seems to have been made only in three; and in only two of these, one in Trask's series and the other my own case, was the diagnosis thought sufficiently probable to justify opening the abdomen. In the histories we read that many of the cases were thought to be due to, for example, acute peritonitis, rupture of the liver, colic or lead poisoning, and so on.

In regard to treatment, I think it is a point of much significance that the only case that recovered in all the seventeen cases, was one that was treated by gastrotomy two hours after the accident. In my own case, the operation was done eleven hours after the accident, and the patient had already lost a very large quantity of blood. The rupture was still bleeding a little at the time of the operation: had the operation been done several hours earlier, the prospect would have been very much better. On the whole, when the history, and particularly the sudden onset of symptoms, render a diagnosis of rupture of the uterus, or of rupture of an extra-uterine gestation, probable, I think an exploratory incision would be the best treatment to pursue.

To recapitulate.—(1) The expression "rupture of the uterus during pregnancy" should be limited to cases where the fetus has not reached a large size. Cases of premature labour should not be included, as then the causes producing rupture of the uterus during labour come in, which are of an entirely different nature. (2) Ruptures of the uterus from direct violence or from attempts at criminal abortion should be excluded, the cause of the accident here being evident. (3) The evidence that pathological softening of the uterine tissue is the cause of so-called spontaneous rupture of the uterus in pregnancy is altogether unsatisfactory. Though it is not intended to deny that morbid softening of the uterine tissue, when there is proof that it exists, would be a sufficient explanation of the rupture. (4) It is here suggested that limiting the expression rupture of the uterus during pregnancy in the manner described, this accident is always due to the presence of an interstitial gestation. (5) That cases where the diagnosis is fairly probable should be treated by exploratory incision.

ON LICHEN ANNULATUS SERPIGINOSUS (WILSON).

By T. COLCOTT FOX, B.A., M.B. LOND.,

Physician for Diseases of the Skin to the Westminster Hospital.

AMONGST the late Sir Erasmus Wilson's *Portraits of Skin-Diseases*, published in 1847, is a representation of what is described as a peculiar form of lichen. It is illustrated, also, in the collection at the Royal College of Surgeons, and in that at Guy's Hospital, and is a form of eruption well known to those specially interested in the subject. To sum up the eruption shortly, it is characterised by a considerable number of rings, generally situated on the upper part of the back and the breast, and liable to be mistaken by the unwary for tinea versicolor. It commences by tiny papules, which become flat, erythematous discs, half an inch in diameter, bounded by a sharp and defined margin. As they spread circumferentially, they project all round, or at some portion of, their borders bright red papules, and rapidly increasing in diameter to one, two, or more inches, they are converted into rings or segments of circles with a tawny centre covered with a corrugated cuticle, or even slight mealy exfoliation. By confluence, the rings may form an extensive patch, upon and around which traces of circles are visible. The papules may be entirely absent from some patches, and the margin be simply raised and frayed. The affection is chronic and itchy, and its distribution over the sternum and in the hollow of the back between the shoulders very characteristic. Wilson says that, whilst this is the usual distribution in young men, in elderly people it chiefly occupies the loins, and in women the limbs as well as the trunk.

Now, although this eruption is well known, its exact nature has been a subject of much discussion, and, amongst other things, a parasite has been strongly suspected, but not proved, to be the cause. An attentive examination of the cases coming under my notice has led me to the conclusion that the name lichen is a misnomer for it, and that it is in reality a peculiar phase of seborrhœa.

