circular method at the junction of the middle and lower thirds of the thigh. The greater part of the wound healed by first intention, and in a short time the whole had granulated up, and the man left the hospital on May 30th. Examination of the amputated leg revealed a severe comminuted fracture of the neck of the fibula in which there was not the slightest attempt at repair, the fragments lying loose in the macerated fibres of the surrounding muscular tissue. The posterior tibial vessels were uninjured and free from atheroma, but on following the anterior vessels it was at once seen that they were the source of the bleeding, although owing to the disorganised condition of the vascular tissue they were traced with difficulty. In close proximity to them were several small splinters from the fibula, but it was quite impossible to determine which fragment had injured the vessels. There was a large extravasation of blood in front of the interosseous membrane lying amongst the degenerated and destroyed fibres of the tibialis anticus and the extensor muscles of the toes. The hæmorrhage had also extended backwards in the muscles under the gastrocnemius and soleus, but had not destroyed the tissues to the same extent as in front. It did not extend as far as the fracture of the tibia and fibula, which was found firmly united, but had almost reached the limits of the popliteal space above.

Remarks.—The case at first appeared to be a simple one of fracture of tibia and fibula, and it was not until nearly seven weeks after the accident that any further symptoms developed. The injury at the neck of the fibula took place at the same time as the fracture below, but there may be some doubt as to whether the anterior tibial vessels were injured at the same time, or the artery perforated or ulcerated by the movements of the patient after leaving the hospital.

Esher.

THE TRANSMISSION OF DIPHTHERIA BY NON-SUFFERERS.

BY HERBERT PECK, L.R.C.P. EDIN., D.P.H. CAMB.,
MEDICAL OFFICER OF HEALTH TO THE ORMSKIRK RURAL
DISTRICT COUNCIL.

THE following series of cases is of interest as showing the possibility of the conveyance of the diphtheria poison by persons who do not themselves suffer from the disease.

HOUSE A.

CASE 1.—A man aged forty-five years began to be ill on Oct 4th, 1894. The case was typical and was followed by double "drop-wrist." No other person in this house suffered from sore throat.

HOUSE B.

This is half-a-mile distant from House A. There was no communication between the houses till Dec. 26th, when the occupier began to work for the preceding patient.

CASE 2.—A child aged seven years and a half had a sore-throat on or about Jan. 2nd, 1895. The case was a typical one, followed by paralysis of both legs. The patient died from cardiac syncope.

CASE 3.—A child aged four years began to be ill on Feb. 6th. This was a typical case and resulted in death from asphyxia.

CASE 4.—A child aged twelve years had a sore-throat on Feb. 16th. The case was typical and was followed by dimness of sight and strabismus. Bacteriological examination of cultures from the throat showed the presence of large numbers of diphtheria bacilli.

HOUSE C.

This farmhouse stands on a peat-moss and is one mile and a quarter distant from Houses A and B.

CASE 5.—A youth aged eighteen years, brother of the last three patients, worked here from Jan. 15th. His mother stated that he was at home for a few minutes on the days his sisters were buried, but at no other time. He himself admitted having been home on each Sunday to change his shirt, which he did in the room occupied by the patients. He stated that he did not suffer from sore-throat at any time, but bacteriological examination showed typical diphtheria bacilli in large numbers to be present in his throat. There is no history of his ever having had diphtheria.

CASE 6.—A youth aged eighteen years began to be ill on Feb. 26th. He worked on the same farm as the last youth

and slept with him. He went home to House D on the 27th, being then "full of cooth" and suffering from sore-throat, and unable to work. Typical diphtheria bacilli were present in great abundance on March 15th.

HOUSE D.

This is a mile and a half distant from House C, two miles from House B, and two miles and a half from House A.

CASE 7.—The patient was a boy aged thirteen years, who slept with the last patient, his brother. He came home from chapel on March 3rd, complaining of sore-throat. On the 8th he was seen for the first time by his medical attendant, and was then dying. No bacteriological examination was made.

CASE 8.—A child aged three years, sister of the last two patients, began to be ill on March 12th. The case was a typical one, and an abundance of typical diphtheria bacilli was found on bacteriological examination.

Remarks.—House B was probably infected by the father of the family, who himself did not suffer from the disease. His son (Case 5) did not suffer from the disease, though he was proved to have its germs in his throat, but he was the means by which it was carried to House C, whence it was taken to House D.

Ormskirk, Lancashire.

ON SO-CALLED GOUTY PSORIASIS.

BY T. FREDERICK PEARSE, M.D. BRUX., F.R.C.S. ENG.

