spluttering and catching on the paper, and the attempt being given up finally in despair. A fuller report of the nervous symptoms is reserved for the account of the next joint examination, but it should be added that there was even then no evidence of any loss of muscular power, nor was there any recognisable rigidity.

On May 2nd, 1900, we again saw the patient together. His condition was as follows:—

Motor system.—He was now able to walk by himself and on the whole steadily, though every now and then there was a little loss of balance. He walked, however, with great care, putting one foot before the other slowly and deliberately, saying that he had to be careful lest he should fall. The feet were kept rather widely apart and turning was especially difficult. He was quite unable to walk along a line without support. Romberg's sign was but slightly marked but when lifting one foot on to a chair there was marked disorder of movement. The movements of the upper extremities were awkward and clumsy; for instance, in attempting to grasp the hand of one of us there was a good deal of coarse, uneven movement. When held out horizontally, with the arms close to the body, the hands were steady, except for slight wavering on the right side, but if the forefingers were pressed together with the arms well out from the body there was very marked rhythmical coarse tremor. There was much unsteadiness in placing the forefinger on the tip of the nose even with the eyes open and there was similar difficulty in bringing the tips of the forefingers together from a distance. The power of writing had considerably improved, though the attempt still caused a good deal of tremor which was only controlled by keeping the pen firmly pressed on the paper. The following is a specimen of the handwriting:—

There was no nystagmus and no tremor of the tongue. The motor power in both upper and lower extremities appeared to be intact, neither was there any paresis of the muscles of the face, the tongue, or the eye. There was perhaps a very slight tendency to rigidity of the legs at the beginning of passive movement, but if present it wore off at once and we were not convinced that it really existed. The bladder and rectum were, and had always been, perfectly under control.

Speech.—Speech was slow, monotonous, and markedly scanning; it would have passed as a most typical example of the scanning speech of disseminated sclerosis. The articulation was distinctly, though slightly, blurred.

Sensation.—Sensation was everywhere perfect both to touch and pain. The temperature sense was not tested.

Reflexes.—The plantar reflexes were sluggish and flexor in type. The knee-jerks were moderately increased. On testing for ankle clonus a few slight contractions were obtained on each side.

Muscles.—The muscles were well nourished and there was no trace of any wasting. The electrical reactions were, however, somewhat sluggish both to faradism and galvanism. Kathodal closing contraction was uniformly greater than was anodal closing contraction.

The optic discs were normal and there was no trophic disorder of any sort. General nutrition and health were excellent. The mental faculties were, we think, quite unimpaired, though the monotonous intonation and blurred articulation gave a false air of mental feebleness.

We have recently made a final examination—namely, on April 28th, 1902—but have practically nothing to add to the foregoing description. There has been perhaps some gain in control over the finer movements of the limbs, but the gait is still slow and careful. The patient is able to do the ordinary work of a butcher's shop and he told us with pride that he had once succeeded in killing a sheep. His handwriting is much as before, his speech retains the same typical scanning character, and in all other respects no change is to be detected.

We have searched the literature of hyperpyrexia in rheumatic fever and have only succeeded in finding the report of one similar case. It occurred at the Birmingham General Hospital and was published by Dr. Arthur Foxwell

in THE LANCET.¹ In that case the highest point reached by the temperature was 111° F. and it remained raised for 10 days afterwards. The hyperpyrexia occurred on Sept. 28th, 1884, and on Oct. 9th it was noticed that there was difficulty in pronouncing consonants and that the intonation was nasal. On Oct. 20th rhythmical tremors were observed; the knee-jerks were exaggerated, more so on the left side; and there was right ankle-clonus with a very slight degree of the same condition on the left. Sensation was normal but the leg movements were very feeble and the electrical reactions were sluggish. On the 22nd the speech was perceptibly scanning and on the 25th the gait was ataxic and there was slight nystagmus. As in our case considerable improvement subsequently occurred in Dr. Foxwell's case, but when the patient was seen a year later there were still some disorder of speech, paresis of the limbs, and tremors, the left arm and right leg being most affected. Dr. Foxwell suggested a diffused inflammation occupying the substance of the medulla and lower half of the pons as a possible explanation of the condition. Some small scattered hæmorrhages would be an alternative solution and the occurrence of convulsions during the hyperpyrexia in our own case would seem to suggest some immediate lesion. We have seen one case of rheumatic hyperpyrexia recorded in which such a lesion was present post mortem but have been unable to find the reference.

