Condition on Admission.

He was suffering from severe pain in the left half of the thorax, shooting from the spine along the track of the intercostal nerves from the fourth to the sixth; most severe in the flank and inframammary region, and shooting across the epigastrium. The pain was said to vary by change of posture, being relieved by turning on the left side and aggravated by lying on the back, but it was doubtful if this was the fact. In person, on admission, he was well nourished, but was pale and looked very ill. The tongue was greatly furred and coated with grey, the pulse was small and contracted; it became hard when the pain was especially severe. There was slight tenderness on percussion over the lower dorsal vertebrae, and marked tenderness in the left flank and inframammary region of the chest; none in the epigastrium. The lung signs and heart sounds were natural; a weak apex beat was felt about $\frac{1}{2}$ in. to the left of the normal situation; the left inframammary region was hyper-resonant; nothing abnormal was detected in the abdomen; abdominal breathing was intact.

History.

The pain precluded any extended inquiry into past history. The patient said it had attacked him suddenly on the 17th, and had continued ever since, lessening when he kept still, and increasing when he moved about or lay in certain positions. On January 22nd he had attended the hospital as an out-patient. He then complained also of "soreness of the chest," and some catarrhal sounds were heard over the lungs; but no physical signs were found to account for the pain. Later in the day he vomited about half a pint of blood. This was repeated once on the same day, twice on January 23rd, and once on the day of admission.

Treatment and After-History.

The most plausible presumption, notwithstanding the absence of direct evidence, being that there was an intrathoracic aneurysm, oozing into the oesophagus, the patient was placed on rectal alimentation and morphine administered subcutaneously. At 8 p.m. he vomited 14 oz. more of blood; and another 5 oz., bright red and frothy, at 4 a.m. Morphine was again given hypodermically, and Ruspini's styptic internally. The patient sank and died without further symptom.

After his death, his wife informed us that the onset of the illness was sudden pain in the chest and difficulty of swallowing, coming on as he was eating a potato.

Necropsy.

A necropsy was made by Dr. Salusbury Trevor, who reported to the following effect: On the anterior wall of the oesophagus were two injected areas, each about the size of a sixpenny bit, one at the level of the cricoid, and the other $\frac{2}{3}$ in. lower. In the middle of each a scratch could be seen with a hand lens. Below the lower injected area was a longitudinal scratch, leading downwards towards a traction diverticulum in the usual situation above the right bronchus. Opposite this pouch, on the left postero-lateral aspect of the oesophagus, was an oval opening, nearly $\frac{1}{2}$ in. long and $\frac{1}{4}$ in. across the centre, where the edges were ragged, from which projected, with the head towards the mouth, an ordinary pin $\frac{1}{2}$ in. in length, blackened, roughened, and a little bent. The pointed end was engaged in the hole. In the wall of the aorta (descending part of the arch), at a slightly lower level than the hole in the oesophagus, was a small ragged opening, to which clot adhered, and from which a probe could be passed directly into the oesophagus. The aorta and oesophagus were adherent along the left side of the latter from the wound downwards, and the tissue between them infiltrated with blood nearly down to the diaphragm. The aorta was rather atheromatous and partly dilated. The alimentary canal was otherwise healthy, but the stomach contained a pint of blood, and the whole intestinal canal was full of blood, emitting an offensive odour.

Dr. Trevor concluded that the pin had been swallowed head downwards, the head being arrested in the pouch and the point accordingly tilted against the opposite wall, in which it stuck. Death was obviously from loss of blood.

As no inquiry obtained from the patient elicited the necessary clue subsequently furnished by his wife, so exceptional a lesion was undiagnosed during life. The seat of the disease could be surmised without much difficulty; the sensory nerves of the parts affected are partly derived from the vagi and partly from the first four or five dorsal ganglia, chiefly of the left side, which are in direct communication with the adjacent intercostal nerves of the same side. The source of pain was presumably the stretching of the parts infiltrated with blood, which had extended as low down as the diaphragm. The subsidence of the blood downwards probably accounted for the fact that it was the intercostal nerves connected with the lower of the said dorsal ganglia which were the chief seat of pain.

