITISH MEDICAL JOURNAL* of March 23rd.

CASE I.—A. B., aged 30, a guard on one of the large railways, was recently examined and failed to pass the colour tests. His eyes were sound, and his vision normal, but he was the subject of red-green colour blindness. He had now been reduced to an inferior position with less pay on account of a defect which ought to have been recognised before he entered the service of the company.

CASE II.—C. D., a signalman in the employ of another of the large railway companies, came complaining of short sight. His distant vision was less than one-tenth ($\frac{1}{10}$) of the normal. He was found to have about four dioptries of myopia in each eye, and with proper correcting glasses his vision was practically normal. He carried in his pocket a pair of spectacles, without which he confessed that he could not be sure of signals, but he was obliged to be cautious in the use of his glasses, for he feared that if it became known that he had to wear spectacles he would be reduced or discharged. He said that his sight had never been tested by the company, but that recently they had been "getting more particular."

W. TILLINGHAST ATWOOD,

Ophthalmic Surgeon to the Torbay Hospital, Torquay.

A CASE OF SEPARATION OF AFTER-COMING HEAD.

At 2 A.M. on March 7th I was called to a collier's wife, who had been in labour at full time just twelve hours. This was her fourth child, and, labour being slow, the midwife sent urgently for me. It was a breech presentation, and on examination my finger came in contact with a rough edge of bone along the lower part of the spine, which proved to be a spina bifida. I hooked my finger round the thigh, and on making slight traction was astonished to feel the bone give way. After getting the body born, the arms gave way as did the thigh. Then I proceeded to get the head, foreseeing a possible separation, and, although only slight traction was made, the vertebræ cracked. I got my finger in the child's mouth to save the neck, and for half an hour tried with care to get the head; but the neck gave way and the head was left *in utero*. I then applied forceps; but there was nothing firm for them to hold by and they came off easily. On passing my hand into the vagina, I found the head very large and hydrocephalic.

I asked Dr. Berry, of Wigan, to assist me. We found the neck presenting. We then passed the perforator into the foramen magnum, one holding the uterus firm while the perforator was pushed through the foramen. There was some resistance, and, fearing the head might slip, Dr. Berry held the perforator while I put the forceps on. We had then a good hold of the head, and I was able to push the perforator home, opening it at the same time and turning it round to break up the brain matter. I next withdrew the perforator, and, passing the crotchet through the opening, was able to get a good purchase on the rim of the foramen magnum. Then we applied traction, the forceps well backwards and the crotchet downwards, until the head got below the brim of the pelvis; the head was then easily born. There was a rush of