gives rise to in its migrations from one part to another. These I will enumerate only, as they are fully described in surgical text-books such as those of Erichsen and Holmes—viz., gangrene of toes, feet, and legs, talipes equinus, hydrocele, scrotal enlargement (elephantiasis), pyæmia, hectic fever, and septic peritonitis. It may prove fatal by producing hectic, pyæmia, exhaustion, peritonitis, or even tetanus.

Treatment: prophylactic, medical, and surgical.—1. Prophylactic: Water for drinking or cooking purposes should be obtained as pure as possible, then boiled for fifteen minutes at least, next filtered, and afterwards, as an additional precaution, thirst tabloids containing citric acid should be dissolved in it. Besides the above, one compound sulphur tabloid (Sir A. Garrod's formula) should be taken every third morning in case these or other parasites have gained entrance to the body, when the sulphur cuts short their life-history and development. 2. Medical: My method of radical cure is to impregnate the body with small doses of precipitated sulphur. This has proved eminently successful in my later cases (thirty-two in number), these being solely treated as follows—one compound sulphur tabloid (five grains), as above, to be taken by the patient every four hours daily for ten days, and then one tabloid twice a day during the next ten days, by which time the desired result is almost always obtained. When, as in these cases, I was able to keep the patients under observation for about three weeks the result was invariably good. 3. Surgical: My object in treatment is to do away with the necessity for any surgical interference. If the knife is to be used the measures must be promptly conceived and as quickly carried out; otherwise the worm will escape by migration. Chloroform being administered, if available, the point of a sharp bistoury should be entered through the skin at or above the vesicle which has formed; the bistoury should be carried rapidly round in the direction of the worm's body, with the edge outwards, in a sweeping manner, and the worm brought out through the incision. The operation wound, being dressed with dermatol powder, which is drying as well as antiseptic, or, if this cannot be obtained, with iodoform (crystals), and closed with antiseptic precautions, generally heals rapidly.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

SPINA BIFIDA; ULCERATION AND RUPTURE OF SAC; SPONTANEOUS CURE.

BY R. KNOX, M.B. EDIN., M.R.C.S. ENG.

THE following case may prove interesting on account of its rarity. On Oct. 18th an infant aged one week came under my care. Its development was good. There was a large swelling in the lower part of the spine, but no other abnormality. The movements of the lower extremities were good. It had slight difficulty in micturition for the first few days after birth. On inspection the tumour was found to be situated in the lumbo-sacral region; it was about the size of a small orange, translucent, fluctuating, tense, and covered by a thin bluish-white membrane, which at parts was reddened and inflamed. The tumour was sessile, umbilicated at the centre, and had a faintly marked longitudinal furrow; it could be partly emptied by pressure, but on account of its extreme thinness it was not thought advisable to handle it much. A notch in the spinal column could be indistinctly made out. At one part the tumour was deeply congested and inflamed, and evidence of commencing ulceration was present. Nothing was done beyond warning the parents to keep the part carefully protected and dry. The ulcerated spot continued to increase, and in a few days perforation occurred, followed by escape of pus and cerebro-spinal fluid; the latter escaped in large quantity and continued to trickle from the wound, the flow increasing when the child cried. The swelling collapsed partially after the rupture. The wound continued to discharge pus and cerebro-spinal fluid. The escape of the latter was prevented by covering the wound with layers of collodion and cotton-wool. After the rupture the general condition of the infant changed;

it became very irritable, cried a great deal, and after a time became drowsy. No convulsions were observed at any time. The tumour partially refilled. In two days the dressing was removed and the condition of the tumour examined. Pus and cerebro-spinal fluid continued to escape, though in much smaller quantities. On applying pressure more cerebro-spinal fluid could be squeezed out of the swelling; the sac walls appeared to be thickened and inflamed, and when palpated were found to be indurated, indicating that inflammatory action was going on. The part was carefully washed with antiseptic lotion, and the dressing of wool and collodion was reapplied. Firm pressure was secured by means of several layers of strong plaster strapping and a firm bandage. The tumour was again examined in four or five days and was found to have diminished in size; it was thickened all over and did not fluctuate, and no cerebro-spinal fluid escaped when firm pressure was applied. Pus continued to discharge from a small ulcer. The skin around the base of the swelling had developed the character of ordinary skin. The ulcer was dressed with simple ointment, and in a few days had healed. On further examination on Dec. 20th the infant was found to have grown considerably, and the power of the lower extremities was good. The site of the spina bifida was occupied by thickened integument freely movable over the parts beneath except at the centre, where it appeared to be adherent. The skin was of normal colour all over, except at the upper part, where it was bluish. There was no fluctuation and no distinct notch could be detected. The central point was slightly umbilicated, and to the right there was a cicatrix indicating the seat of the rupture.

