line below the tubercle, and directed upwards and backwards, will be found sufficient. It is important that the dowels should be a little larger than the awl, so as to fit tightly. The size most suitable is No. 14 Birmingham wire-gauge, that is, about the calibre of a French No. 7 bougie. The soft edge of the silver passes readily through the cancellous tissue, but with difficulty through the compact layer which covers it, and therefore, with a view to avoid entering the popliteal space, silver should be preferred to the steel recommended by Mr. Marrant Baker. It seems to me to be also preferable to the bone pins recommended by Mr. Howard Marsh, more easily introduced, with less injury to the cancellous tissue, and less liable to give way under any sudden strain. The dowels are then cut half an inch from the skin, and their ends included in the dressings. I have usually removed them at the first or second dressing, from two to three weeks after the operation, and generally found the bones firmly united. It is better to use the dowels themselves to bore their way into the bone, once the initial direction has been given by the punctures with the awl, as they fit more tightly, and thus afford greater immobility. They cause no irritation, and the sinuses remaining when they have been withdrawn heal almost immediately. Should these sinuses be found, on larger experience, occasionally to remain open, it would indicate the necessity for bone-drainage, which it seems to me they are capable, under the circumstances, of effecting.

Diagram of front of right knee, to show position of dowels when introduced.

These dowels have been used during the past year not only by myself and my colleagues, Sir William Stokes and Messrs. Corley and Thomson, but by Mr. Franks, of the Adelaide Hospital. They all speak highly of their merits. The fixity of the bones is so complete that the patient is quite free from pain, and does not fear to move the limb or submit it to dressing or manipulation. Those who have seen the pain and terror of examination felt by children after this operation, and the constitutional disturbance due to these causes, will understand the advantage of a method which allows the limb to be moved freely when necessary.

As examples of the advantage of dowels, I may quote three cases in which I have used them.

CASE I.—Maggie M., a delicate strumous-looking girl, aged 17, with extensive disease of the bones, cartilages, and synovial membrane of the right knee, and much suppuration about the joint, was operated on in the Richmond Hospital on March 3rd, 1886. The first dressing was on March 17th, when one dowel was removed. The second

dressing was a week later, when the second was withdrawn. The part was afterwards dressed occasionally at long intervals, and the patient left the hospital perfectly recovered and able to walk, exactly three months after the operation.

CASE II.—Hannah Q., a scrofulous child, aged 5, with enlargement of the epiphyses of most of her bones, and with pulpy disease of the entire synovial membrane of her left knee, and extensive suppuration in the joint, was operated on in the Richmond Hospital on April 5th, 1886. This case recovered without any suppuration, pain, or rise of temperature. It was dressed only twice; the first dressing being fourteen days subsequent to operation. In five weeks from the date of excision the child could walk without pain or assistance, and in a little over six weeks was exhibited at a meeting of the Academy of Medicine, perfectly strong and well.

CASE III.—Richard C., aged 10, a delicate boy in a hectic condition, with extensive suppuration and disease of all the hard and soft tissues about his left knee, was operated on in the Richmond Hospital on November 3rd, 1886. The first dressing, when the dowels were removed, was on the sixteenth day. The bones were then firmly attached to each other. He suffered no pain or local inconvenience, but soon developed pulmonary phthisis, from which he died in the February following the operation.

These three cases, all occurring under unfavourable circumstances, both local and constitutional, afford fair examples of the use of silver dowels in fixing the bones. In my own practice I could quote no other group of three such unpromising cases, where the older methods of fixation were employed, where such rapidity of union occurred, and such complete immunity from suffering. These cases are not selected ones; they are the only instances in which I have myself used the dowels, and were taken at random as they offered themselves for treatment. My colleagues, who have all employed the same procedure, can add to the list of its successes.

LICHEN ANNULATUS SERPIGINOSUS (WILSON).

By JAMES NEVINS HYDE, A.M., M.D.,

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ON January 8th of the current year there appeared in the JOURNAL a short paper with the title given above, by my friend, Dr. T. Colcott Fox. In it the author briefly describes three cases which came under his observation, and suggests that these represent the disorder termed by American dermatologists "*seborrhoea corporis*"; and that this was the malady to which the late Sir Erasmus Wilson gave the title, "*lichen annulatus (seu circinatus) serpiginosus*."

As the subject is both suggestive and interesting, I take occasion to point out a somewhat different view of the disorder, which seems to me indicated by one of these titles. It is proper, however, to begin by admitting very freely that the reproach of dermatology is its bungling nomenclature; and that, in the present instance, it is responsible for a part of the confusion which it is desirable to remove.

