His neck and chest were thickly covered with sudamina. There was tenderness over both sides of the neck but no mastoid cedema. The abdomen was soft. The heart and lungs were normal. The patient, whose voice might be described as "laryngeal," could blow down each nostril but not freely. The sight, said to have failed but little during the course of the illness, was adequate to recognise the position of the seconds-hand of my watch. Both eyeballs were thrust forward more or less in the axis of the orbit and the ocular movements were restricted in all directions. There were no complaints of diplopia. The free edge of each lower lid was overlapped by red and fleshy chemosis, derived from the lower half of the ocular conjunctiva. The superficial parts of each eyeball were normal. The pupils, transverse diameter 3 millimetres, were active to light. The retinal veins were grossly distended, the retinal arteries were small, and the optic discs were somewhat hazy, although definite papillitis could not be said to exist. A diagnosis of thrombosis of the cavernous sinus was made and a correspondingly bad prognosis was given.

At 4.30 A.M. on May 9th the patient was seized with dyspnoea, accompanied by much cyanosis, and his condition was so grave that he seemed likely to die then and there. The attack lasted for six and a half hours. I saw him on the following day. He was desperately ill and although semi-conscious answered questions intelligently. His skin had an earthy colour and was covered with sweat. The pulse was 168, the respirations were 62, and the temperature was 102°. The pupils, 6 millimetres, were active to light. Exophthalmos had increased since the last note, so that the eyeballs could now scarcely be covered by the eyelids. The chemosis was as noted. A reddish, semi-fluctuant swelling was present beneath the inner half of the right upper lid and a similar though smaller swelling beneath the inner third of the lower lid. An abscess had developed at the root of the index finger of the right hand. A small superficial pustule was present, but it was clear that pus was present in the metacarpo-phalangeal joint itself. The patient was obviously suffering from pyæmia and at the point of death. As a matter of fact he died at 3.10 A.M. on May 11th, after an acute illness that had lasted for about 23 days.

Post-mortem examination.—A necropsy was made at 5.45 P.M. on the day of the patient's death by Dr. W. A. Milligan, pathologist to the Queen's Hospital for Children. It was noted that the proptosis had receded and that the chemosis had become reduced. The head alone was examined. On removing the skull-cap the dura mater was found to be bulging and the veins distended. When the dura mater was opened pus was seen on the surface of the brain, extending upon the Sylvian fissure. On raising the frontal lobes a large amount of pus was found to lie beneath the right lobe. When the brain was removed pus was seen to cover the whole of the base and to extend up the Sylvian fissures, more especially as regards the right side. On section the brain and cerebellum were normal. The sinuses were then systematically examined and the following conditions were found. On opening the cavernous and the circular sinuses pus welled up and a little dissection showed that an organised thrombus ran from one cavernous sinus to the other through the circular sinus. The right supra-orbital plate was then cut away and pus was found lying in the orbit, thus accounting for the swellings (abscesses) noted in the right orbit during life. The sphenoidal sinus and the ethmoidal cells also contained pus. The longitudinal venous sinus was also affected in the same way. On the other hand, the right frontal and the right maxillary sinus were free from pus and so was the right ear. The metatarso-phalangeal joint of the right index finger was opened and was found to contain pus. The conclusion reached from the post-mortem examination was that infection had spread from the ethmoidal and sphenoidal to the circular and cavernous sinuses and had set up a septic meningitis associated with pyæmia, to which the patient ultimately succumbed.

Bacteriological examination.—Agar tubes were smeared with pus from (1) the right cavernous sinus, and (2) the finger-joint. Other media were also inoculated and smears were also made from the sources named. From pus in the cavernous sinus after incubation cultures of the pneumococcus were obtained and organisms answering to that description were also found in the cover-slip preparations. Staphylococci were cultivated from pus in the finger-joint.

Welbeck-street, W.

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

ENDEMIC FUNICULITIS.

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AFTER reading Mr. D. K. Coutts's interesting article under the above heading in THE LANCET of Jan. 23rd (p. 227) I feel that the following (?) example of the malady may be worth recording.

