miscarriages; sore-throat; has been salivated. The present symptoms are, small pits of old ulcers on left tonsil; much tenderness of scalp.

Physical signs.—Dull percussion under both clavicles, with very marked bronchial (whiffing) respiration.

CASE 7.—Charles A—, aged thirty-four (August, 1877). Mother's brother died of phthisis; one brother died of phthisis; contracted a chancre in Paris ten years ago, for which he was treated with mercury; lost his hair and suffered from tenderness of scalp some time after; has suffered from bronchial symptoms for four years; has been losing flesh for eighteen months; no hæmoptysis.

Physical signs.—Both lungs are dull on percussion, from the clavicle to the third rib, the left being the more so; harsh papery respiration over this region.

CASE 8.—Julia N—, aged twenty-three, single, housemaid. Mother died of phthisis. No history of syphilis obtainable, but had a hoarse raucous voice, and had been losing flesh for twelve months. This was a case in which the history was very unsatisfactory.

Physical signs.—Dull percussion under both clavicles, with harsh bronchial (papery) respiration.

She was treated with drachm doses of the syrup of iodide of iron from August 8th to October 16th. Her voice became clear and natural; she improved very much; ceased losing flesh; and the vesicular murmur returned at both apices.

CASE 9.—Mary A. W—, aged twenty-seven; married; four miscarriages; two premature confinements. Has been ill since July, 1876, suffering notably from dyspnœa on exertion. Three years ago she had a bad sore-throat and enlarged glands; and a skin eruption last Christmas. Present symptoms: very thin and bloodless; skin of a bronze colour.

Physical signs.—Dull percussion-note on both sides below clavicle, well marked, and extending to the fourth rib. Harsh papery respiration, blowing sound, over this region; no true vesicular murmur; no crepitation.

CASE 10.—Ellen G—, aged forty-six; married; one miscarriage. Has had a slight cough for some time, and twice suffered from hæmoptysis (a tablespoonful at a time). The present symptoms consist of bronzing of the skin, tenderness of scalp, and cough.

Physical signs.—Harsh papery respiration under the right clavicle to the third rib. The same condition in less degree in the left lung.

CASE 10.—Eliza M—, aged forty-six, single, dress-maker (Oct., 1877). Has suffered from aphonia five years, and cough with occasional hæmoptysis for the same period. Suffers now from dyspnœa, but has not been losing flesh. Her present symptoms are, aphonia, and ulceration of the fauces of specific character.

Physical signs.—Marked dull percussion under both clavicles. Prolonged expiratory murmur, with peculiar papery whiffing sounds at both apices, but most marked under the right clavicle.

CASE 12.—Louisa B—, aged thirty-four, married; four miscarriages. Has suffered from cough for three months, and has been losing flesh. She has now headache, worse at night, with tenderness of scalp; bronzing of the skin; ulcer at back of fauces.

Physical signs.—Dull percussion at the right apex under the clavicle, with harsh papery respiration.

These notes, taken rough and ready as they are from my case-book, present a similarity of symptoms and physical signs such as indicate a peculiar form of disease. The description of the physical signs is in all cases one and the same, and is not to be considered as in any way similar either to that which would be given to describe an early stage of phthisis or a condition of cicatrisation. The special point about this condition is that there are no concomitant signs of liquefaction, and if excavation occurs afterwards, as it does sometimes, a secondary process must be credited with this result.

With regard to the special treatment adopted, in many cases it has a speedy effect in relieving symptoms and restoring the natural healthy condition of the lungs, but further experience is necessary before I feel inclined to make any definite statement as to the best mode of treating syphilitic phthisis.

A CENTENARIAN.—The obituary of "The Times" of Monday last recorded the death of a lady who had reached the great age of 100 years and six months.

ON PRURITUS VULVÆ AND DIABETES.

By ALFRED WILTSHIRE, M.D., M.R.C.P. LOND.,
JOINT LECTURER ON MIDWIFERY AND THE DISEASES OF WOMEN AND
CHILDREN AT ST. MARY'S HOSPITAL.

A FEW years ago, at a meeting of the Harveian Society, I called attention to the frequent association of pruritus vulvæ with diabetes. As continued observation confirms and strengthens the statements then made, and as my observations have never been made known otherwise than as above stated and in my lectures, I desire again very briefly to call attention to and emphasise the fact that pruritus vulvæ is often the only symptom of diabetes, and to point out the desirability of a systematic examination of the urine for sugar in suspicious cases.

Diabetes is only one among many affections with which pruritus vulvæ may be associated; but notwithstanding that it is mentioned in some books as a cause of vulvar itching, it is nowhere, that I am aware of, stated with adequate prominence.

