over the whole of the remainder of the left lung, front and back; the breath-sounds were cavernous at the left apex with very distinct bronchophony and pectoriloquy and much coarse metallic râle. The breathing became bronchial in the axillary region and faded to a weak respiratory murmur over the base, where also pleuritic friction sounds were to be heard. There were also signs of commencing disease of the right apex. A specimen of the sputum was sent to the Clinical Research Association for examination, and the report was that "tubercle bacilli are present in small numbers."

As the prospect of the patient's recovery seemed to be under ordinary conditions very slight I advised that she should undergo the open-air treatment. To this she and her friends willingly consented, but as residence in a sanatorium was out of the question, I persuaded them, being influenced by the account of a very successful case reported by Mr. T. A. Somerville and Dr. Eugene S. Yonge,¹ to carry out the treatment at home. For this purpose a shepherd's van which happened to be on the premises was moved into the garden at the rear of the house. The side of the van facing south was removed and rebuilt to the height of three feet six inches from the floor, leaving a space of four feet between it and the roof the whole length of the van, provided with shutters for use in stormy weather. A small stove with a flue was placed in the van for the sake of comfort, and the patient then took up her residence there. The season was winter (she commenced the treatment on Feb. 7th) but she spent the whole of the time between breakfast and sunset lying on a couch or sometimes sitting in an easy-chair in this situation with the exception of half an hour for dinner in the middle of the day, when she went in-doors. Whilst in-doors—in her sitting-room in the evening and in her bedroom at night—the window was always kept wide open, a screen being placed between the window and the bed to prevent any draught being felt. Although the other occupants of the house complained of the cold and discomfort she herself felt no inconvenience even in the coldest weather. Occasionally, in very stormy weather she would remain in-doors for a day or two, wind and a damp atmosphere apparently causing laryngeal catarrh, whilst a cold dry air had no such effect. When the weather was favourable she took short walks. She was enjoined to take a liberal diet, but her distaste for food was such that she could never take much meat or solid food of any sort. Her usual daily menu was three pints of milk, one egg, a little bacon (at breakfast), a few thin slices of bread-and-butter, occasionally a little meat and vegetable, and, in the winter months, a plate of oatmeal porridge with milk for supper. During the first three or four months of treatment she took a capsule containing one minim of creasote three times a day. She also used inhalations of terebene several times daily, and frequently took an anodyne cough mixture. I visited the patient twice a week during the first few months of treatment, and afterwards at gradually lengthening intervals. She kept a daily record of her morning and evening temperature and a weekly record of her weight. Within a week or two of her taking up her out-of-door residence her condition began to improve—the cough diminished in frequency and the sputum in amount, the evening temperature fell to below 100°, and she commenced to gain in weight. In the first seven weeks she gained 7 lb.; then her weight remained practically stationary for two months. During this period the evening temperature averaged about one degree above normal. In April she had a slight relapse; the temperature rose to 101° (for a few days it was 102°), there were considerable prostration and nervous irritability, and she was much troubled with laryngeal hoarseness and cough, so that I deemed it advisable that she should remain indoors and in bed. Under the influence of rest and warm inhalations of compound tincture of benzoin the symptoms subsided and in a week or two she was able to resume her out-of-door life. After this, with the exception of a second slight relapse in May, the improvement was gradual but continuous.

The record shows that the fall in temperature and the gain in body-weight proceeded *pari passu*. By the beginning of August the evening temperature had fallen to normal and has never once since risen above it. Her weight at that time had risen to 102 lb.; by the end of the year it had increased to 114 lb., at which it remained at the beginning of February, 1901. The improvement in her condition at

this time, 12 months after the commencement of the treatment, is very marked. In place of being a fragile, cachectic woman with sunken cheeks and a hectic flush she is now plump and well-conditioned, with a healthy complexion; in fact, she complains of being uncomfortably stout. Cough and expectoration have almost disappeared—she coughs a few times in the course of the day and occasionally expectorates a little mucus which is never blood-stained. She has had no night-sweats for many months, no hoarseness, and no pleuritic pain. As to the physical signs, there are flattening and deficiency of expansion of the chest-wall on the left side, the percussion note is dull at the apex and impaired at the base, whilst there are still tubular breathing, bronchophony, and pectoriloquy at the apex, and the breath-sounds are weak at the base. The loud metallic râle which was so audible at the apex has disappeared and there is now only a faint crepitus at the extreme end of inspiration, whilst the crepitation at the base is much less in amount and pleuritic friction is absent. The signs of commencing disease of the right apex have disappeared. There is still considerable dyspnoea on exertion, but otherwise she feels quite well. The Clinical Research Association reported of a specimen of sputum examined on Dec. 24th, 1900, "No tubercle bacilli were discovered."