The specimen, which was shown by me at a meeting of the West London District held at St. George's Hospital on March 25th, will shortly be placed in the Hospital Museum as No. 5328.

REQUESTS TO HOSPITALS.—Among the legacies bequeathed under the will of the late Mr. Henry Noble, Norwegian and Swedish Consul in the Isle of Man, are £1,000 each to the Seamen's Hospital and the Eye and Ear Infirmary in Liverpool.

THE EPIDEMIOLOGY OF PLAGUE: NOTE ON THE FLEAS OF RATS.

By FRANK TIDSWELL, M.B., CH.M.SYD., D.P.H.CAMB.,
Principal Assistant Medical Officer to the Government of
New South Wales.

IN opposition to Simond's hypothesis that bubonic plague is disseminated by fleas from infected rats, it has been urged that the fleas of rats will not bite human beings. Simond himself, whilst admitting his inability to pronounce upon the species of the fleas found by him upon rats, nevertheless clearly states that they bit human beings upon whom they were placed. Professor Galli Valerio, of Lausanne, has reported that the species of fleas found by him upon rats are *Typhlopsylla musculi* and *Pulex fasciatus*, and that neither of them will bite man. Simond's observations were made in India and Galli Valerio's in Europe, and it seemed by no means improbable that their conflicting results were due to the fleas found by them being of different species.

It does not follow that the fleas harboured by the rats in two widely different places would be exclusively of the same species. With a view to determine this point a collection of fleas was made from the rats coming under my examination during the recent epidemic of plague at Sydney. Of 100 fleas obtained, 10 were identified as *Pulex fasciatus*, 8 as *Typhlopsylla musculi*, 1 as *Pulex serraticeps*, and 81 as *Pulex pallidus*. It will be seen that no less than four species were represented, and most abundantly one (*pallidus*) not hitherto mentioned, as far as I am aware, as occurring on ordinary rats. Its stated hosts are *Mus albipes* of Socotra and *Herpestes ichneumon* of Egypt. This species bit us in laboratory trials, as did also *Pulex fasciatus* upon one occasion. *Pulex serraticeps* is well known to attack man. The remaining species, *Typhlopsylla musculi* did not bite us. The details of the observations form part of a forthcoming official report, but in the meantime it may be noted that they tend to remove an otherwise fatal objection to Simond's views.

POTASSIUM PERMANGANATE IN THE TREATMENT OF LUPUS.

By J. HALL-EDWARDS, L.R.C.P.,
Surgeon Radiographer to the General Hospital, Birmingham.

DURING my observations of a large number of cases treated by means of the x rays I have tried the action of a number of drugs in conjunction with the rays. Some have been used for the purpose of bringing about a more speedy reaction; others with the object of limiting the dermatitis. During these experiments I was early struck by the good effects produced by potassium permanganate, not only as an adjunct to x-ray treatment, but in clearing up patches left after the administration of the rays.

After having used the drug for a considerable length of time, and in a variety of ways, I discovered that the treatment of lupus by this means was not new; and my attention was drawn to an article in the BRITISH MEDICAL JOURNAL, April 5th, 1902. It appears that the use of this drug for the treatment of lupus vulgaris and erythematous was first suggested by Butte. In the article mentioned Dupuy gives the results of his observations on a number of cases treated by Butte's methods. Butte used a compress of a 2 per cent. solution of potassium permanganate, which was applied for twelve to fifteen minutes daily, for about a fortnight, or, in non-ulcerative patches, the powdered drug was spread over the part with a spatula, a piece of dry absorbent wool applied, and the whole left on the part for a quarter of an hour. This latter method is somewhat severe, and produces a considerable amount of inflammation. Dupuy maintains that the action of permanganate is more rapid than scraping, and the resulting cicatrices are softer, flatter, and less likely to contract than those following other methods. One disadvantage (he says) is that the tissues are considerably stained.