A point to be noticed before proceeding further is the fact that this affection is not recognised out of England, as far as I know, under the name here given to it. Turning our attention now to seborrhœa, it appears, on reference to the literature of the subject, that seborrhœa of the face has been universally recognised since Biett, and later on Rayer, first described it. I do not find any mention, however, of seborrhœa of the body or limbs by French writers, such as Bazin and Hardy, or by English writers. Hebra, it is true, described a widely diffused form of oily skin (*S. oleosa*) and a generalised *S. sicca*, but the latter is only what we understand by the pityriasis of various

wasting diseases, especially tuberculosis. In the United States different views exist. Van Harlingen, writing in 1878, says, "there is one variety of seborrhœa sicca, which is essentially the same disease as those just mentioned. This is found in its most characteristic form on the chest and back, in the shape of nummular or annular patches, made up of a reddish base, surmounted by yellowish, brown, fatty, pellicle-like scales, occasionally massed together to form a greasy coating." He found extensive fatty degeneration of these scales, and noticed that they left a greasy stain on a piece of paper. Bulkley wrote to much the same effect; and Duhring, in his well known work, gives an excellent account of seborrhœa corporis; and the point I wish to bring out is that I do not think anyone can doubt that he is describing Wilson's lichen annulatus.

The question will, no doubt, be put, "Allowing this, are they right in the United States, in including this so-called lichen with seborrhœa?" I think so, and on the following grounds. Seborrhœa certainly takes on a different aspect in various portions of the surface. We all know that, in extensive seborrhœa of the scalp, the skin beneath the fatty crusts is usually of a characteristic ashy-grey colour; but when, as is frequently the case, the disorder extends beyond the hairy scalp on to the forehead, the skin assumes a bright congested aspect, like an eczema, and the surface is but scantily covered with greasy scales. Then, again, on the face, the different phases of seborrhœa, with varying degrees of congestion and scaling or crusting, are well known. Further, the so-called lichen annulatus is often associated with seborrhœa of the face and scalp, and the remarkably greasy coating of the eruption on the body is very striking under the microscope. I ought to mention that I have never detected the presence of a fungus. Lastly, I would add that many cases coming under the category of *L. annulatus* are less marked than in the typical case portrayed by Wilson; and, in such cases, the papulated rings are the exception, and the bulk of the eruption is made up of patches indistinguishable from seborrhœa of the forehead. I will give, very shortly, one or two such cases.

CASE I.—A gentleman, aged 25, consulted me lately for a chronic disease of the scalp, axillæ, and chest. The scalp was the seat of marked seborrhœa, extending on to the forehead. The hollow of each axilla was mostly occupied by a somewhat infiltrated, uniformly dull red patch, never weeping, and covered with slight greasy scales. On the chest were several oval or rounded patches, one as big as the palm of the hand, faintly red, with a brighter border and a few erected follicles. There was no clue to any eczematous lesions past or present.

CASE II.—A gentleman, aged 23, was sent me for moderately severe seborrhœa of the scalp. On each side of the nose and on the cheek was a broad irregular band, half an inch wide, faintly reddened, not actively inflamed, covered with little adherent scales, greasy, but never weeping. This face-eruption was very chronic, and reminded one of some slight cases of lupus erythematosus, but there was no trace of scarring, and no clue to the formation by the confluence of discs. The point of the nose was the site of a similar, though fainter, patch with plugged follicles. On the chest were several similar, more or less rounded areas, but the lowest one was very significant. It was the size of half the palm, irregularly oblong, pinkish in colour, with very little scaling or infiltration, and simulated a ringworm by the appearance of projection and freshness of the border, which was studded with a number of small, congested, and erected follicles. A few papules existed, also, over the surface, and it was evident that, as the patch spread, the follicles were specially involved, and, later on, the congestion mostly subsided. The scales were crowded with oil-globules and granules.

CASE III.—A Scotch gentleman was sent me, with typical seborrhœa of the scalp, extending to the forehead and temples, also across the bridge of the nose and adjoining portion of the cheeks. The chest looked, at the first glance, as if it were the seat of tinea versicolor, but the fused irregular patches with scattered congested follicles were redder. One patch was ringed with a few papules on the border. The original characters had been much altered by the use of strong soaps.

It would be easy to multiply instances of this kind, which show, I think, the occurrence of seborrhœa on the trunk, and connect it with the lichen annulatus portrayed by Wilson. I have already mentioned that the latter is frequently associated with seborrhœa of the scalp.

