eyebrow, and runs up to shade off into healthy skin at the root of the hairs. A fourth spot of disease is an inch and a half long and half an inch wide, is situated in the front part of the left side of the head (the temporal region). There is a fifth place on the crown of the head, the size of a two-shilling piece, with a tail-piece as it were. The spots all appeared in the order above given. All the spots are hard, dense, and whitish in colour, and some are slightly depressed. There is no areola visible with any of them. The tactile sensibility is fair in all the places, which are the seat, however, of a certain amount of itching. The mouth has lately felt uncomfortably stiff, and the angle of the mouth appears to be slightly drawn down as it were by the condensation of the diseased tissue on one side, giving the appearance of slight paralysis affecting the left side of the mouth. The woman is married, but has never exhibited any sign of syphilis. The only thing she complains of is debility. This patient was put upon a general tonic regimen, and, I believe, improved ultimately in the hands of the medical man who sent the case for my opinion.

When cases of morphea come under treatment, the patient should at once be made to understand that a long time may be needed for the cure if it progresses ever so well. The disease will in all probability get quite well. At the same time, the use of the knife, caustics, and every other irritant must be scrupulously avoided, and trust be placed entirely in appropriate general tonics.

ON THE CAUSE AND PREVENTION OF SEA-SICKNESS IN SHORT PASSAGES.

By J. HENRY BENNET, M.D.

DURING the last fifteen years I have crossed the Channel between thirty and forty times, and I have made scores of voyages in the Mediterranean in spring, in all kinds of weather. I have thus increased former experience of sea-sickness, and have arrived at some practical results, as regards prevention, which prove valuable to myself and friends, and to which I am desirous to give publicity.

On one of my late voyages in the Mediterranean I encountered vile weather, and succumbed, after being twenty-four hours at sea. Whilst enduring all the misery of sea-sickness I once more tried to analyse my own sensations, and to find why it was I was suffering. The most approved theory is that sea-sickness is a nervous affection, connected with the brain, and with the ever-changing position of surrounding objects, relatively to the body and vision. I feel convinced, however, that such is not the sole cause, from my own personal experience. I have no fear whatever of the sea. Unless actually ill, I delight in being on it, however rough, in any way—swimming, in a boat, a steamer, a yacht, or a sailing vessel. If not very rough, I am quite happy and well, and can eat ravenously. Yet sometimes, when the motion is very great, especially when it is a cross motion, such as a combination of plunging and deep rolling, as on this occasion, I become desperately ill, throwing up huge quantities of bile. What has the nervous system, or change of position, to do with such sickness in one who, like myself, on land feels no inconvenience whatever from any description of motion or gyration? Whilst lying on my back in the cabin, crossways to the ship, which rolled until twenty times in the minute, the port-hole window was many feet beneath the sea, I watched the water in the decanters and basins. As we rolled the water rolled too, swashing violently from side to side, and I felt that my internal economy was doing the same. At one moment all the moveable contents of the body, liquid and solid, were thrown one way, towards the feet, as it were; the next, they were thrown with violence upwards, and on the diaphragm, on the liver. This latter organ is so imprisoned under the ribs, so bound that it cannot get out of the way. Tickled, pounded, in this manner, it gets angry, excited, stimulated, pours out bile into the intestines and stomach, which ought never to receive it, except during the process of digestion, and this occasions sickness and vomiting. This mechanical theory would explain the real efficacy of purgatives taken a day or two before starting, which clear the liver of bile; of a bandage, which protects it from being thus pounded; of

habit, of opiates, and of nerve stimulants, such as tea, coffee, wine, spirits, which deaden its susceptibility, and induce it to bear insult and actual blows without resentment. The disturbance of the circulation is also an important element in sea-sickness to be taken into consideration.