Clinical Notes: MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

OBSERVATIONS ON ERYTHEMA NODOSUM.

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THERE is a fixed belief—at all events this is the opinion that would be formed by anyone who takes the trouble to refer to text-books—that the connexion between acute rheumatism and erythema nodosum is a very definite and, indeed, close one. Yet an appeal to personal experience—that appeal which is so seldom made—will show that the belief in this link uniting the two maladies is altogether groundless. I have been interested in this question for a long time and have made observations on the nature and affinities of erythema nodosum in a very large number of cases extending over a long series of years. My experience has been that erythema nodosum has nothing whatever to do with rheumatism, either acute or chronic. In my cases rheumatism had never preceded or followed the cutaneous lesion, joint pains being entirely absent throughout its course. In every case a most careful examination of the heart was made, but the result was in every instance negative, there being no evidence whatever of valvular or other heart disease. It was equally impossible to associate erythema nodosum with other morbid general conditions, and from this point of view the malady should undoubtedly be regarded as *sui generis*.

But there is one cutaneous malady to which the symptoms of erythema nodosum are certainly closely allied—urticaria. Not long ago I saw a middle-aged woman who for four days had been suffering from a rash giving rise to much irritation. The characteristic appearances of erythema nodosum were slightly marked over the shaft of the tibia, but on the extensor surfaces of both forearms the rash was very well developed and quite unmistakeable. At the same time examination of the neck showed the presence of urticarial wheals situated just where the collar presses. If the investigation had been limited to that of the rash on the neck there can be no doubt as to the diagnosis which would have been made; that diagnosis would certainly have been urticaria. These patches were anæmic in the centre and were, according to the patient's statement, extremely fugitive. It is worthy of note, too, in this connexion that the skin generally was extremely irritable and that "dermographism" was well marked. In this case, at all

¹ THE LANCET, May 29th, 1886, p. 1012—"A Case of Rheumatic Hyperpyrexia, with Nervous Sequelæ, simulating Multiple Sclerosis."

events, there can be no doubt that the clinical features of erythema nodosum and of urticaria were combined in one and the same patient. But such cases are not so very rare. I have met with them several times. The deduction to be drawn from these observations is clearly that the alliances of erythema nodosum are with urticaria and that the malady has nothing to do with rheumatism, acute or chronic.

As regards the distribution of the lesions in erythema nodosum it is generally considered that the rash is more or less confined to the lower extremities, its seat of election being the front of the tibia, yet in my experience it is by no means unusual to meet with the characteristic appearances on the flexor and extensor surfaces of the arms and forearms as well as the legs and thighs. In a few instances I have found the lower extremities to be practically free from the rash which was almost entirely confined to the arms and forearms.

It is scarcely necessary to say that the treatment of this malady by salicylates or by anti-rheumatic measures generally is a perfectly futile proceeding. The relations of the affection are certainly not with acute rheumatism; hence it is not surprising that therapeutic measures adapted to the management of that malady are altogether fruitless in this disease. Most important of all details of treatment is rest in the recumbent position and the use of lead and opium lotion may be agreeable and soothing to the patient. But when severe pain is present warmth seems to be the most efficient method of relieving it. Internally quinine may be administered, but it is more than doubtful if any drugs control the course of the malady.

In view of the close relationship existing between erythema nodosum and urticaria it is scarcely necessary to insist upon the importance of attention being devoted to the diet, the condition of the stomach, and the state of the bowels.

Wimpole-street, W.

A CASE OF CHRONIC PULMONARY TUBERCULOSIS TERMINATING IN ACUTE SURGICAL EMPHYSEMA.

By J. F. HODGSON, M.B., CH.B. VICT.,

RESIDENT MEDICAL OFFICER, HALIFAX UNION POOR-LAW HOSPITAL.

It is probably a rare occurrence for a case of chronic pulmonary tuberculosis to terminate in acute surgical emphysema. Such a state of things was found in the case of a patient in the Halifax Union Poor-law Hospital.