After trying many methods I have now for some time used one, with such good results, that I make no apology for bringing it before your readers. I use a saturated solution of the salt, which is made by dissolving a drachm in an ounce of distilled water. In non-ulcerative cases I first wash the patch with carbolic or ichthyol soap, and afterwards wipe it over with a pledget of cotton wool moistened with methylated spirit. When dry I apply the solution of potassium

permanganate with a brush. In cases covered with crusts the surface is cleaned as well as possible without removing them, and the crusts themselves are saturated with the solution. The applications are repeated every day or every other day until relief is obtained.

In many cases of lupus treated by the *x* rays, the centres of the patches rapidly get well, whilst the edges continue to spread slowly. In these I have met with my best results. In most of these I have continued the *x*-ray treatment in addition to the application of permanganate, so that it is difficult to judge the effects of either method alone. Recently, however, I have treated several cases with the permanganate alone, and have been surprised at the results obtained. In several typical cases of large areas of lupus, where the centres of the patches have undergone cicatrization, whilst the edges have been marked by a thick line of dry crusts, two applications of the paint have caused the crusts to fall off, leaving a dry, healthy scar behind them, the active points remaining being painted over and over again until they finally disappear. The potassium permanganate treatment appears to have little or no effect upon those indurated, shiny, non-ulcerative, slow-growing patches, which are so difficult to treat either with light or the *x* rays. In all other cases the method suggested is worthy of consideration, and I shall be most anxious to hear of the results achieved in other hands. As an adjunct to *x*-ray treatment I consider potassium permanganate invaluable. I am trying its effect in several other diseases, and shall hope to report thereon on some future occasion. I have not noticed any staining result from this method of treatment.

REFERENCE.

¹ *Thèse de Paris*, 1901.

MEMORANDA:

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

PYREXIA AND RIGOR FOLLOWING DOUCHING IN THE PUERPERAL WOMAN, WITH A THEORY OF THEIR CAUSATION.

DR. SYKES'S communication on the above subject in the *BRITISH MEDICAL JOURNAL* of May 16th, p. 1145, is interesting and suggests food for reflection.

A good many years ago I had a case that might be said to come under this category. A thin anaemic person had had a tedious labour owing to inertia, but was progressing satisfactorily enough until the third or fourth day, when the nurse administered a douche of Condy. The same evening I was sent for and found the patient in great distress, and with a temperature of 103°. Thinking that the nozzle might have entered the uterus, I proceeded to examine the position and condition as to dilatation of the os, and in doing so discovered a large clot imprisoned, on the removal of which all trouble speedily disappeared, the temperature being normal next morning. I was thus led to regard the clot, with commencing sapraemia, as the cause and the use of the douche as a coincidence.

Sunderland.

B. STRACHAN, M.B.

TURPENTINE IN THE TREATMENT OF PNEUMONIA. I wish to bring to notice the usefulness of turpentine in the treatment of pneumonia, those cases more especially which too often complicate influenza. For many years I have used this drug in these cases, and such is the result of my experience—which is fairly extensive—that I have come to regard it almost as a specific. I can recall cases of the worst type recovering by its use, and seldom have I known it fail. It must, however, be given early, persistently, and in adequate doses.

My usual method is, after giving an efficient dose of calomel, to prescribe the following mixture:

R. Ol. terebinth. pur., 3ij to 3iv
Pulv. trag. coꝝ, 3j
Spt. amm. arom. } 3ss 3ij
Spt. chloroform. }
Aq. ad. 3viij. M.

Sig., two tablespoonfuls every four hours.