PSORIASIS occurring for the first time in or after middle life presents distinctive characters and requires different treatment to psoriasis occurring in the young. Most writers divide psoriasis into syphilitic and non-syphilitic. Leaving aside syphilitic eruptions of a scaly nature (to which the term "psoriasis" is incorrectly applied for a scaly syphilide), I wish to draw attention to some differences in the cases of what are termed true psoriasis. There are roughly two chief varieties: (1) the psoriasis of the young, and (2) the psoriasis of the gouty. This distinction was first pointed out by Liveing. The former variety is characterised by occurring generally before puberty, by attacking the extensor surface of the limbs, by the scales being numerous and thick, by the almost entire absence of itching, by the absence of any eczematous eruption or history of it, by being symmetrical, and by the effect of treatment. The latter variety never commences in childhood and rarely before middle age; there is generally a history of gout in the patient or in his family. It does not affect the extensor more than the flexor surface; the itching is considerable, the patches are thin, not very scaly, and the scales are small and easily rubbed off. The eruption is scattered irregularly over the body and may be said to show a disregard for symmetry. Moreover, it has a great tendency to be complicated with undoubted eczema, and sometimes assumes an inflammatory aspect almost passing into eczema. It is often made worse by the ordinary applications for psoriasis. These patients bear arsenic badly, and stimulating fluids and highly seasoned articles of food, as well as sugar, affect the eruption unfavourably. This form in some cases alternates with acute attacks of gout, and in others seems to be suspended by them. At times the eruption develops very rapidly, even in a night. Under "gouty" remedies it often rapidly disappears—much more rapidly than psoriasis ever does in the young. The treatment most successful is the free use of liquor potassæ internally, with perhaps the addition of quinine. The addition of colchicum, however, is sometimes of great service. These patients require the ordinary routine and dietary for gout. They generally require to drink more water, and alkaline waters taken freely are especially to be advised. As the skin acts feebly in many gouty persons, bathing frequently is desirable, and warm baths may be recommended. The diet should be plain, and fish or white meat should be preferred to beef or mutton. Plenty of fruit and vegetables are desirable, but the more complete the avoidance of wine, beer, or spirits the better. Clinically, this variety is closely allied to dry eczema. Its appearance is similar and the itching in both cases is marked. Contrary to true psoriasis, it is not symmetrical and does not attack the same parts. What is its pathology? Is it a true psoriasis occurring in the gouty and modified in its clinical characters by the gouty state, or does gout have a psoriasis-like eruption

as one of its manifestations? I believe the latter is the correct supposition. The facts that the eruption in these cases occurs for the first time late in life, that it has not the same clinical characters as the psoriasis of the young—the true psoriasis—and that it yields to totally different treatment, incline me to classify it as a distinct disease of the skin from psoriasis. The same anatomical changes are often brought about by different ways, and the scaly eruptions resembling psoriasis must be differentiated from it. If there is a psoriasis-like eruption in a syphilitic subject, it should not be called “psoriasis,” but “syphilis,” and a similar kind of eruption occurring in the gouty should not be termed “gouty psoriasis,” but “gout.” Psoriasis as a name for a distinct disease should be reserved for that scaly eruption of the young which constituted the first variety. The underlying cause producing its external manifestations is not known. In its clinical character it varies considerably in different cases, and it may possibly before long be capable of further sub-division.

Southsea.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

HEREDITARY CONGENITAL NYSTAGMUS.

BY F. W. BURTON-FANNING, M.B. CAMB., M.R.C.P. LOND.,

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THE following history was obtained from the father of a child brought to the Jenny Lind Infirmary for Sick Children, Norwich, with marked nystagmus, and I wish to record it in conjunction with the recent publications of Dr. George Dickson¹ and Dr. Angus McGillivray,² and that of the late Dr. Hadden.³ The grandparents of the first generation lived to an old age and had no ocular abnormality. There were seven children as follows:—(a) Male, who had constant nystagmus from birth to his death, which occurred at the age of twenty-four from an accident. (b) Female, who was unaffected and died from poisoning aged eighteen years. (c) Male, in whom nystagmus remained constant all his life; on fixing his attention he also manifested head-nodding, which disappeared during repose. He died aged twenty-four years from phthisis, leaving four children. (d) Male, who had nystagmus at the age of forty-two years as marked as at birth. (e) Male, who was unaffected. (f) Male, who had constant nystagmus; he has had seven children. (g) Male, who had nystagmus in a most marked degree; head-nodding also, except during repose. He had one child. As to the third generation, C's family of three girls and one boy had no nystagmus, but one girl's head shook when excited. F's family consisted of three daughters and four sons; nystagmus was present in all the girls, though one at the age of eight years was improving. The four boys were unaffected, but all died between the ages of seventeen months and four years; two from convulsions, one from imperforate anus, and one from diarrhoea and dentition. G's boy died aged seven weeks, and I cannot ascertain if he had nystagmus. Here then we meet with oscillation of the eyes occurring in five members of a family of seven whose parents and other relatives had presented no such peculiarity. Of these five three married and had altogether twelve children, three of whom had definite nystagmus and a fourth a tendency to head-nodding. The liability of the two sexes was almost equal in this family, for, of eleven boys, five had nystagmus, and of seven girls three had it. I have had the opportunity of examining five members of this family; in all the nystagmus was horizontal only, it was slow during repose and became more rapid when the eyes were fixed on any object or when the person was excited. Their complexions were mostly dark, their vision and ophthalmoscopic appearances normal, and their general health good. My informant discovered this “jumping” of the eyes within a few hours of