Remarks.—The ulceration of part of the sac led to a general inflammation of the sac wall; the surfaces of the sac came into contact and were united by adhesive inflammatory changes. The cleft in the vertebræ was closed by the inflammatory change, and the further escape of the cerebro-spinal fluid was prevented. The remarkable point about the case is the entire absence of evidence of any inflammatory changes in the membranes of the cord. Septic meningitis is the almost invariable sequel of a ruptured spina bifida, yet no symptoms occurred to indicate that such had followed the rupture.

Hafod, near Pontypridd.

A CASE OF ACUTE PEMPHIGUS.

BY H. W. WEBBER, M.D., B.S. LOND.

SEVERAL interesting cases of acute pemphigus have lately been recorded, notably a series by Dr. Payne¹ last year, and one case under the care of Dr. Penrose.² The present case seems noteworthy on account of the severity of the constitutional symptoms in combination with a rather ill-developed skin eruption of inflammatory character. This is not unusual in some of the exanthemata and may suggest the possibility of an alliance in nature with these diseases.

A man thirty-four years of age was seen first on Nov. 4th, 1892, complaining of a skin eruption on the legs and thighs. He had noticed it for a fortnight. It began with a "boil" on the left leg, which was followed at intervals by others on the other leg and both thighs. On examination the eruption was found to consist of about a dozen blebs varying in size from a split pea to that of a sixpenny piece and a rather larger number of scabbed and crusted areas marking the position of previous blebs. The contents of those still remaining unbroken were more or less seropurulent, and the distribution of the eruption as a whole was more on the flexor than the extensor surfaces. The bases of nearly all the lesions were inflamed, and round one scabbed area on the extensor surface of the left leg there was a wide margin of redness, with oedema and tenderness extending downwards over the front of the leg. The tongue was coated, the pulse 90, and the temperature 99° F.; the bowels had been confined for two days. The patient was ordered a mixture containing citrate of potassium and compound tincture of cinchona every four hours, hot boracic fomentations were applied to the inflamed areas, and an aperient was ordered. On Nov. 5th, in addition to the previous lesions, which continued in much the same condition, a tense bleb about the size of a walnut, containing clear serum, appeared about the middle of the flexor surface of the left leg, and one rather

¹ THE LANCET, Aug. 16th, 1893.

² THE LANCET, Feb. 3rd, 1894.

smaller bleb on the right gluteal region. On the next day the contents of both were becoming purulent, and their bases inflamed. On Nov. 7th the inflammation around the large bleb on the left leg was increasing rapidly, with œdema extending for a distance of two or three inches around it. No fresh eruption now appeared. On the following day the patient was ordered tincture of perchloride of iron in ten-minim doses every four hours; the eruption seemed to be healing a little, with less inflammation. The patient's condition gradually improved till Nov. 14th, although very little healing took place in the skin eruption, the bases of most of the lesions being inflamed, and œdema was present over both tibiae, especially the left. In the morning the patient had an attack of vomiting, with severe vertical headache. The temperature still kept at from 98° to 99°. On examining the urine it was found to contain albumen, and under the microscope blood corpuscles and some epithelial casts were seen. The headache, with sickness two or three times a day, continued, and on the morning of Nov. 17th the patient was found to be delirious at times, complaining much, when conscious, of pain in the head. Both legs were markedly œdematous, and the skin of the face seemed a little puffy. No signs of fluid in the peritoneal or pleuritic cavities could be detected. The skin eruption remained in much the same condition. The urine contained blood corpuscles and blood casts. The temperature was found to be 104.2° and the pulse 90. Three grains of sulphate of quinine were given every four hours, and an ice-bag was applied to the head. At 9.30 P.M. the temperature was 105°, the pulse 90, and the optic discs were blurred. The patient was sponged with tepid water, which reduced the temperature to 103.2°. On Nov. 18th the morning temperature was 105° and the evening temperature 104.2°, both being reduced temporarily by tepid sponging. The pulse was 120 and the respiration 30; inspiratory crepitations were audible over the base of the left lung. The bowels were opened four times in the morning, the motions being loose, yellowish, and flocculent. The urine contained blood corpuscles and casts. On the following day the morning temperature was 104.2° and the evening temperature 102.2° (after sponging); the pulse was 120. Inspiratory moist sounds could be heard over both apices; both legs were œdematous. On the 20th the temperature was 103.2°, the respiration 36, and the pulse 120. The patient was very delirious and was kept in bed with difficulty. On the 21st the patient was still very delirious and restless. The temperature was 102.4°, the respiration 40, and the pulse 120. He lingered till the next day, when he sank gradually. No post-mortem examination was obtained.

Church-road, Rickmansworth.

