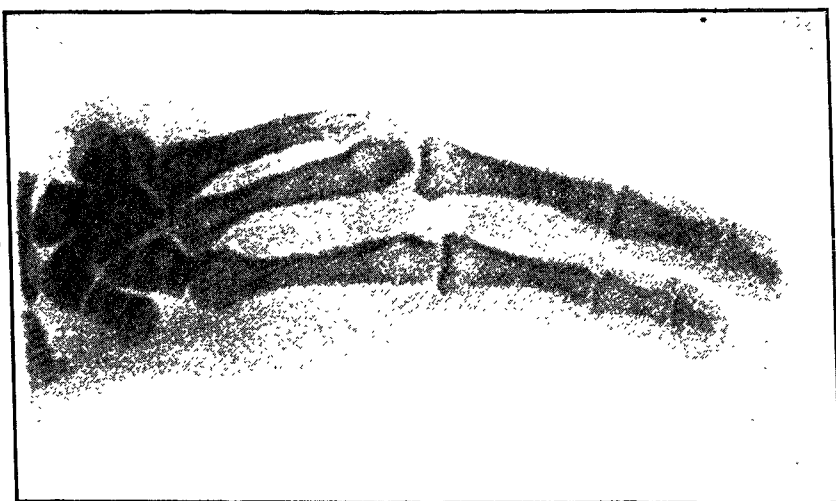


## CLOVEN FEET AND HANDS.

BY JOHN BELL, M.R.C.S. ENG., L.R.C.P. LOND., D.P.H.,  
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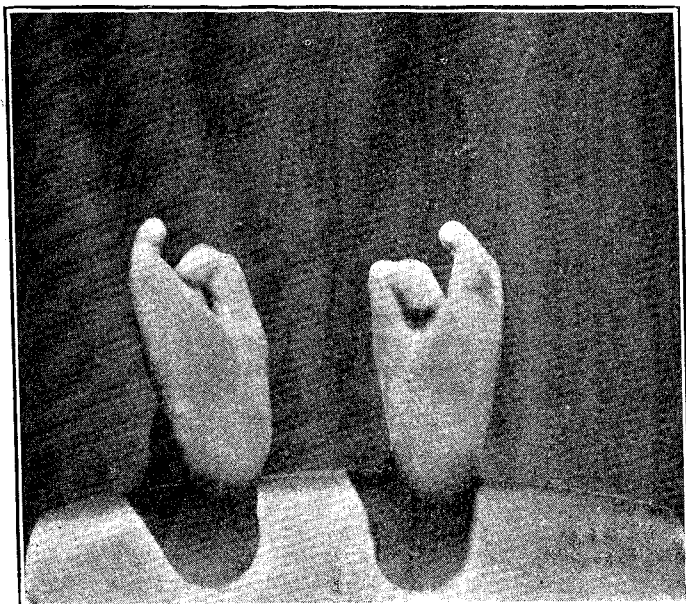
THE accompanying pictures illustrate what I believe to be a rare congenital malformation, and they may therefore be of interest. The subject was a Chinaman, aged 26, who was sent to us at the Civil Hospital, Hong-Kong, as a curiosity. Except for his hands and feet he was normal in all ways,

FIG. 1.



Reproduction of skiagram of right hand; the skiagram of the left hand showed similar deformity.

FIG. 2.



Reproduction of photograph of feet, the hooked halluces being very marked.

and, indeed, a good specimen of his class. No family history as to similar or other deformities could be obtained. He was able to use his chopsticks between his fingers in a most dexterous manner.

Hong-Kong.

## THE TREATMENT OF BASIC MENINGITIS BY THE INUNCTION OF IODOFORM OINTMENT.

BY HAROLD MOWAT, M.D. EDIN.

I WAS interested in reading up the subject of meningitis to find a reference in THE LANCET of Sept. 30th, 1905, by Mr. H. C. Wilson to the value of inunction of iodoform ointment into the neck in a case of tubercular meningitis. The writer claimed that he had treated a case of this deadly disease successfully by this means, and, while admitting that

the diagnosis of "tubercular" might possibly be incorrect, stated that all the symptoms of the case pointed to such an origin. It occurred to me that it would be useful to try the inunction in cases of ordinary basic meningitis of the toxæmic variety, as our ordinary remedies have never proved very efficacious, the mortality from the disease being extremely high. Within the last few months I have been successful in two cases, and believe that the satisfactory results were largely due to the inunction.

The first case was that of a boy, aged 9 years, who contracted measles. When the rash had disappeared a temperature of 103° F. remained, and the boy complained of severe frontal headache and stiffness of the neck. His neighbours were kept awake during the night by his shrieks, which were of the typical meningeal type. These passed off in two days and were replaced by constant moaning. He took no notice of his surroundings, except when sharply spoken to, when he replied to questions in a dazed fashion. He was very sick. *Tache cérébrale* was well marked, the muscles of the neck were rigid, while Kernig's sign was also present. As soon as I was told of the screaming I suspected the onset of meningitis and made up an ointment containing 15 grains of iodoform to the ounce of vaseline, which I instructed the parents to rub thoroughly into the back of his neck and posterior part of his scalp night and morning. I also gave him small doses of potassium iodide and bromide. Within the week his symptoms were greatly relieved and his temperature had fallen. Since then he has been in perfectly normal health.