birth, and was convinced that the affection diminished in intensity as the child grew. To my mind this hereditary oscillation of the eyes, with or without movement of the head, seems most allied to hereditary tremor of the limbs and head.

Norwich.

A HEAVY FŒTUS.

BY W. WOODWARD, L.R.C.P. LOND., M.R.C.S. ENG.

ON Nov. 29th, 1895, I was called to see a married woman of robust constitution, who, the midwife said, had been in strong labour for twelve hours, but “nothing seemed to shift. The waters,” she added, “had come an hour previously.” I found, per vaginam, the head to be high up in the first position and the os fully dilated. The patient was bearing the labour well; but as the head did not appear to move, though the pains were frequent and strong, I applied forceps. In an hour and a half the forceps were taken off, the head being now well down on the perineum. During its passage the mother had cramping pains in the legs, but these were neither more continuous nor more severe than is common in ordinary cases. The head was born in twenty minutes more without injury to the perineum. Then for about another twenty minutes the shoulders refused to move. Traction on the axilla effected nothing, so I pulled down the left arm and the child (a female) followed, but slipped out slowly, fully dilating the maternal outlet. The infant had vomited three times a fluid resembling liquor amnii and was becoming cyanosed before I interfered. It seemed, therefore, necessary to risk the perineum in order to save the infant. After delivery the latter lay flaccid, the cord feebly pulsating, but the escape of about one ounce of blood from the cut cord restored her, and her cries were comforting to hear. The rest of the labour gave no trouble. When the mother was comfortable the child was weighed. Two separate and distinct pairs of scales registered her weight as 11 lb. 10 oz. before she was washed. Both mother and child were doing well.

Wilton, Wilts.

CASE OF SLOW PULSE (BRADYCARDIA) EVIDENTLY DUE TO SIMPLE CONSTIPATION.

BY M. M. BOWLAN, M.B. DURH., D.P.H. CAMB.,

MEDICAL SUPERINTENDENT OF THE WORKHOUSE INFIRMARY, ST. GEORGE'S-IN-THE-EAST.

THE interesting article by Dr. A. Morison on the Causes of Bradycardia which appeared in THE LANCET of Nov. 23rd is my excuse for submitting the following short note. A woman aged twenty-five, well nourished, was admitted to St. George's-in-the-East Infirmary on Jan. 13th, 1892, with a history of constipation and occasional vomiting after food. There was no history of alcoholism or dietetic error, and there was no history or sign of lead poisoning. There was no hernia or any sign of organic intestinal obstruction. She looked gloomy, complained of headache, and had a dirty tongue and foul breath, but all her organs appeared to be healthy. Her heart, however, though otherwise normal, was only beating at the rate of 48 per minute. She was given five grains of calomel on admission, but was not purged. On Jan. 14th the house mixture, sulphate of magnesia and senna, was given, but without effect upon the bowels. She was still sick occasionally after food. The pulse was still slow. On Jan. 16th the pulse-rate was 48 per minute. The patient was still constipated. On the 19th one ounce and a half of castor oil was administered. On the 20th the bowels acted well. A magnesia and sulphate of sodium mixture was ordered thrice daily. On the 21st the bowels were freely opened. The patient looked brighter and expressed herself as feeling better. The pulse was now 76 per minute, the patient being recumbent, and continued normal till her discharge on Feb. 3rd, since which time she has not come under my observation.

This case was regarded as due to the absorption of poisonous, effete, and fermentation products from the intestinal tract (whether ptomaines, leucomaines, or what not), and treated accordingly. There was no marked abdominal distension and very little vomiting, so that any local mechanical theory was out of the question.

Raine-street, E.

¹ THE LANCET, Oct. 5th, 1895.

² Ophthalmic Review, August, 1895.

³ THE LANCET, June 14th, 21st, and 28th, 1890.