The disease which seems to me to be at least included in the description appended by the late Sir Erasmus Wilson to his term *lichen annulatus serpiginosus* does not correspond with what my American colleagues would generally agree to call *seborrhoea corporis*; and yet, unless I greatly err, they would be willing to use this latter name as descriptive of the interesting cases described by Dr. Fox.

Now, laying completely aside, for the moment, the several names which have been employed in this connection, let the reader understand, clearly and without reserve of any kind, that there is a particular disease of the skin, *sui generis*, differing from all other cutaneous affections, shading, perhaps, into others at some points, but perfectly distinguishable by an expert in its specific identity, relatively rare of occurrence, and, under different titles, recognised, defined, and limited by a group of authors. This disease is characterised in both sexes, at a relatively early period of life, by a superficial efflorescence, displayed chiefly over the anterior and posterior surfaces of the upper portion of the trunk, less often over the extremities, in the form of multiple, discrete, and at times confluent, definitely circumscribed, ovalish or roundish discs, split-pea to large coin in size. They are slightly elevated, occasionally slightly depressed beyond the general level of the integument; and on careful inspection, these discs are seen to be made up of macules, papules, or maculo-papules, coloured in a faintly rosy, yellowish, tawny, or somewhat darker hue, and covered with typical, scanty, rather adherent,

lightish-shaded, furfuraceous scales of pityriasic type. When these discs coalesce, the composite configuration is the resultant of the outline of the primary disc, which very often is a purely annular lesion with a cleared centre, at times a segment of a ring only.

The subjective sensations are moderate or quite severe pruritus, though it is rare to see the marks of traumatism by scratching upon or about the lesions. With this, there is rarely a slight pyrexia, but more often a distinct malaise, recognised by French authors under their comprehensive term, *courbature*. The disease, beginning with a sudden or gradual onset, seems to have a definite period of evolution and involution, lasting from a few weeks to not more than two or three months. The disease may be expressed in quite numerous multiple lesions over the chest, or in not more than eight to a dozen, of which number one or three may be seen upon the arms or upper thighs, and the rest irregularly scattered over the upper part of the trunk.

I have not been able to recognise the "spores" which Vidal claims to have discovered in these lesions; and, viewing the small number of cases collated, it is judicious to-day to regard the affection as one of uncertain nature. My personal conviction is that it will be one day recognised as a specific exanthem, as distinct as variola or rubella.

As to the matter of diagnosis, I now believe that, when this subject was first brought to the attention of the American Dermatological Association by my friend and colleague, Dr. Duhring, of Philadelphia, I had not recognised the identity of the disease. Since that date, a careful collation of all the phenomena, coming under my observation in a score of cases, has demonstrated the remarkable similarity of symptoms in all. Touching upon the subject in a late conversation with Dr. Duhring, I found that he agreed with me in believing that a typical case could be recognised by a single glance of the expert at the affected surface, so characteristic is the picture. The latter always particularly impresses me as to three points:

1. A delicate but distinct salmon hue of the discs, difficult to describe in words, but never seen in psoriatic lesions, or those of tinea versicolor or tinea circinata.

2. A decided tendency of the oval-shaped discs to arrange themselves over the trunk, with the long axis at right angles to the vertical axis of the body.

3. Occasionally only, a tendency to fraying of the branny borders of the disc at the line of the contour nearest the poles of the long axis, with a more clean-cut definition of the ring near the poles of the shorter, usually vertically disposed, axis.

Now this disease, of distinct lesions and probably specific character, has been given a number of names by the authors who have made a study of the subject; among the latter may be mentioned Gibert, Bazin, Hardy, Duhring, Horand, Weyl, and Behrend. If Wilson has not included this disease in his descriptions, I am at a loss to name an English author who has made record of his observation of it in person. The names used in this connection are "pityriasis rosea," "pityriasis disseminé," "pityriasis maculata et circinata," "pityriasis rubra," "pityriasis circiné," "pityriasis maculeux," and "pityriasis pseudo-exanthématique."

