these curve forwards and downwards in the manner of herpes, but they neither begin on the back nor are they continued forward to the middle line in front. They are very irregular in shape, and quite island-like in abruptness of definition, about as large as an outspread child's hand. These, as well as the others, present the ordinary condition of the smooth ivory patch with a border of congestion. The next patches are seen over the great trochanters, and from these a number pass downwards on the outer sides of the thighs, being here for the most part rounded and about the size of halfpence. Indistinct patches, definite but so slightly marked that they might easily have been overlooked, occur on both sides of the leg from the knee to within a handbreadth of the ankles. The uppermost patches—that is, those on the sides of the abdomen and over the trochanters are much thicker, more indurated, and more yellow than the others. On the lower parts of the thighs and on the legs the tint is a dead white without any mixture of yellow, and there is so little of the thickening that they are not easily distinguished by the finger. The smoothness of the skin, however, is quite evident in certain lights. There is a somewhat doubtful yellow discoloration just below the groin on each side, possibly due to the wearing of a truss. There is one white patch exactly under the truss on the back, but this is the only one which would suggest that pressure has had anything to do with locating the disease. Our patient is a man of 68 in excellent health; he says that he thinks he should never have discovered the patches but for seeing them, as they were at first unaccompanied by tingling, etc. He says that they have somewhat increased in size since he first noticed them.

VIII.—HERPETIFORM AND ACROTIC MORPHEA TOGETHER.

GROUP VIII.—Another important clinical group consists of cases in which localised or herpetiform morphea occurs in connection with diffuse or acroscleroderma. In most cases these two diseases are met with quite independently of each other, but in a few they are combined. In the case of a man of middle age, who was sent to me by Mr. Joseph White, of Nottingham,²¹ the patient exhibited large symmetrically-placed ivory patches on both sides of the abdomen, together with diffuse scleroderma of both hands and forearms and of the cheeks. It was the sides of the cheeks only which were affected, the nose, lips, and middle parts having wholly escaped. The disease had not been preceded by any symptoms of feeble circulation, but had set in rather suddenly about a year before I saw him. In estimating the relationship between Raynaud's phenomena and diffuse morphea or acroscleroderma, an inquiry must always be made as to the occurrence of paroxysmal duskiness—the “asphyxia” of Raynaud—and the development of the hidebound condition. In scleroderma there is, I think, always a tendency to paroxysmal aggravations, attended by pallor and risk of gangrene; but it may be doubted whether the venous turgescence, which is the prominent feature of asphyxia, ever occurs, and the most marked examples of the latter (that is, the most typical instances of true Raynaud) may go on for years without the slightest tendency to the sclerodermic condition.

A MODE OF MORE EASILY AND RAPIDLY DILATING THE CERVIX OF THE UNIMPREGNATED UTERUS.

By JAMES BRAITHWAITE, M.D. LOND.,
Obstetric Physician and Surgeon to the Leeds General Infirmary.

DILATATION of the unimpregnated uterus is necessary chiefly for two purposes, namely, for the treatment of certain cases of dysmenorrhœa, and in order to examine the uterine cavity with the finger for diagnostic purposes. The object of the following short paper is not to estimate the value or utility of dilatation, or to consider in what cases it should be done, but to point out that when it is done for either of the above reasons, the time chosen should be the last day of the menstrual period, just when the discharge is ceasing or has ceased. The directions given as to the best time for dilata-

tion in textbooks, if any are given (and usually there are none) are to dilate between the periods, and this I believe is the universal practice, and it is the one I myself always at one time followed. I have generally dilated with smaller-sized Hegar's dilators until some resistance is met with, which usually occurs when Nos. 9 or 10 are reached. Then a large laminaria tent is introduced, or possibly two or even three smaller ones. On the next day the dilatation is completed by the larger-sized Hegar's, and if a most unyielding os internum is met with, Reid's screw dilators are employed. I believe, however, that this plan is a mistake as to the time chosen, and as a sequence of this a mistake as to the mode of operating.

The os internum between the periods firmly resists dilatation, and only yields to considerable force. All who have tried the use of laminaria tents must be familiar with their appearance when withdrawn, showing a narrow ring corresponding to the tight undilated os internum, all the rest of the tent being fully expanded. Moreover, as stated, it takes two sittings on consecutive days to dilate with tents and dilators, and even then it is often very imperfectly accomplished. Not infrequently a rise of temperature and rigor will follow the introduction of a tent, and the continuance of these symptoms with pain may necessitate its early removal.