Excepting itching, there may be no symptom whatever of diabetes—neither polyuria, loss of flesh, nor large appetite; and it is not therefore a matter for surprise that the underlying diabetic affection frequently remains unsuspected.

The observations of friends who have become acquainted with my views are confirmatory of them, and show that there is a more frequent connexion between diabetes and pruritus vulvæ than is generally believed. Accordingly, it seems desirable that further attention should be directed to the fact seeing the gravity of the more important affection. It is hoped that a wider diffusion of the knowledge may prove useful to many.

Though matter of high interest, I am not concerned at present to discuss the pathogeny of diabetes; but regarding it from a purely clinical aspect, it is difficult to avoid the conclusion that there are at least two (if no more) forms of diabetes; or, to put it in another way, that sugar, or some allied body equally capable of reducing copper, on the test being applied in the usual way, may often be found in the urine of stout, florid (gouty) persons, as well as in the lean, wasted people who are looked upon as classical types of the disease.

I have at present under my care at St. Mary's Hospital an excellent illustration of this fact. When the patient, a stout, florid, middle-aged woman, first came under my care some months ago, she was tormented with violent itching of the privates. Suspecting diabetes, I had the urine examined, and then, and ever since, it has contained an abundance of sugar. She rarely passes more than a normal amount of urine, looks as hearty as can be, and from the first application of the treatment—a borax lotion—has almost lost the itching. As the object of this short paper is merely to put others on the track of diabetes through the pruritic symptom, I will add no more, but await hopefully the statement of the experience of others.

Wimpole-street, W.

CASE OF

STRANGULATED FEMORAL HERNIA,

PRESENTING SOME CHARACTERS AND SYMPTOMS OF
NOT VERY COMMON OCCURRENCE.

By WILLIAM EVANS, M.R.C.S. ENG., L.R.C.P.E.

THE following case, which occurred recently in my practice, seems to present some features which may entitle it to be placed on record.

Miss N. M—, aged fifty-eight years, had frequently, during an interval of eight or ten years, obtained by messenger some medicines for the relief of attacks of colicky abdominal pains, generally accompanied with constipation. Being of a somewhat timid and reserved disposition, and having an aversion to being examined by a medical man, I had not, prior to the attack about to be described, had an opportunity of personally examining her, and this seemed the less necessary inasmuch as her attacks had hitherto

yielded to an anodyne and antispasmodic, combined with some antacid, and followed by a brisk purgative.

The present attack commenced early on a Monday morning, and, contrary to its usual history, there had been a sharp diarrhoea and vomiting preceding it for some days, which still continued at the time relief was sought. The usual draughts were forwarded about 4 A.M., and about 10 A.M. her brother called stating no relief had been obtained. On visiting her I ascertained that the vomiting had ceased shortly after the medicine had been taken, but the pains and diarrhoea she affirmed persisted. I also elicited that there was a small lump in the right groin, which she said had been there for years, and which she reluctantly consented I should examine, alleging she was certain it had nothing to do with the attacks, although upon close questioning she was obliged to admit it felt a little harder than usual, and had also done so during her former attacks. This tumour was situated just under Poupart's ligament, its longer axis (about two inches and a half) parallel to it; it felt hard and movable, and lacked all the characteristic feeling of hernia, except that on coughing I thought I could detect a very indistinct impulse. An attempt at taxis proving unavailing, anodynes and fomentations were ordered, and a mild aperient administered, much against her will, as she feared the diarrhoea, which, however, had not troubled her since about 8 A.M. The symptoms continued much the same the rest of the day, and in the evening, the aperient not having acted, an enema was given. On Tuesday, the symptoms persisting, another ineffectual attempt at taxis was made under chloroform, and the rest of the treatment consisted of opiates and repeated enemata. On Wednesday, vomiting, which had been in abeyance since Monday, became a little troublesome, but not very persistent, and there was no other change in the symptoms, except that the tumour was rather harder, the impulse on coughing entirely absent, and the feeling more unlike that of hernia than at first. I advised a consultation with Dr. Lloyd, surgeon, of Llangefni, who agreed as to the doubtful character of the tumour, and counseled temporising for a day, giving small doses of calomel at intervals, with opiates and belladonna to allay pain, and continuing the enemata. On Thursday Dr. Lloyd again saw the case with me, and as the symptoms were still not very urgent, a delay of another day was advised and agreed to, and the same treatment continued. On Friday the symptoms became more urgent, the vomiting being uncontrollable and the pains more severe, with some distension of the abdomen. The case altogether wore a more serious aspect. Dr. Lloyd was telegraphed for, and he agreed to adopt the safe old maxim—"When in doubt, operate." With his assistance I divided the usual superficial coverings, and brought to view a dense fibrous mass, which we had some difficulty in recognising as an enlarged and altered inguinal gland. Having regard to the doubtful character of the tumour, my first impulse was to close the wound, and to look upon the case as one of ordinary intestinal obstruction. We determined, however, to dissect through it with a view to further exploration and perhaps its removal, when, on reaching the saphenic opening, I exposed the sac of a small enterocoele just about to pass through that aperture, having no doubt been prevented from doing so by the enlarged gland which occupied that situation. The usual seat of stricture (Gimbernati's insertion) was divided, but not until some bands under the edge of the falciform process had been notched could the bowel be returned. The case eventually did well, recovery being slightly retarded by suppuration of the divided gland.