It remains to be added that beyond the fact of its being situated in the country the patient's residence presented no special advantages for the carrying out of the treatment. It is situated in the low-lying valley of a river where mist and fog are very prevalent. On the other hand, the patient and her friends are people of intelligence; they entered into the treatment with zest and carried it out with zeal and thoroughness, and to this, no doubt, the satisfactory result is largely attributable.

Romsey, Hants.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF CONCURRENT ERYTHEMA MULTIFORME AND ERYTHEMA NODOSUM.

BY EDWARD McCULLOCH, M.B., CH.B. EDIN.

ALTHOUGH modern dermatological literature favours the view that erythema nodosum is but one of the many manifestations of erythema exudativum multiforme, sufficient difference of opinion perhaps remains to warrant the consideration of those rare cases where definite erythema nodosum co-exists in the same individual with other undoubted manifestations of erythema multiforme. In the following case the character of the lesions was unquestionable, and the family history has also an interesting bearing on the etiology of the disease.

The patient was a boy, 15 years of age, who came to me on Dec. 31st, 1900, complaining of "lumps on his legs and spots on his face." He had been exposed to rain and had got a wetting a few days previously. Examination of the shins revealed a typical eruption of erythema nodosum, about five nodes being visible on either shin. Each node was of about the size of a small walnut. Their colour was a dusky red and they were tender on pressure. Their margins were ill-defined and they were unassociated with itching or pain. On the middle of the extensor aspect of the left thigh there was one similar node. On the face there were a few small groups of reddish papules; some coalesced to form small raised patches, situated on the infra-orbital regions and just external to both outer canthi. A few papules were also visible on the *ala nasi* and adjacent parts of the cheeks. The patient's temperature was 100.5° F. Little general discomfort was felt. I sent him home with directions to go to bed, and ordered 15-grain doses of sodium salicylate every four hours. Next morning the facial eruption had increased in extent, and fresh patches had appeared behind both ears and on the bridge of the nose. Coalescence of some of the original papules had taken place. The papules were moderately

¹ THE LANCET, Jan. 20th, 1900, p. 162.

hard to the touch and they paled on pressure. They varied in size from a pin's head to a split pea. During the next few days the rash continued to extend, and in a couple of days after the first visit opalescence appeared in some of the papules and others displayed slight vesication, the vesicles being minute and containing a puriform secretion. A certain degree of general swelling was present for a day or two over the area of the eruption, but it rapidly subsided. Papules also appeared on the backs of the hands and fingers and fresh nodes appeared on the shins from day to day for the first week, all gradually passing through the usual succession of chromatic changes. The temperature remained slightly above 100° for six days, with the exception of Jan. 3rd, 1901, when it sank to 99.5°. On the eighth day it was 99.8° and it did not rise above this subsequently. The eruption gradually faded from both face and legs, leaving slight pigmentation behind. This pigmentation was visible on the face as late as the 20th—i.e., for about three weeks—but had disappeared by Jan. 25th.

From the above history it will be evident that the nature of the lesions was unmistakeable. The slight rise of temperature, the local appearances, their symmetrical arrangement and their distribution, were all characteristic of erythema multiforme, while the condition of the shins was absolutely typical of erythema nodosum. The case, to my mind, is a very definite demonstration of the identity of erythema nodosum with erythema multiforme. The family history was remarkable. The patient's mother had similar "lumps on the legs" before marriage; his maternal grandmother had had rheumatic fever; an elder sister died at the age of 16 years from rheumatic endocarditis with multiple joint affections; a younger sister was under my care last year with rheumatic fever, and had endocarditis and subsequent signs of mitral stenosis; another sister had had frequent attacks of acute tonsillitis (from which the patient himself has often suffered); and a maternal uncle and three of his children had had rheumatic fever. In contrast to this the patient's father is healthy and has no rheumatic personal or family history. Thus additional support is given, if it be needed, to the view that erythema multiforme is but one of the expressions of rheumatism.

Torpoint, Devonport.

NOTE ON THE TREATMENT OF OTORRHOEA.

BY DAVID WILLIAM AITKEN, M.B., C.M. EDIN.

AS the method about to be described has proved successful in cases where the alternative is antral perforation it seems well to call the attention of the profession to it. Although it is quite prompt in its effects upon acute otorrhœa its benefits are greatest in old-standing cases where the mastoid has become infected. Such cases have lasted for years; there is an abominable discharge, probably with polypoid growths, and if the more threatening head symptoms are not present there are the impaired health, the atonic dyspepsia, the anæmia, and the loss of flesh to denote the dire effects upon the constitution which follow absorption.