Rapid dilatation without tents in the intermenstrual interval must necessarily be imperfect, for if done by Hegar's, or Galabin's, or Duncan's dilators, great upward pressure is required to introduce them when the larger sizes are passed, and this pressure may be, and frequently is, so great as to cause the vulsellum or hook used to steady the anterior lip of the uterus to lacerate it, and possibly tear out. If the dilatation is begun with Hegar's dilators and continued with Reid's screw dilators the power is so great that the narrow parts must yield; this, however, cannot be called dilatation, but stretching, and is probably accompanied by minute lacerations of tissue. Unless the dilatation, in whatever way it is done, is thorough, a permanent cure does not result in dysmenorrhœa, and is insufficient to admit the finger if diagnosis is the object.

Many years ago I found out accidentally that if the dilatation is done on the last day of the period, just when the discharge has ceased, the parts are perfectly elastic and soft, and have very little resisting power. Hegar's dilators can in many cases be passed in, one after the other, until No. 17 is reached. This admits of the passage of a medium-sized index finger. An anæsthetic is necessary, as the patient would not remain sufficiently quiet. Two Sims's hooks close together, so that the handles are held as one, are better than a vulsellum. They hold better, and are less likely to scratch the operator's finger. The process should be done leisurely, but it does not take above twenty minutes. The smaller sizes of the dilators should have the terminal inch a little curved forwards and less in size, so as to enter more readily.

This plan opens up quite a vista of utility in other cases than those of dysmenorrhœa; for instance, it is often next to impossible to examine with the finger the interior of the uterus of a sterile woman over 40. The parts absolutely refuse to dilate sufficiently. But by dilating on the last day of the period it can be done very easily. Every uterus does not yield so readily as described, and, indeed, now and then a tough cartilaginous os internum is met with which almost refuses to yield at all, but even this is more dilatable than it would be in the intermenstrual interval.

A very interesting case of menorrhagia was recorded some years ago which had been under two of the most eminent men in the country, and in which subsequently the womb was removed entire on the Continent. It was then found that the cause of the hæmorrhage had been a small fibroid not as large as a boy's marble. This had never been diagnosed.

Another case was read before one of the London Societies, in which vaginal hysterectomy was performed in consequence of incurable hæmorrhage. It was thought to be cancer of the uterine cavity; but on examination of the uterus after removal, the cause was found to be a small fibroid polypus projecting into the cavity near one cornu. In these cases, if the finger could have been inserted for examination no doubt it would have been.

By adopting the plan recommended such examinations

²¹ *Archives*, vol. iii, p .

become easier, although such small fibroids and so situated as in these two cases must always be very difficult to diagnose. Much assistance is given by curving the intra-uterine finger well forwards and pressing the fundus down upon it by the right hand outside. For this purpose the patient should lie on her left side, as the recti muscles are thereby relaxed. It might be supposed that the anæsthetic would cause sufficient relaxation; but it often does not.

In conclusion, the advantages of the plan recommended are:

1. Danger from sepsis by the use of tents is avoided.
2. Inflammation, if rise of temperature with rigors and much pain indicate it—traumatic rather than septic—is also avoided.
3. The process, both to patient and operator, is more easy, and is incomparably quicker.
4. Less structural injury is done to the parts, as they dilate more kindly and without much resistance.
5. The dilatation is more complete and perfect, so that if used for dysmenorrhœa a permanent cure is more likely to result, and if for diagnostic purposes, examination is possible in cases in which otherwise it would have been impossible.

MEMORANDA:

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

A STONE EMBEDDED IN THE ARM FOR SEVEN YEARS.

RECENTLY a man came to me complaining of most severe pain in his forearm. On examination I found the anterior aspect of the forearm to be very much swollen, livid, and indurated over a great area, at the centre of which was a small opening the size of a pin's head, about 4 inches from the bend of the elbow. He had met with a somewhat trivial accident some seven years previously: a fall while trying to escape from a shot about to be fired down a coal mine.

The result was a small wound on the posterior aspect of his forearm, which bled profusely at the time. He immediately proceeded to the colliery surgeon, who dressed the wound, which healed in the course of a few days. After that he returned to his work. In about two years he complained of pain at the seat of the old injury, and becoming unable to work, he again visited the surgeon, who painted the painful spot with various lotions and liniments, but without success. The patient, however, managed to go to work, off and on, until September, 1894, when he was forced to give up, owing to the most excruciating pain, sleeplessness, and anxiety.

He consulted various medical men, who advised rest and poulticing, but without success. When he came to my surgery I probed the pin head opening to the depth of 3 inches, and there detected a foreign body. I had to coax him for a long time before I could get consent to make an incision. After great deliberation he gave in, and the result was that I extracted, with a slight twist of the dressing forceps, an irregular piece of rock, which had become rooted in the depths of the forearm; it weighed $11\frac{1}{2}$ grains, was half an inch long, and three-eighths of an inch broad in its widest dimensions.