Patients take this mixture—it is not so unpalatable—without demur, and it hardly ever disagrees. Amelioration of symptoms is soon apparent, and it is wonderful how it cleans and moistens a dry, furred tongue, improves the appetite, and

keeps the bowels open. Children take it without difficulty and it acts well on them. On two occasions only have I known it produce stranguary and once diarrhoea. Once or twice I have given a drachm every four hours, but the usual dose is from 15 m to 30 m; children in proportion. The virtue of the drug probably lies in its antiseptic properties, and the ease by which it is absorbed. It is also a stimulant and so much safer to administer than the depressing coal-tar products.

Perhaps what I have tried to say is not very convincing, and I will conclude by stating that if medical men will only give the oil of turpentine a fair trial in pneumonia they will find it a safe and most effective remedy in this, one of the most fatal of acute diseases.

Rhyl.

W. THOMAS, M.R.C.S.Eng.

CHICKEN-POX ERUPTION ON THE CONJUNCTIVA.

I THINK the above condition must be of sufficient rarity to be worth noting, as I can find no mention of it in the textbooks. It occurred in the case of a child aged 2½, and was in the form of a distinct pock on the bulbar conjunctiva at the outer canthus of the right eye. The eruption was present on the mucous membrane of the mouth, and there was marked enlargement of the lymphatic glands all over the body. The child was quite unconscious of any inflammation in the eye, and there was practically no constitutional disturbance, the disease running its usual mild course.

Guards' Camp, Pirbright. ALLAN C. PEARSON, M.B., D.P.H.

CASE OF ACUTE ALCOHOLIC POISONING IN A CHILD, AGED 6 YEARS.

IN the *BRITISH MEDICAL JOURNAL* of May 16th, Mr. Forster reports a case of recovery from alcoholic poisoning in a child of 4 years. In his case the child had taken 2 oz. of neat whisky. Some months ago I had to treat a case in which a child of 6 years had taken 9 or 10 oz. of pure whisky and yet made an excellent recovery.

On December 2nd, F. B., a little boy, aged 6 years, was found by his parents at 8 a.m. sound asleep in bed with an empty whisky bottle beside him. The father stated that the bottle, of a pint capacity, was left by him half full on the table the previous night. At 5 a.m. the father and mother heard the boy get out of bed but thought nothing of it. It appears that the boy had taken the bottle to bed with him at that time and drunk the contents. On trying to waken the child at 8 a.m. the parents could not rouse him, and therefore at once sent for me. I found the boy lying on his back with face deeply suffused. He was deeply comatose; the pupils were widely dilated and fixed; the conjunctival reflex was absent; the pulse was small, very rapid and irregular, and could not be counted; respiration was deeply stertorous. Without delay I passed the stomach tube, and washed out the viscus five or six times until the liquid returning was perfectly clear water. The liquid first withdrawn smelt strongly of whisky, and was mixed up with much "coffee ground" material, evidently proceeding from the congested mucous membrane. A hypodermic injection of strychnine (gr. ½) was then given and repeated in half an hour. Thereafter the child was flicked over the face and chest with cold wet towels. Recovery was rapid. In about an hour the conjunctival reflex returned, and although the boy remained dull and somnolent throughout the day he was perfectly well again next morning.

The interesting points in this case are (1) the large amount of spirit taken—at least 9 oz. of neat whisky; and (2) the fact that although three hours and a half had elapsed before treatment was commenced, recovery was rapid.

Muswell Hill, N.

J. D. R. MONRO, M.D.

REPORTS

ON
MEDICAL AND SURGICAL PRACTICE IN THE
HOSPITALS AND ASYLUMS OF THE
BRITISH EMPIRE.

PUBLIC HOSPITAL, KINGSTON, JAMAICA, W.I.

TUMOUR OF LEFT KIDNEY WEIGHING 9 LB. 10 OZ.: REMOVAL.
RECOVERY.

(Reported by J. ALDRED ALLWOOD, M.B., M.S.)

M. G., black, aged 36, was admitted on September 1st, 1902.

History.—Eight years ago he noticed a small swelling in his