Following this train of thought, I think I have discovered the means of avoiding sea-sickness entirely in many cases, not in all, in short passages, and of preparing for long passages. The stomach should be absolutely empty before going on board, for I have noticed that sick people generally throw up basinfuls of food on the Channel steamers; but, to avoid exhaustion, a good meal should be taken three, four, or five hours before, according to the nature of the food. Meat requires four, in some five, hours for complete digestion. Then, one or two hours before embarking, some very strong coffee, tea, or spirits and water, should be taken, without milk or other food. This is to tonify the nervous system, and yet to secure emptiness of the stomach, fluids being usually absorbed in less than an hour. Once on board, repose should be enjoined—the recumbent position is best,—and nothing whatever, solid or fluid, should be taken for twelve hours or more, even then very little. On this system food and the medicinal stimulant are taken *before* the stomach is exposed to sympathetic irritation, and the general economy and the nervous system are thereby invigorated. As there is nothing left in the stomach or given it to digest, it remains quiescent under difficulty. The reason that medicines given in sickness do no good is that they are not absorbed. Once even nausea commences, the stomach refuses to absorb liquids or to digest solids, and the more there is in it the worse it behaves. The best stimulant in my experience is very strong black coffee. Scores and scores of my friends and patients have escaped sea-sickness in short passages by observing these rules, and have diminished suffering in longer ones.

It will be perceived that, so far from countenancing the prevalent idea that travellers at sea should go on board with a stomach full of food, I consider that it is an error to do so. To fill the stomach with food before starting is to give it several hours' work to perform at the very time that it is disturbed, bewildered, and annoyed by the tumultuous motions of the vessel. How can it do its work? It cannot, refuses, and sickness follows. On the Channel steamers it is very seldom indeed that the basins are empty; generally speaking they contain at first pints, quarts of semi-digested food, showing that its presence in the stomach has been a cause of sickness, not a prevention.

In longer voyages, of course, food and fluids must be taken, but I feel inclined to wait until they are wanted, and then to give very simple food at first, such as milk with brandy or coffee, gradually increasing its quantity and varying its nature, as the stomach gains power and becomes accustomed to the motion of the ship.

In long voyages many patients of mine have derived very great relief from the injection of laudanum into the rectum, retained; ten, twenty, or thirty drops at night. Long sleep is secured, during which the body becomes accustomed to the motion, and the next morning light food is often kept on the stomach. I should think that the hypodermic injection of morphia in extreme cases might be beneficial; it is certainly deserving of a trial, and I am not aware that its use, which I recommended many years ago, has been yet tried.

Grosvenor-street.

ON AN IMPROVED EXTENSION APPARATUS FOR THE TREATMENT OF FRACTURES OF THE SHAFT OF THE FEMUR.

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THE perfect cure of an oblique fracture of the shaft of the femur, when the ends of the bone have been completely displaced, has baffled the ingenuity and the skill of surgeons from the time of Hippocrates. The fact that a recovery with half or three-quarters of an inch shortening is at present considered satisfactory should serve as an excuse for the introduction of any improvement in treatment, however slight the alteration may appear.

The opinion of surgeons at the present day will be found to be almost unanimously in favour of treatment in the straight position, as ordinarily practised before Percivall Pott advocated the so-called physiological method or treatment by position.

Hitherto the difficulty has been the proper application of extension. Ordinarily it has been kept up by means of a long splint (Liston's splint), or by means of weights or screws, or, more recently, by elastic traction. The objections to Liston's long splint are that it is apt to strain the ankle-joint, and that, notwithstanding the greatest care, awkward sores are liable to form about the malleoli and over the tendo Achillis. Serious shortening, moreover, not unfrequently attends this mode of treatment. Weight extension, however carefully applied, is generally cumbrous, and always more or less remittent, for the cord is very apt to get entangled with the bedclothes, or to slip off its pulley, especially when the patient has to be moved.