The patient, an Egyptian, aged 65 years, was admitted to hospital under my care in June last. He gave a history of having had a right inguinal hernia for some years, which about ten days before admission became irreducible and progressively more and more painful. There was no vomiting or constipation. On admission the temperature was 38.5° C. and the right inguinal canal and upper part of the scrotum were filled with a tense, tender, doughy, cylindrical mass which gave no impulse on coughing. Although aware of Mr. F. C. Madden's paper,¹ I must confess that I diagnosed the case as one of strangulated hernia and operated immediately. After cutting through the skin and superficial tissues I first entered a large, evil-smelling abscess cavity with sloughy walls. In the floor of this I found a dark-purplish sausage-shaped mass running upwards towards the internal ring and downwards into the scrotum. A little blunt dissection showed me that this was formed by the tissues of the cord inflamed and swollen to a thickness of one and a quarter inches in diameter. The mass was studded with tiny cavities. Imbedded in its upper end a finger-shaped structure attracted my attention and it proved on investigation to be the inflamed vermiform appendix. I amputated the appendix at its base and freed the rest of the inflammatory mass from the cæcum, to which it was adherent on the outer aspect. The cord was then ligated and divided, the junction of the ileum and cæcum was pulled out and cleansed with saline solution, and, lastly, the gangrenous tissues composed of the cord-imbedded appendix and testis were removed *en masse*. A cigarette drain was placed in the internal ring and another in the scrotum. The patient, in spite of his advanced age, made a rapid and uninterrupted recovery.

The relation of this case as it stands might of course suggest that we had a hernia containing an adherent appendix which, becoming inflamed, subsequently infected the cord, producing thrombosis of the pampiniform plexus and cellulitis. However, apart from the rarity of appendicitis amongst the Egyptians, I am persuaded that this was not the case. A few months before I had an opportunity of removing an appendix contained in the sac of a strangulated hernia and the picture was utterly different. In this case the parts removed, after hardening in formalin, were kindly examined for me by Dr. M. Amand Ruffer and I think the term "embedded in" best describes the relation which we found the appendix presented to the tissues of the cord. The testis apparently was little affected.

If this case may be grouped in the same category as those of Mr. Coutts, there is one point of contrast which I think deserves mention—namely, the advanced age of the patient. I notice that Mr. Coutts says that it appears to be a disease of young adults. In one point I cannot quite agree with him. He advocates the conservative treatment of the testis, partly on account of the value of its internal secretion. Surely this is of less importance after the age of puberty and the presence of the remaining organ will be sufficient guarantee against any of the unpleasant sequelæ sometimes seen when orchidectomy was practised as a remedy for prostatic hypertrophy. Again, with drainage the dangers of having possibly left an infected stump should be, at any rate, not greater than those incident to the method of treatment by incision and lysol fomentations.

I had one other case in December, 1907, which was also successfully treated by orchidectomy, whilst I also have had

¹ THE LANCET, Feb. 23rd, 1907, p. 505.

an opportunity of seeing one fatal case in the practice of another surgeon in which no treatment had been adopted. Seeing, therefore, that the condition may have a serious termination, my own inclination would be for the more radical measure, except in cases where the other testis was absent or diseased.

Alexandria.

NOTE ON A CASE OF ELEPHANTIASIS VULVÆ.

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A MARRIED woman, aged 42 years, was admitted to the Oldham Infirmary on June 27th, 1907, under the care of Dr. A. H. Godson. She complained of large growths between her legs which prevented her from sitting down. Very briefly the history of the case is as follows. Four years previously she noticed a lump on the left side of the vulva of about the size of a pigeon's egg. This continued to enlarge painlessly until its size gave her some concern. She then sought advice at a gynæcological hospital in a neighbouring city. She was admitted for a few days and was then treated as an out-patient for some time. Two years later a similar growth appeared on the other side, while that on the left side had now reached a considerable size. She again became a patient at the aforementioned hospital. She now began to have difficulty in micturition and on several occasions a medical man had to be called in to pass a catheter. The growths continued to enlarge and her difficulties in walking, sitting, and micturating increased proportionately until her life became a misery. On examination her general appearance was that of a fairly healthy woman. On separating the thighs three large growths could be seen attaching themselves to the vulvar region. The lateral growths were each of about the size of a cocoanut and they hung down by a broad pedicle from each labium majus. The middle growth was smaller and was attached by a broad pedicle to the left labium minus. The right labium minus was thickened but did not present any prominent growth. (These appearances are shown in the photograph which is here reproduced.)