The appliances required are a probe, some antiseptic lotion, and some absorbent cotton. The best probe for the purpose which I have seen is that supplied by Messrs. Hockin and Wilson. It has at the end two spiral teeth which, while they hold the wadding firmly, permit of its easy removal by rotating the stem counter clock-wise. The first step is to pour into the ear some of the lotion. Then take as large a plug of wadding as is deemed sufficient when screwed upon the probe to easily fit the meatus. It is now possible to make the probe and ear canal a suction syringe. The plug of wadding which forms the piston is gently pushed in and then withdrawn. If it is found to be either too large or too small another can be at once substituted which acts both easily and also fits close enough to force some of the fluid before it. This fluid reaches both the attic and also the mastoid recesses. At any rate, on the first withdrawal sufficient vacuum is produced to allow the lotion to enter the accessory cavities. It will surprise anyone who has not carried out this procedure to note how much discharge and débris are brought to the surface even after syringing and swabbing have been efficiently performed. After several repetitions of the manœuvre, the head each time being turned to the opposite side to permit of emptying the meatus, the lotion will well up clean. Now one can get any medicament to the clean surfaces. Begin with chinisol,

iodoform, or amyloform in alcohol which, in my experience, is best in the absolute state. It is practically painless in almost all cases and in the exceptions the smarting is but momentary. Its advantages are: (1) it acts promptly upon the polypoid growths; (2) it is a most satisfactory antiseptic; and (3) as it evaporates it leaves a dry surface. This is most important. Many of the cases which progress so unsatisfactorily are those of patients who get a "powder to put in water to syringe the ear with." While the ear is never clean it is kept constantly in a sodden state. When the solution has been poured into the ear the process with the "piston-rod" is repeated several times. Thus the fluid is forced into all the recesses. That this is so is seen by the prompt improvement both in the local condition and also in the constitutional state. Of course, discretion is used as to the nature of the drug selected in the progress of the cure, according to the requirements—stimulant, astringent, &c.—of the case. It is unnecessary to select examples. Suffice it to say that many cases have been treated and that in some the patients have probably been saved from the somewhat serious operation of trephining the mastoid.

It is my belief that this plan, if properly carried out, would greatly diminish the number of antral perforations. In fact, it is as an alternative to that procedure that my device has been matured.

Packington-street, N.

BARIUM WATER IN WEAKNESS OF THE HEART.

BY W. BLACK JONES, M.D., B.S. LOND., D.P.H.,
PHYSICIAN TO THE LLANGAMMARCH WELLS SPA.

THE following case, which illustrates others of a similar nature treated at the Llangammarch Wells Spa, may be found to be of interest.

A man, aged 53 years, consulted me for weakness of the heart. He had had influenza seven years previously and since then had suffered from dyspnœa on exertion. He had been losing flesh of late. He was a very thin man, weighing only seven stones. The apex beat of the heart was in the nipple line and the cardiac dulness was increased to a corresponding extent. At the apex a soft systolic murmur was heard which became louder as the right base was approached; over the pulmonary area the second sound was accentuated. The pulse was thin and wiry and the frequency varied from 90 to 100 per minute. Nothing abnormal was observed in the other organs; the urine was unaffected. The patient was advised to drink the Llangammarch barium water, to have a course of barium baths, and to take outdoor exercise in moderation. He soon began to improve and after three weeks' treatment he left, feeling considerably better. After an absence of six weeks he reported that he had made greater progress; the pulse was slower, he had practically lost the dyspnœa, and he was able to walk up hill with comparative ease. He was also gaining in weight and was feeling better than he had for years.

Similar to the above case are many in which the heart has been damaged after attacks of influenza. They all receive considerable benefit from the treatment at Llangammarch and often gain considerably in strength after their return home.

Llangammarch Wells, Breconshire.

SOCIETY FOR RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN.—A quarterly court of the directors of this society was held on April 10th, Mr. Christopher Heath, the President, being in the chair. Ten new members were elected and the deaths of three were reported. The death of a widow was announced. Fresh applications for grants were read from two widows and three orphans and grants amounting to £96 per annum were made and a grant of £25 for the self-maintenance of an orphan was given. Applications for continuation of grants were read from 50 widows, 14 orphans, and six on the Copeland Fund, and it was resolved that £1218 be given at the July court. The following were recommended for election at the annual general meeting to fill vacancies in the list of officers for 1901-2—viz.: Dr. Blandford as treasurer, and Mr. Sleeman, Mr. Elwin, Sir Hermann Weber, Mr. Stowers, Dr. Nix, and Dr. Palmer as directors. It was decided to hold the annual general meeting on May 22nd at 5 P.M.