Mr. De Morgan and Mr. Cripps have each invented ingenious splints, in which continuous elastic traction is employed. It was in search of an apparatus rather simpler than these that the writer first employed the elastic stirrup extension, described in Mr. Berkeley Hill's "Essentials of Bandaging," p. 74. It was found, however, that the extension could not be properly regulated, and that the foot was drawn so forcibly outwards towards the splint that much force was lost, and the skin over the external malleolus endangered. To remove these objections the apparatus here figured was proposed, and, meeting with Mr. Erichsen's approval, was adopted in his wards, with hitherto good results.

FIG. 1.

FIG. 2.

The figures will for the most part explain themselves. The foot-piece (G, Fig. 1) is a piece of wood, four inches by two and a half, notched to receive a stout india-rubber ring (F), technically known as a "horse's cutting ring." The foot-piece and the ring are secured to the limb by means of

an ordinary stirrup of stout strapping, two inches wide, extending above the knee, so as to relieve the joint of strain. A long splint is prepared, reaching from the axilla to about eight inches beyond the foot, to the lower four inches of which is screwed a piece of one-inch plank (A), about eight inches long. This piece of wood throws the direction of the traction into a line with the axis of the limb. The limb is then bandaged in the usual way to the long splint, the bandaging being begun above the ankle. When the bandage has been carried above the knee, the leg and splint are grasped together by the surgeon, and extension is made while the perineal band is tightened. A hip spica and a body roller complete the bandaging, but it is well to secure the body roller to the splint by a row of tinned tacks. (In the figure the bandaging is left imperfect to show the perineal band.) Then on the plank (A) is screwed the bracket (B), through which slides the stem (D) of the hook (E). Along the stem and below the bracket runs the screw-nut (C). The hook is now fixed to the ring; and, the stem being passed through the bracket, extension can be made by screwing up the nut. The bracket and stem are similar to those sold by ironmongers for securing the cords of window-blinds, except that in place of the hook there is a little grooved wheel. This wheel is easily changed for a hook; or the whole apparatus, ring and hook, can be obtained from Messrs. Mayer and Meltzer, of Great Portland-street.

The advantages of this instrument may be thus summed up:—The amount of extension can be regulated to a nicety; the extension is constant, for it remains unaltered when the patient is moved or lifted out of bed; and the bony prominences of the foot are free from all pressure. Finally, it is hoped that by the adoption of this very cheap and simple method shortening may be reduced to a minimum.

The following results have been obtained by the writer, and by his successor as house-surgeon, Mr. Maclean, in five consecutive cases of oblique fracture of the shaft. All, except the second, were caused by indirect violence, the last two being very severe cases of double fracture:—

Name.	Sex.	Age.	Seat of Fracture.	Result.
A. M. ...	Male ...	23 ...	In lower third ...	No shortening.
J. B. ...	" ...	17 ...	In middle third ...	"
J. C. ...	" ...	65 ...	{ Junction of upper and middle third ... }	"
J. N. ...	" ...	37 ...	{ Double fracture: 1. Lower third (oblique) 2. A fracture into the knee-joint ... }	½-in. shortening.
A. W. ...	" ...	8 ...	{ Double fracture: 1. Junction of upper and middle third. 2. Junction of middle and lower third ... }	½-in. shortening.

Many other cases of fracture of the femur which have been treated in this way are not mentioned, as they do not come under the head of oblique fracture of the shaft with shortening and deformity.

INSANITARY CONDITION OF CANAL BOATS.

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MANY thousands of the inhabitants of the United Kingdom use the large boats and barges that ply upon the canals and rivers as dwellings. In Ireland there are more than 4000 "boatmen," of whom a large proportion is employed on the inland waters. The sanitary conditions under which boatmen are placed are therefore a subject of considerable importance; and I propose to show that, so far at least as my observation extends, they are far from satisfactory.

I have inspected a large number of the boats which ply on the two canals that enter Dublin, and anything more insanitary than the condition of the cabins of the majority of them it would be difficult to conceive. These "dwellings" are rarely five feet, and sometimes not more than three feet, in height; only a small proportion of them is provided