From the corrected rates given in Table V. the following conclusions are derived: (1) The cancer death-rate in New Zealand is really higher for females than for males. This is important as correcting the fallacy of the crude rates (see Table III.) and bringing the New Zealand statistics into agreement with those of other countries. (2) The cancer death-rate is slightly lower in New Zealand than in England and Wales. There is, however, no very great difference and probably there will in the future be less still as the certification of deaths from cancer is improved. (3) The registered cancer death-rate is increasing in New Zealand as in England. Unfortunately, however, the New Zealand statistics do not afford any assistance in determining whether cancer is truly increasing or whether the apparent increase is due merely to improved diagnosis and registration.

Summary.—1. Tuberculosis in New Zealand gives a death-rate of only one-half of the English rate. This appears to be due to the relative absence in New Zealand of conditions which favour the growth and spread of this disease. 2. The death-rate of cancer, on the other hand, in New Zealand is practically equal to that in England. Hence it is probable that the conditions favourable to this disease are present to an equal extent in the two countries.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

TAPEWORM AS A CAUSE OF CHOREA.

BY JOSEPH A. W. PEREIRA, L.R.C.P. LOND., M.R.C.S. ENG.

In his "Principles and Practice of Medicine" Professor W. Osler says: "Reflex irritation was believed to play an important rôle in the disease (i.e., chorea), particularly the presence of worms or genital irritation, but I have met with no instance in which the disease could be attributed to either of these causes." He also says: "Various nervous phenomena, such as chorea, convulsions, or epilepsy, are believed to be caused by the parasites (tapeworms). Such effects, however, are very rare."

These words of Professor Osler are my excuse for publishing a case which came under my care two months ago and in which a girl, aged six years, suffering from tapeworm became the subject of an attack of chorea. The child was passing segments of the worm for two or three weeks when the first manifestations of chorea became evident. When I saw the child she was in the second grade, or the severe form of the disease, in which the movements were general and she could not talk. There was never any suspicion of rheumatism in the case and her heart remained normal throughout. A dose of filix mas dislodged the parasite and in a month's time the child was practically well. The cestode was, in my opinion, the direct exciting cause of the chorea.

Both Dr. F. T. Roberts and Dr. A. H. Carter of Birmingham mention the irritation of worms as exciting causes of chorea, whilst Dr. F. Taylor and the late Dr. Edward Ellis¹ are silent on the point. I believe that the occurrence of tapeworms in children under six years of age is rare, an opinion which Dr. Ellis likewise expressed in his book. Professor Osler, however, says it is not uncommon.

Exeter.

A NOTE ON FOUR CASES OF BLACKWATER FEVER.

BY J. CLEASBY TAYLOR, M.D. EDIN., M.R.C.S. ENG.,
HONORARY PHYSICIAN, SEAMEN'S HOSPITAL, LAS PALMAS.

DURING the past winter four cases of this fever came under my notice. There are three points to which I wish to draw attention. 1. All these cases developed on board ship homeward bound from the west coast of Africa, presumably away from any direct or recent infection. Only one of the cases had suffered from a previous attack. 2. In all the cases there

had been a slight chill (malarial), for which one gramme of quinine had been taken and within a few hours the symptoms developed. 3. The last point is the satisfactory use of boric acid, one gramme of which in hot water was given every two or three hours according to the severity of the attack. If there is vomiting it could be given by rectal or subcutaneous injection.

The following is an abstract of the clinical record of the last case. The patient, who was a French explorer, developed the characteristic symptoms at 4 A.M. On the first day, at 8.30 A.M., his temperature was 103.8° F. He had an icteric tinge and his urine looked like blood. At 1 P.M. his temperature was 103.8°. At 5 P.M. his temperature was 101.2°; the icteric tinge was less and the urine was clearer. At 9 P.M. his temperature was 101°. On that day he had five one-gramme (15-grain) doses of boric acid—namely, at 10 A.M., 1 P.M., 4 P.M., 7 P.M., and 11 P.M. On the second day at 4 A.M. his temperature was 99°. At 8 A.M. it was 99°; the icteric tinge was now much less and the urine was of a brownish colour. At 1 P.M. his temperature was 98.8°. At 8 P.M. it was 98.6° and his urine was then clear. On this day he had three one-gramme doses of boric acid—namely, at 4 A.M., 8 A.M., and 1 P.M. After this date the patient made a satisfactory and rapid recovery. In none of the cases was any albumin found in the urine during convalescence.

Orilla del Marc, Las Palmas, Grand Canary.

PURPURA (PELIOSIS) RHEUMATICA WITH STERCORACEOUS VOMITING.

BY JOSEPH EDWARD JUDSON, M.R.C.S. ENG.,
L.R.C.P. LOND.,

HOUSE SURGEON, DISTRICT INFIRMARY AND CHILDREN'S HOSPITAL,
ASHTON-UNDER-LYNE.

THE patient was a male, aged 17 years, and was admitted to the District Infirmary, Ashton-under-Lyne, as a supposed case of intestinal obstruction on May 3rd, 1903. He had been ill and under medical treatment for ten days with rheumatism of a subacute character and had been having only a milk diet. On the evening of May 1st he began to vomit and on the night of the 2nd the vomited matter, which had been of a bilious nature during the day, was from the description of a faecal character.

On admission he was found to be very collapsed with a quick, thready pulse. There was no distension whatever of the abdomen, neither was there any hernia or any tenderness over the appendicular region; the liver dulness was present and there was no accumulation of faeces in the rectum. He complained of pain over the epigastric and umbilical regions. There was a marked purpuric rash over both ankles and the outer sides of the legs and also on the forearms. The hypodermic injections of strychnine and digitalis, which were given for the collapse, were followed by a marked subcutaneous extravasation of blood. He was given sips of hot water and small quantities of milk, but vomited immediately afterwards. On the 4th, at 12.45 A.M., the vomit was large and distinctly faecal. A glycerine enema was given at 2.30 P.M. with a slight result. At 4.30 P.M. he again vomited, but this time it was of a bilious character. Feeding by the mouth was stopped and no more vomiting occurred; rectal feeding, however, was continued for 48 hours. The question of laparotomy was discussed but the operation was not considered justifiable. The symptoms subsided, the purpura disappeared, and the patient made a good recovery, leaving the hospital on June 23rd. I have seen him several times since and he appears to be perfectly well. There is no evidence of hysteria.

Ashton-under-Lyne.

ROYAL CITY OF DUBLIN HOSPITAL.—At the monthly meeting of the board of the Royal City of Dublin Hospital, held on Sept. 11th, a letter was read from Lord Plunket inclosing His Majesty's reply to the address presented on his recent visit to Ireland. The directors passed a vote of sympathy with the relatives of the late Mr. Henry Gray Croly, who had served the hospital for 40 years, and accepted the resignation with regret of Sir George F. Duffey, owing to ill-health, and placed on record its appreciation of his skilful services as visiting physician to the hospital during 21 years.

¹ A Practical Manual of the Diseases of Children. London: J. and A. Churchill.