Reproduction of a photograph taken just before operation.

The surface of the growths was everywhere irregularly nodulated and was covered by unbroken skin. There was no sign of ulceration or fungation. Much decomposing secretion lay in the folds of the groin and where the growths lay in contact with each other and with the skin of the thighs. The whole mass was offensively odorous.

The diagnosis was not very certain, but it was thought

that lymphatic obstruction had much to do with the swellings from the larger labia. In order to facilitate the lymphatic flow the central mass (that from the left labium minus) was amputated. The patient was put on a course of izar baths and the larger tumours diminished somewhat. There being no marked improvement both were amputated at a later date. The patient made a good recovery and left the hospital on Oct. 7th. Four months later she was examined and no sign of recurrence was present. She was quite well and at work.

A histological examination proved the growths to be non-malignant and to be composed chiefly of fibrous tissue with enlarged lymph spaces and groups of small round cells congregated round the blood-vessels.

The history, clinical appearances, and the histological examination all point to a diagnosis of elephantiasis, the causal agent being unknown. Dr. G. F. Barbour Simpson of Edinburgh who has examined the photographs and section agrees with this view.

I am indebted to Dr. Godson for permission to publish the case and to Mr. Sneyd, the radiographer, for the photograph.

Warrington.

A CASE SHOWING THE VALUE OF WATER AS A DIET FOR PREMATURE INFANTS.

BY A. G. WHITEHORNE-COLE, L.R.C.P. LOND.,
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AND

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Mrs. — gave premature birth on Nov. 15th, 1907, to a male child at the sixth month. The labour, which was natural, altogether lasted one hour. Immediately after birth the infant was wrapped in cotton-wool. Since he made no effort to suck when put to the breast the milk was withdrawn and the child was fed with it but he could not digest it. He was then fed hourly for the next 12 hours with 3 drachms of warm water to which a quarter of a grain of bicarbonate of sodium was added, and in addition spiritus ammoniæ aromaticus, $\mathfrak{m}$ iii., with distilled water to 1 drachm, was given every hour. For the following 24 hours the water diet was given as before and the aromatic spirit of ammonia every three hours. The child was then put to the breast again, but he still had no idea of suction; the milk withdrawn was given to him but still he could not digest it. The milk was then used diluted to various strengths with sterile water, barley-water, and lime-water, but in each case it disagreed with the child. He had now lived four and a half days and showed signs of improvement. Fully peptonised milk in the proportion of 1 of milk and 7 of water was now tried; this he continued to take for two and a half days, when he became fretful and flatulent. Half a grain of grey powder was given, also a little aromatic spirit of ammonia and peppermint water, and the "water diet" adopted for a day. Peptonised milk in the above proportions was now given for two days and "water diet" on the third day. This alternate method of feeding continued until the child was 31 days old. At this age the child was in good condition; he had gained 10½ ounces (he weighed 2 pounds at birth); the cheeks had filled out; the yellowish discolouration of the skin which was present at birth had disappeared; the umbilicus was healed naturally; the child had a much stronger cry, slept well, and showed quite a keen desire for his food.

On his thirty-first day he suddenly became cold and rigid; the jaws were fixed; the respiration was slow and very shallow; the pulse was weak and rapid; the colour was unaffected; there were no twitchings, and the legs were not drawn up. This attack passed off rapidly on the child being immersed in hot water and a little brandy ($\mathfrak{m}$ v.) being given. For the next three days the child was put on the "water diet," but his progress was most unsatisfactory, frequent doses of brandy having to be administered. He then had another attack of a similar nature to the previous one, which he did not survive. The infant lived 34 days.

Remarks.—This case is rare and of considerable interest for the following reasons. The infant survived 34 days (very exceptional).¹ There must have been very fair

¹ Jellott: Manual of Midwifery, p. 107; also Edgar: Practice of Obstetrics, p. 85.