In conclusion, I will add that, besides papulated ringed patches and non-ringed patches without special congestion of the follicles, I have met with another variety in which a triangular area of character-

¹ I have made a prolonged search lately by various methods of staining in several typical cases, but have failed to find any organisms but micrococci.

istic shape on the back, was occupied almost entirely by erected follicles, and there existed only one or two little macules, and a ringed patch which gave me the clue to the nature of the disorder.

SURGICAL MEMORANDA.

ROTATION OF KNEE-JOINT.

On the evening of November 23rd I was summoned to see J. H., a boy aged 12. He had been "sky-larking" with some other boys, and was thrown down heavily, apparently when in the act of turning round. The right knee was semi-flexed when seen, and the leg rotated upon it, so that the anterior edge of the tibia looked forwards and outwards, and the outer surface of the fibula backwards and outwards; but the tibia was not dislocated in any other direction forwards, backwards, or laterally. Reduction was easily effected on acute flexion of the knee, and the leg slipped into position with a creaking sound in the joint. There has been no inflammation or swelling of the joint since. The interest of this case seems to be not so much in the rotation as in its being unaccompanied by dislocation in any of the four possible directions, the previously described cases having, I believe, been almost invariably accompanied by dislocation outwards.

MARCUS H. BULTEEL, M.R.C.S.,

Assistant-Surgeon to the Royal Albert Hospital, Devonport.

SUBCORACOID DISLOCATION OF SHOULDER REDUCED BY RIGHT-ANGLE TRACTION.

J. G., aged 85, sustained a dislocation of the right shoulder, the head of the humerus resting under the coracoid process. I directed the mattress on which he rested to be placed on the floor; and, fearing that his weight (about 115 lbs.) would not be sufficient to act as counter-extension, I passed a roller towel round the thorax, giving the end to an assistant, desiring him to "hold against" me. Grasping the arm above the wrist, I made steady traction, at the same time gradually raising it from the side; when at a right angle from the body, I ceased to elevate, but maintained the traction, and, in less than five seconds, the bone went into place with a faintly audible snap. When the arm was raised, the discomfort lessened, and the patient bore the manipulation with less complaint. I substituted the towel for counter-pressure by the foot, as I was uncertain of the elasticity of his ribs. I have, on former occasions, reduced dislocations in the same manner, but unintentionally—that is to say, I was endeavouring to carry out White's method, or one of its modifications, and I presume many others have had similar experiences.

JAMES H. PARKINSON, L.R.C.S.,

City Physician, Sacramento, Cal.

DISLOCATION OF THE HUMERUS REDUCED BY RIGHT-ANGLE TRACTION.

In his memorandum on the above subject in the BRITISH MEDICAL JOURNAL of November 6th, Fleet-Surgeon W. Digby Longfield speaks of "steadying the shoulder with his left hand." Now, as I think that the acromion has not hitherto been sufficiently made use of as a point at which the scapula may be fixed, and counter-extension be advantageously applied, I venture to bring forward, without claiming any merit of priority, a "variety" of the right-angle traction method of reduction which I first tried in 1859, when house-surgeon at the London Hospital, and have used since then in my army practice. It is briefly as follows: the patient being seated, the surgeon stands by his side, places the palm of his right hand above the inner condyle of the humerus, grasps the arm, and raises it to a right angle with the patient's trunk; he grips the patient's wrist firmly between his own arm and right side. Then, having placed the upper margin of his left palm on the prominent acromion, he makes steady traction on the arm to disengage the head of the humerus from its abnormal position, at the same time making counter-pressure on the acromion in a direction inwards and somewhat downwards; the head of the bone is then lifted into the glenoid cavity by making use of the patient's arm as a lever of the third kind, the fulcrum being at the wrist, firmly fixed to the side of the operator.

The force required for reduction by the right-angle methods is, as stated by Dr. Macleod and Fleet-Surgeon Longfield, comparatively small; but, with the hand on the acromion, considerable traction-power can be used, if necessary; the surgeon's knee, too, may be placed against the axillary border of the scapula.