I dressed the wound with antiseptic dressings for five weeks, when it healed up well. The man has since resumed his duties with no ill effects, except that he has had a very slight tingling sensation in his little finger and half the next finger, the area which is controlled by the ulnar nerve. I attribute the tingling sensation to a slight twig of that nerve becoming attached to a little puckering at the corner of the wound.

I think the foregoing case deserves mention for the following reasons: First, that the patient was able to work off and on for years; and, secondly, that the removal of the fragment of rock should occur at the end of the seventh year.

W. OWEN EVANS, L.R.C.S.,
L.R.C.P., L.M. Edin., L.F.P.S. Glasg.

Buckley, near Chester.

THE ADJUSTMENT OF AN ARTIFICIAL NOSE.

THE case described by Mr. Arthur S. Underwood, in the BRITISH MEDICAL JOURNAL of June 1st is very similar to one I undertook many years ago, at the request of Mr. Skey. The disease had been the same, only more severe, as the whole of the nose had been lost with some portion of the face as well. The patient, also a female, came to me wearing an artificial nose constructed of very thin metal, and retained in the usual manner by spectacles. The pressure of the latter caused soreness and at times ulceration of the skin. My method of procedure was somewhat different from that adopted by Mr. Underwood. I constructed a model of the parts, to which I adapted a cast of a nose from the human face, and thus obtained a vulcanite representative which adapted itself accurately to the face and caused no inconvenient pressure whatever.

There was an element of the comic in my case. First, the patient insisted on having a nose of the perfect Grecian type, though I felt confident that hers, like her twin sister's, had been decidedly *retroussé*; however, I was able to accommodate her. The colouring of the appliance was kindly undertaken for me by a friend, a portrait painter of some eminence, who told me it was the most difficult nose he had ever attempted to paint. He succeeded admirably; but still there was this defect: If the lady, as she often did, became flushed, the nose appeared distressingly anæmic; on the other hand, if she became pallid, the nose then looked—well, almost suspicious! However, I think I may say that both Mr. Skey and the patient were fairly well satisfied.

Streatham.

ALFRED COLEMAN, F.R.C.S. Eng.

A NOTE ON THE ETIOLOGY OF APPENDICITIS.

AMONGST the numerous causes which have been given as directly or indirectly leading to inflammation of the vermiform appendix no decided question of heredity has arisen. Yet if the large amount of lymphoid tissue in the appendix predisposes to inflammation of its lining membrane, knowing the hereditary tendency of lymphoid tissue to become inflamed, heredity may play a not unimportant part in appendicitis. There is, moreover, I believe, much truth in the idea which regards persons liable to sore throat, and overgrowth of lymphoid tissue there, as liable to appendicular mischief, and tendencies to throat affections of this nature are certainly hereditary.

The following cases, occurring in one family in my practice, are in this connection worthy of note. The father, whose family history was good, died from diabetes mellitus when the youngest patient was 14, and suffered for many years from repeated attacks of what was apparently appendicular colic, but no *post mortem* examination was allowed. The mother is a healthy woman, but one of her sisters and one of her brothers died from phthisis and a child from tuberculous meningitis. The three patients now to be mentioned were fairly strong adolescents, without any rheumatic tendencies, living in a large house in comparative luxury.

C. Y., an athletic young man, aged 24, frequently has had simple pharyngitis; a severe attack of appendicitis, followed by slow convalescence, occurred in October, 1892.

P. Y., brother to the above, aged 21, also liable to pharyngeal catarrh. A moderately severe attack of appendicitis occurred in July, 1893.

M. Y., sister to the above, aged 21, has enlarged tonsils, and frequently has pharyngitis. Is now convalescing from a comparatively mild appendicitis.

Newcastle-on-Tyne.

G. ARMSTRONG ATKINSON, M.D.

"HERNIOTOMY UNDER DIFFICULTIES."

ON September 16th, 1894, last, when visiting a patient some dozen miles by train, I was asked to see "another case" about a mile distant in a very remote country spot. I found the patient, a widow, aged 62, suffering from symptoms of intestinal obstruction. The vomiting, which was almost incessant, set in on the evening of September 12th, and for the same period (96 hours) the bowels had been absolutely constipated.

In searching for a cause I found (for it was not visible) a left femoral hernia about the size of a bantam's egg, and

¹ Read before the South Wales and Monmouthshire Branch of the British Medical Association.