The second case was that of a girl 3 years old, whom I treated quite recently. She was taken ill with severe diarrhoea and vomiting, attributable to the eating of a sausage on the previous day. Under treatment the diarrhoea soon disappeared but the sickness continued. She uttered the meningeal cry and afterwards moaned. She took no notice of anyone except when she was spoken to. Her temperature rose to 102° F. Her tongue was clean. *Tache cérébrale* was present. Kernig's sign was apparent on the fourth day. She squinted and showed marked extensor reflex of the big toes. On the sixth day she sank into a comatose state. I treated her in the same manner as the former case, but when the state of coma was reached I was compelled to tell her parents that I considered the case hopeless. On the eighth day she woke as from a natural sleep, spoke to her parents, and showed every sign of recovery. Since then she has had no relapse. Although I told her mother to apply the iodoform ointment twice a day she afterwards informed me that she had done so four times within each 24 hours.

Personally I have now a good deal of confidence in this method of treatment, and believe if it were more largely used our mortality from meningitis would be lessened.

Bromley-road, S.E.

## A CASE OF FISTULA OF THE LACRYMAL SAC.

BY S. CHURCHILL, M.A., M.B., B.C. CANTAB.,

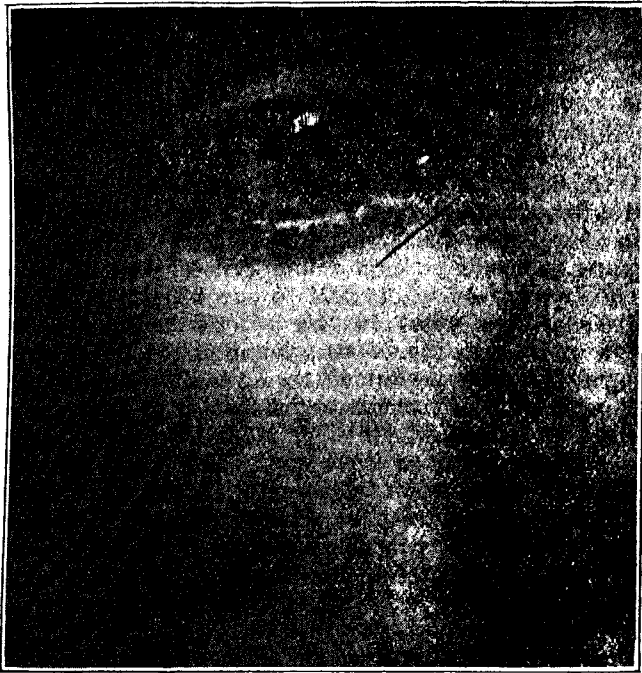
HOUSE SURGEON TO THE ROYAL ISLE OF WIGHT COUNTY HOSPITAL, RYDE; LATE HOUSE PHYSICIAN TO ST. THOMAS'S HOSPITAL, LONDON.

THE accompanying illustration shows a unilateral fistulous opening whereby the right lacrymal sac communicates with the exterior by a channel other than those afforded by the canaliculi and the naso-lacrymal canal.

The patient is a married woman, aged 26 years, who was sent to the ophthalmic department as a case of lacrymal obstruction. Mr. H. J. May examined her. He was unable to squeeze any mucus or pus from the sac through either punctum and asked me to confirm this by syringing the canaliculi. This I did and noticed that the fluid issued as a jet from the region of the lacrymal sac. At first I thought this was due to the presence of obstruction causing the fluid to return through the upper punctum. But on closer examination I found a minute opening in the skin over the lacrymal sac, skirted by a semilunar fold and admitting the point of a Nettleship's caraculus dilator. A piece of

horse-hair pushed into the opening (as in illustration) passed for a length of 3 inches down into the nose. Fluid injected by either the upper or the lower canaliculus is partly voided from the nose and throat and partly from this opening.

Referring to J. H. Parsons's "Pathology of the Eye," vol. iii., Part I., p. 906, the following words on the subject of fistulæ occur: "They have been attributed to arrest of



development, and minimal failure of the fissura facialis to close (Harman). This may be true of some cases, but they are probably more often of inflammatory origin. There is usually blennorrhœa of the sac. Adler attributes the fistula to arrested development and the blennorrhœa to foetal inflammation, an unnecessary complication." As there is no evidence in this case of blennorrhœa, I conclude that this is a presentation of the morphological variety.

Ryde.

## Medical Societies.

### UNITED SERVICES MEDICAL SOCIETY.

*The Development of the Army Medical Service.—Pruritus Ani.*

A MEETING of this society was held at the Royal Army Medical College on Dec. 14th, 1910, Surgeon-General W. BARTIE, V.C., C.M.G., being in the chair.