It is time that the old heel-in-axilla method should be altogether

discarded; it cannot but tend to produce still further laceration of ligaments and muscular fibres.

E. H. LLOYD, M.B., F.R.C.S., Brigade-Surgeon R.P.

PLUGGING THE POSTERIOR NARES.

THERE is often considerable difficulty in getting a string from the anterior nares round by the pharynx and out at the mouth, preparatory to performing this operation; and various appliances have been devised for the purpose. For several years, I have always resorted to the following method, and found it both easy of application, efficient, and handy, as the apparatus is always obtainable. Take a piece of twine of sufficient length, and fasten to the end of it a pledget of lint or rag, the size of a large pea, or a small globular button with a neck does very well. Then form a ring about a quarter of an inch in diameter, on the small end of a silver probe or piece of wire, and bend it down. Run the twine through the ring till the pledget or button is close against it. Then pass the wire or probe along the floor of the nose; tell the patient to hawk, and spit out, and at once the pledget with the twine attached is ejected.

JAMES BRYDON, M.D., Hawick.

CLINICAL MEMORANDA.

PREVENTION OF IRRITATION OF THE AUDITORY MEATUS.

IN the treatment of discharge from the middle ear by insufflation of boracic acid, a good deal of trouble is sometimes caused, especially in frosty weather, by the mixture of discharge and boracic acid causing irritation of the meatus. A good deal can be done to prevent this by drying the meatus well with the cottoned probe before using the acid, so as to prevent deposit of the powder on moist spots, to which it adheres, and to allow its free passage towards the membrane. I have found the following expedient very serviceable. After the powder has been blown in, a small piece of absorbent wool is rolled tightly round the end of the probe, which is then introduced into the meatus, and carried round its circumference, so as to remove all adherent particles. The probe having been withdrawn, the wool is removed, and a fresh piece applied as before; this time, however, it is dipped in eucalyptus and vaseline ointment (one of the oil to seven of vaseline in a good proportion), and the probe is again carried round the meatus. The ear is now closed in the usual way with cotton, medicated or otherwise. When the discharge is not excessive, I think the above treatment will be found not only to prevent irritation, but to cure it when it has occurred.

DUNCAN J. MACKENZIE, M.D., Glossop, near Manchester.

BLACK TONGUE.

IN the JOURNAL of October 2nd there is an account of a case of the above, and I am desirous to call attention to one that came under my notice about two years ago, while I was assistant to Dr. Lyall, J.P., Leven, with whose kind permission I publish it. The patient was a rather neurotic woman, about 37 years of age, whose nervousness was, no doubt, added to by a complication of diseases, comprising caries of the dorsal vertebrae, chronic rheumatic arthritis, and chronic Bright's disease; she also had recurrent attacks of an erysipelatous nature on her face, legs, and hands. Her tongue presented over fully half the dorsum a blackness for which I can find no better simile than the appearance of the surface of a dog's nose. The tip and edges were almost free from blackness, as also most of the circumvallate papillae at the base. To the touch the tongue was hard, but fairly moist. The patient told me that the blackness began with her other ailments, about twelve years ago, and was caused by the administration of large quantities of mercury by the doctor who attended her; that drug was also, she believed, the cause of her losing all her teeth. The latter statement was probably correct. The only remedy that seemed to give the patient any satisfaction (for she claimed to be as good a judge of her condition as any doctor) was a simple stomachic powder containing pulv. rhei, five grains, sodæ bicarb. ten grains, and calomel two grains. She said that it was the only powder that had ever produced a "moisture" on her skin, which was generally dry and furfuraceous, but its effect on her tongue was not observable. Lotions seemed to have no effect, and scraping simply irritated the mucous membrane. In this case, unlike that recorded by Dr. Stocker, the discoloration never altered in character, and remains unchanged to this day.

R. BALFOUR-GRAHAM, L.R.C.P., L.R.C.S., etc. (Edin.),

Falkland, Fifeshire, N.B.