A Mirror OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

UNIVERSITY COLLEGE HOSPITAL.

CECAL INTUSSUSCEPTION IN AN INFANT AGED SEVEN MONTHS; REDUCTION AFTER LAPAROTOMY; RECOVERY; REMARKS.

(Under the care of Mr. BILTON POLLARD.)

THERE are some surgical conditions which a few years ago were regarded as being incurable and invariably fatal, whilst now scarcely a day passes without examples of a record of their successful treatment. Intussusception is hardly in this category, for its treatment is still unsatisfactory; yet the results are more encouraging than they were, a position we think due either to the earlier resort to abdominal section on the failure of other methods, or, in special cases, to the resort to abdominal section without the trial of other methods. As Mr. Bilton Pollard remarks, it is important that cases should be reported in order that the profession may have more certain grounds to go upon in treating this dangerous condition. We have for some years advocated a more frequent resort to abdo-

minal section at an early stage of the disease, and we still continue to do so.¹ In the early stages, if the operation be performed immediately on failure of injection of air or fluid to effect relief, the intestines may be found on exposure to be free from adhesion and the reduction may be effected rapidly and through a small incision. Cases of recovery after abdominal section for intussusception at the age of seven months are rare. Dr. Kammerer² and Mr. Howard Marsh³ have, however, recorded successes at the age of six months. Few diseases require more prompt surgical treatment than intussusception if life is to be saved.

A female child aged seven months was admitted to University College Hospital on Dec. 14th, 1893. She had recently suffered from constipation, for which aperients had been given. On the day before admission, between 4 and 5 P.M., the child appeared to be suffering severe pain; she screamed, clenched her hands, and became "black in the face"; she also "strained and heaved." Soon after this, on changing the diaper, the child's mother noticed that blood and "slime" were being passed from the bowel. A medical man prescribed something for diarrhoea, and on seeing the child again about noon on the following day sent her to the hospital. No vomiting occurred in the interval between admission and operation. The discharges from the rectum had a distinctly ammoniacal and "fishy" smell. The intussusception could be felt extending from the left costal margin to the pelvic brim, and by rectal examination the end of it could be felt a little below the latter level. Preparations were being made for attempting reduction by the pressure of water run into the bowel from an irrigator, when Mr. Barker remarked that he considered the smell of the rectal discharges to be suggestive of gangrene of the gut and that he had previously observed it in gangrenous intussusceptions. Mr. Pollard thereupon determined to perform laparotomy at once. The operation of median laparotomy was begun at 2.30 P.M. (twenty-two hours after the onset of symptoms). The intussusception was drawn into the wound. The gut looked healthy. As much as possible was reduced by pushing up the intussusceptum, as originally advocated by Mr. Hutchinson. After as much as possible had been reduced outside the wound the intussusception was returned into the abdomen, and the invaginated gut was pressed along the course of the transverse and ascending colon into the right loin. As no further reduction could be effected by intra-abdominal manipulations the intussusception was again, though with some difficulty, brought through the wound. The reduction of the remainder of the intussusception required pressure, and, indeed, as much as it seemed safe to use. After the reduction of the ileo-cæcal valve the cæcum itself still remained invaginated. The last point to be reduced was on the right side of the extremity of the cæcum, where the bowel was dark-coloured and coated with a small patch of lymph. It was, however, thought safe to return it into the abdomen. The laparotomy wound was stitched up and dressed antiseptically. Half a minim of tincture of opium was ordered to be given every four hours. This dose was continued for five days, and then it was gradually diminished and finally omitted on the twelfth day. Three drachms of a mixture, in equal quantities, of milk and barley water were at first given every hour. The quantity was gradually increased until, on the seventh day, an ounce of milk and half an ounce of barley water were given every two hours. The bowels acted naturally on the day after the operation. The child was restless and febrile, owing apparently to teething, for a few days. The wound healed by first intention, and the child was sent home on the seventeenth day after the operation.

Remarks by Mr. BILTON POLLARD.—This was a case of cæcal intussusception. The cæcum had first of all been invaginated into the ascending colon, and then the ileo-cæcal valve and the ascending colon followed. Recovery does not generally follow the reduction of an intussusception after laparotomy in a child as young as this one. I believe the mortality of laparotomy is largely due to the delay which is caused through the trial of other methods of reduction. If water pressure succeeds it is, of course, a most simple and perfect method of treatment. If, on the other hand, it fails, the operation itself probably adds to the shock of the disease itself, and the delay which is necessary in order to test the effect of the water pressure certainly increases the gravity

¹ THE LANCET, Jan. 26th, 1889; Nov. 29th, 1890; and May 23rd and June 13th, 1891.

² Med. Record, New York, 1890; p. 114. ³ In 1875.