Lieutenant-Colonel M. W. H. RUSSELL, R.A.M.C., opened a discussion on Recent Tendencies in the Development of Army Medical Services. He pointed out that under modern conditions it had become impossible for wounded men to be removed from the fighting line till dark, or at any rate till there was a lull in the fire; the wounded at the front could only be collected in "nests" and treated by the regimental *personnel* till this happened, and so there was a general tendency in most armies to increase the efficiency of the regimental aid by improving training and increasing the regimental supply of appliances. He suggested that in our army the water *personnel* should be made available for regimental aid during action, since their duties in connexion with water were in abeyance at that time; also that we might well follow the example of Germany, France, and Austria in making the regimental bearers devote their whole time to their bearer duties, and thus become not only more efficient but entitled to the protection of the Geneva Cross. The speaker then discussed the uses and organisation of collecting stations for lightly wounded, which are established five or six miles behind the firing line, and which occupy themselves not only in attention to lightly wounded men, so relieving the dressing stations, but also in the care of those unfit to go into action and in the collection of improvised transport. Lastly, he drew attention to the very considerable changes in arrangements which were likely to follow the more

extended use of mechanical transport in war.—Lieutenant-Colonel O. H. BURCHALL, R.A.M.C., thought it would be impossible to combine the duties of water men and first aid. He also thought it impracticable to send lightly wounded direct from the regiments to the collecting station; in the Japanese army these men passed through the dressing station.—Major C. F. WANHILL, R.A.M.C., protested against the diversion of water men from their legitimate duties.—Colonel A. PETERKIN, A.M.S., doubted if one collecting station for a division would be sufficient on account of the distance from the flanks.—Surgeon-General BARTIE called special attention to the alterations necessitated by the employment of mechanical transport.—Surgeon-General G. J. H. EVATT, A.M.S. (retired), Lieutenant-Colonel A. P. BLENKINSOP, R.A.M.C., and Lieutenant-Colonel H. D. ROWAN, R.A.M.C., also took part in the discussion.—Lieutenant-Colonel RUSSELL, in reply, pointed out that in action everything, even sanitation, must be subordinated to the defeat of the enemy, hence his recommendation to utilise the water men for first aid at this time. As the collecting station was five or six miles in the rear there was no need to duplicate these establishments.

Major W. E. MILES, R.A.M.C., T.F., read a paper on *Pruritus Ani*. He was of opinion that it should more properly be labelled "dermatitis ani." He considered that it was not of nerve origin since most cases yielded to local treatment, but that it usually arose in patients with a gouty or eczematous diathesis, and that of the exciting causes rectal constipation was the most prominent. Treatment consisted in local applications of hot water, sedative and astringent ointments and powders, and in the removal of the exciting cause, especially rectal constipation.

Major T. W. GIBBARD, R.A.M.C., showed a case of Extensive Syphilitic Ulceration of the Head and Face which had resisted the usual treatment but which healed promptly after injection of "606." The demonstration was accompanied by photographs of the condition before and after treatment.

### LIVERPOOL MEDICAL INSTITUTION.

*Miscellaneous Business.—Operations for Varicose Veins.—Ehrlich-Hata Remedy for Syphilis.*

A MEETING of this institution was held on Dec. 22nd, 1910, Dr. T. R. BRADSHAW, the President, being in the chair.

In reply to a communication from the Education Committee addressed to the secretary the following resolution was passed:—

The members of the Liverpool Medical Institution are absolutely opposed to any plan by which school children found on inspection by the school medical officer to be defective receive treatment by the voluntary hospitals. They are also of opinion that the fee proposed by the local education authority for the correction of defective vision is inadequate.

Mr. R. E. KELLY read a note on the Operations for Varicose Veins. He gave an account of the historical evolution of the various methods of operative treatment, and then described Mayo's operation, which he had performed recently about 12 times with excellent results.—Mr. K. W. MONSARRAT read a note on the same subject. He considered that no standard operation was suitable to all cases; that as reflux from deep to superficial veins was the main cause of varicosity in the latter, it was of the first importance to ascertain where this reflux was occurring. On this investigation depended the choice of operation. There were three types of operation: (1) simple resection of the internal saphenous close to its termination; (2) resection confined to varicose branches below the knee; and (3) total saphenectomy.—Mr. W. THELWALL THOMAS, Mr. RUSHTON PARKER, and Mr. G. P. NEWBOLT all considered that there were some cases which no operation would cure.—Mr. THOMAS said that usually some modification of the Trendelenburg operation was the best. In Trendelenburg's original description the saphena was ligatured at the junction of the middle and lower third of the thigh or a little lower. Mr. Thomas found that this was not always satisfactory, and in 1896 recommended in the *Liverpool Medico-Chirurgical Journal* that the vein should be tied near to the saphena opening.—Mr. NEWBOLT mentioned the case of a patient in whom the operation promised to be very