The patient was a man, aged 41 years. He had been phthisical for 25 years and presented all the signs of chronic pulmonary tuberculosis. When I saw him on the day of his death he was suffering excruciating pain in the region of his left shoulder. A slight emphysematous puffiness on the left side of his neck was all that could be made out then. The emphysema was very acute, two and a half hours only elapsing between the appearance of the first symptom and death. The patient, naturally a very thin man, soon became enormously distended. The emphysema was general, the skin all over the body being very tightly stretched.

At the post-mortem examination on opening the thorax the right lung was found to be fixed to the chest wall in places by old adhesions. The lung itself showed evidence of old-standing phthisical lesions. The left pleural cavity was entirely obliterated, it being quite impossible to separate the lung from the chest wall. On attempting to do this there was disclosed, situated at the posterior portion of the apex of the left lung, a cavity of the size of a pigeon's egg. Projecting into this cavity was a sharp spicule of bone. A portion of the thick cap of pleura covering the apex of the left lung was necrosed opposite to the third left rib. The inflammatory process had spread to the bone and so weakened it that it had snapped about two inches from its vertebral end. Very little force must have sufficed for this, as the patient was kept in bed and had very little cough.

I am indebted to Mr. J. F. Woodyatt, the principal medical officer, for permission to publish the case.

Halifax.

A SERIES OF CASES OF JAUNDICE IN THE FŒTUS

By G. FRANCIS SMITH, M.R.C.S. ENG., L.R.C.P. LOND.

It is no uncommon thing to meet with a mild attack of jaundice in the newly-born infant, but I believe that the

same condition in the fœtus is rare, and still more so when the resulting poisoning causes death, as described in the following cases, all children of the same mother.

Four years ago a patient under my care, then aged 29 years, was delivered of a male child who was free from jaundice and who is now living. At the age of two years he had a very severe attack which at the time I attributed to obstructive catarrh of the bile-ducts. Three years ago the same woman had another boy born. The child was full-time but stillborn. He was intensely yellow, as were the liquor amnii, the membranes, and the placenta, all of them being deeply stained with bile. Death had presumably occurred one week before birth. Two years ago another boy was born and the same condition of the liquor amnii and membranes obtained. The child, who lived three days, was green at birth and became more so afterwards. Symptoms of bile-poisoning supervened, terminating in coma. One year ago a girl was born. Here again the same condition prevailed, only that the child lived five days. On June 26th, 1902, another boy was born. The liquor amnii was less dark and the child was less stained than on the previous occasions; but here, again, life seemed to flicker a few hours after birth. The child would not take the breast, cried pitifully and moaned, gradually became comatose, and died on the third day.

In none of these cases was there obstruction to the flow of bile into the intestines, for the first and subsequent motions were deeply bile-stained. The mother had one attack of jaundice some three and a half years ago whilst pregnant with the child that was stillborn. She is otherwise healthy though fragile-looking. The father is the picture of health and strength and the family history is good on both sides. I am utterly at a loss to account for these strange cases and I cannot even suggest a probable cause of the jaundice, or rather the excessive secretion of bile, which in each case was present before birth and was the direct cause of death.

Watford.

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.

WESTMINSTER HOSPITAL.

A CASE OF SPLENIC LEUKÆMIA TERMINATING IN TUBERCULOSIS.

(Under the care of Dr. W. MURRELL.)

THE association of tuberculosis with splenic leukæmia is so rare that it is very desirable that every case in which these two conditions coexist should be published. The completeness with which the details of the following case are recorded greatly enhances its value.

A woman, aged 21 years, was admitted into Westminster Hospital on July 9th, 1901, complaining of general weakness and debility. She stated that she was perfectly well until the previous September, when after an attack of influenza she noticed a swelling in the abdomen on the left side. Three months later she had rheumatic fever with which she was laid up for eight weeks. Failing to recover her strength and experiencing some discomfort from the swelling she went to the Charing Cross Hospital, where she was treated with arsenic, iron, and galvanism with benefit. She stated that both her father and mother were living and well. She had four sisters, all of whom suffered from anæmia, and two brothers who were in good health. Her mother's brother died from phthisis at the age of 35 years and two of her maternal aunt's children died from the same disease.

On admission, and for some days after, her temperature varied from 100° to 101° F. She was pale but not markedly so, and there was dyspœna on exertion. There was a considerable amount of pigmentation, especially of the abdomen and in the neighbourhood of the axillæ, nipples, and groins. There were brown pigment spots ranging in size from that of