Remarks.—The points of practical importance in connexion with this case are: the occurrence of strangulation in a hernia during or immediately succeeding a sharp attack of diarrhoea; that the character of the tumour should not deter us from operating; that if an enlarged gland should obtrude itself, it is desirable to ascertain what may be concealed beneath it; and that the division of Gimbernati's ligament is not always sufficient for the reduction of the hernia. I am aware that each and all of these points have been noticed and dwelt on by the authorities on the subject, and I am also certain that they are not seen in the common run of cases of strangulated hernia.

Llanerchymedd, Anglesey.

A MEDICAL STUDENT named Cleary died on the 5th instant from small-pox in the Hardwicke Hospital, Dublin.

A CASE OF SNAKE-POISONING; NO TREATMENT; RECOVERY.

BY VINCENT RICHARDS,

CIVIL SURGEON, LATE MEMBER OF THE INDIAN SNAKE-BITE COMMISSION.

THIS case is almost, if not quite, unique; for, although thousands of people die from snake-poisoning in India, very few cases of any description come under the immediate observation of European medical officers. The natives regard snake-bite with such superstitious awe that they almost invariably call in their "snake-charmers" and other quacks who are supposed to be versed in the mystery of its treatment; consequently, the European medical officer is consulted only as a *dernier ressort*, when charms and incantations have failed, and the victim is either dead or dying. Moreover, such a case as this—in which all the prominent symptoms of snake-poisoning were more or less marked—must be of extremely rare occurrence, owing to the subtle nature of the poison and the rapidity with which the snake injects it. There are plenty of cases of "Recovery from snake-bite" on record; but it would be easy to prove that they are not cases of snake-poisoning—differing as they do in all the more important particulars. Although the snake was not clearly identified, I have little doubt but that it was a cobra.

On the 28th August I was sent for to see a man named Bámon Dás, aged forty years, who was said to have been bitten by a snake at 3 o'clock in the morning. On arrival I was informed that having heard the rats making a great squeaking noise, and wishing to find out the cause, the patient had raised himself from the floor on which he was sleeping, when he felt something biting him on the left arm near the shoulder. He jumped up and saw a snake, which he was unable to identify, gliding from him towards a hole in the mat wall of his hut, through which the moon was shining. He thinks it was a *Tentulia karis* (spectacled cobra of a tamarind colour), about four feet long. He had been very ill indeed, much worse, it was said, than when I saw him. He had complained of feeling *nisha* (intoxicated), had vomited, and could neither stand nor speak, though he had continued to be perfectly conscious.

At 10 A.M., when I saw him, I noticed the following particulars:—He was being supported on the ground in a sitting posture by two men. Near the posterior border of the deltoid of the left arm were two rather indistinct fang marks, at some considerable distance from each other, as if the snake had failed at first to insert both fangs, and had then twisted its head and endeavoured to insert the other. One fang-mark, however, more resembled a scratch than a puncture. The arm was painful, hot, and swollen, measuring 11 in. in circumference, whereas the other arm, at a similar part, measured only 9½ in. On cutting through the puncture, around which the skin was raised to an extent corresponding to the size of a threepenny bit, the track of the fang was clearly visible, though there was little infiltration into the subcutaneous areolar tissue, owing, no doubt, to the small quantity of poison that had been injected into it. The swelling was in some measure due to ligatures that had been applied for a short time above and below the bitten part. He had no power whatever over the eyelids, which had dropped, leaving only the lower part of the pupil visible. The pupils were perfectly natural, and the irides responded to light. When asked to identify people around him, he put his head back so as to bring the person in the line of vision. He could see perfectly well both those near him and those some distance off. The hearing was not affected. There was profuse salivation, the saliva streaming down from the corners of his mouth. The lower lip had dropped, as if he had lost all power over the orbicularis oris muscle. He could speak, but very indistinctly, so indistinctly that his friends had to ask him to repeat what he said. The intonation was peculiarly nasal, much resembling that of a person who has lost part of his palate. The lips were not used in his endeavour to tell me his name, consequently the labial "B" was omitted, and he answered with a very indistinct and nasal "Aon Dás" for Bámon Dás. On attempting to swallow some water, it was returned through his nostrils. He was unable to clear his