I am impressed with the conviction that the late Sir Erasmus Wilson observed this disease, and at least included it with others in his description of lichen annulatus serpiginosus, even though his plates do not furnish an accurate portrait of what has been included, in the nomenclature of the American Dermatological Association, as pityriasis maculata et circinata. Wilson stated that the rings in his lichen, for example, were "numerous." This is true of the annular discs I have described above, but it is by no means true of the lesions recognised by Americans as characteristic of seborrhœa corporis. It is within bounds to say that a large number of annular lesions on the chest and back, even if otherwise resembling the patches of seborrhœa recognised upon the body, would by their number alone lead the expert diagnostician to be exceedingly cautious in declaring them to be seborrhœic in character. The lesions of seborrhœa trunci are in fact much more like those described by Dr. Fox as observed by him in his interesting group of cases. Often there are not more than two to six of these ringed patches, seen over the sternum, particularly in adults of both sexes; and, unless I err, more often in those of both sexes with a decided tendency to the growth of sparse long hairs in this region; they are pea to coin sized, dull-reddish, greyish, or dirty yellowish in colour, covered with the characteristic greasy pellicles, more or less closely attached to the underlying integument. When removed with care, the staccatiform prolongations of the crust may be at times discovered on its under surface, resembling the same peculiarities in seborrhœic crusts removed from the face. The greatest possible contrast is therefore presented between the patient having a few of these

patches on the front or back of the chest, and another patient, with the front, back, and lateral surfaces of the trunk plentifully sprinkled with the rings and discs of pityriasis maculata et circinata.

Again, in seborrhœa corporis, there is never the "rapid spreading of the rings" to which Sir Erasmus Wilson called attention in his description of lichen annulatus serpiginosus, the process, in the disorder first named, being always chronic in type and slow in evolution. Sir Erasmus also called attention in the malady, or group of maladies, which he termed lichen annulatus serpiginosus, to a "very considerable itching," which is far more true of the pityriasis described above than of any variety of seborrhœa; and, lastly, employed the very phrase to characterise his lichen which should be used of the pityriasis discs I have described above, namely "furfuraceous exfoliation." The pellicle formed in seborrhœa of the trunk is never strictly furfuraceous in character, but breaks up into minute greasy cakes rather than branny scales. Wilson uses the word "mealy" in another connection to describe the character of the exfoliation in the cases under his observation. He mentions further the "yellowish" tint of colour, the "smooth and uniform area rarely presenting any trace of pimples," and the "broken cuticle" at the margin, which I have described above as a species of "fraying."

It is true that the plate portraying Wilson's lichen does not give an accurate picture of pityriasis maculata et circinata. But on this point it should be remembered: 1. That the plates of that date give no very accurate picture of any cutaneous disease, when compared with the artistic excellence of many given to the profession in this day; 2. That very few plates indeed are in such exact correspondence with the features of disease as to serve for their study in the light of a wider knowledge, since both the scientist and the artist have their attention especially attracted to certain definite symptoms which it is purposed at the time to demonstrate in the picture; 3. That it may be reasonably concluded that, if the distinguished author of the great treatise on diseases of the skin were living to-day, he would be willing, in the light of a wider experience and more extended observation, to modify the opinions expressed by him over forty years ago.

In conclusion, then, I beg leave to suggest that Dr. Fox is right in assuming that his cases would be recognized on this side of the Atlantic as instances of seborrhœa corporis; that the lichen annulatus serpiginosus of Wilson may have included cases of that character, but that there is strong ground for believing that the pityriasis maculata et circinata of modern authors was also described by him in the same connection; and, lastly, that at this date it is absolutely essential for the expert in making a differential diagnosis of any annular cutaneous affection of the chest surface, after excluding tinea versicolor, tinea circinata, psoriasis, and the ringed pigmentary syphiloderma, to make a careful distinction between the seborrhœa corporis of the American school and the pityriasis maculata et circinata whose lesions are described above. It would certainly be in the interest of a simpler nomenclature if the word "lichen" were used hereafter only in connection with three relatively rare affections, lichen planus, lichen ruber, and lichen scrofulosorum; keratosis pilaris taking the place of lichen pilaris; the lichen annulatus serpiginosus of Wilson being dropped from its old place in the line. It should stand hereafter as a historical landmark, full of interest to the student who traces the devious path by which science emerges from the mazes of language and gains the broad and open highway of fact.

ABSCESS IN THE BRAIN RESULTING FROM DISEASE OF THE EAR.¹

By THOMAS BARR, M.D.,

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It is generally admitted that where abscess in the brain is not due to an injury, it depends usually upon some other pre-existing purulent centre, and I shall limit my remarks to that frequent form of abscess in the brain which has its origin in a pre-existing purulent centre in the ear.

What is the situation and what is the nature of the ear-disease in such cases? The situation is almost invariably, in the first case, at all events, in the middle ear. Many of the published records mention the internal ear as the source of the mischief. This is a mistake. No doubt the internal ear as well as the external ear is sometimes implicated, but then nearly always secondary to the middle ear affection. The air-filled cavities of the middle ear, especially the tym-

¹ Read before the Medico-Chirurgical Society, Glasgow, in February last, in connection with the discussion on Abscess in the Brain.