a return on the second day following. Since then I have frequently seen intermittent fever in the winter season, and especially in the early months of spring, before the generation of malaria could be suspected from an elevated temperature.

The anomalous forms of intermittent disease are, however, of more frequent occurrence during cold weather, than the more simple and easily distinguished cases, of which I shall have more to say in a future article. The occurrence of such cases as these has great influence with the non-professional observer, who cannot appreciate the action of a cause remote from the attack, in strengthening his opinion against the malarial origin of fever.

Humidity of the atmosphere, fogs and rains have often been regarded as the essential causes of fever, from the apparently intimate relation of one with the other in many instances.

It is very common in malarial regions for a large accession of fever cases to occur immediately after the falling of rain, especially if accompanied by a low temperature of the atmosphere. The effect of the rain, under such circumstances, is merely to excite the dormant malaria that has been previously taken into the system to action, or in other words, developing the fever that had been previously cumulating. Acting thus as an exciting cause, the unthinking look no further back for one pre-existing. Another equally plausible supposition is oftentimes offered to the physician, viz., that the fever is the result of a cold, which it will readily be seen may frequently be a coincidence.

The effect of fogs, dews, and otherwise humid states of the atmosphere, consists more essentially in the capacity of aqueous vapor to hold malaria by absorption. In this way it is taken into the system in a concentrated state, and more promptly develops fever.

The assertion that fevers are more rife in tropical climates during the rainy season, made by Lind, Fordyce, La Roche and many others, is not always true. On the Isthmus of Panama, the rainy season is proverbially the healthiest. The more continued the rain, the less fever. On the other hand, with the setting in of the dry season fevers become more frequent and more severe. In climates where rains are not as continuous during the wet season as they are on the Isthmus of Panama, I can readily suppose that the cause of fever would be generated to a degree even worse than during the dry. The law which governs the generation of malaria holds good in all climates, however varying in temperature, and this will be found to accord with the relative degrees of continued saturation of the soil, succeeded by drought, as I have attempted to show in the preceding article.

DISLOCATION AT THE TARSO-METATARSAL ARTICULATION.

[Communicated for the Boston Medical and Surgical Journal.]

THE following case of dislocation having occurred under my observation, I thought its extreme rarity and almost impossible nature sufficient apology for reporting it.

C. F., the patient, a robust and vigorous young man, æt. 25, while riding on horseback, was suddenly dismounted by the stumbling and falling of the animal, whose whole weight fell upon his left foot.

It presented, upon the examination of Dr. L. J. Ham, of this place, the following appearances. The length of the foot was shortened about one inch. There was a prominent elevation upon the dorsum, indicating the tarsal extremities of the first, second and third metatarsal bones, riding over the cuneiforms. I saw the case several times in connection with Dr. H., and fully concur in the correctness of the diagnosis.

The strong ligamentous union of this articulation, its slight mobility and the compactness of the bones implicated, show the impossibility of dislocation from all ordinary applications of force.

Cruveilhier, in describing the mechanism of this articulation, says that "no example of the luxation of these bones upon the tarsus has been recorded." Consulting several surgical authorities, I do not find this species of dislocation described.

In the present case I have been only able to account for its occurrence on the supposition that the force was communicated in such a manner as to double the phalanges and metatarsal bones upon the plantar surface, dislocating upwards the tarsal extremities of the latter.

The reduction was accomplished in the following manner:—an assistant taking hold of the heel, made powerful counter-extension, while the surgeon, with both hands grasping the foot, made extension, and having brought the dislocated extremities in opposition, they were reduced by strong compression with the thumbs.

There being not much tendency to displacement, in order to prevent the active inflammation which must supervene upon so extensive a laceration of the ligaments, light dressings and evaporating lotions were employed.

A high grade of inflammation followed, and at one time the lividity of the surface gave strong indications of an approach to gangrene; this, however, did not occur, and with the subsidence of the inflammation the foot has progressed slowly, but favorably, to recovery.

Some time must necessarily elapse before the normal elasticity and strength are acquired, owing to the extensive infiltration and the slowness of the reparative process in these dense fibrinous tissues.

D. W. HERSHEY, M.D.

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