patient's condition was naturally sufficiently wretched, and she had scarcely dared to venture out of doors since her confinement. I declined to attempt to deal with the fistula, but proposed to close the vaginal outlet in order to stop the existing incontinence of urine.

The records of this operation are scanty, but the author of one of the text-books on surgery says he has performed it twice "with good success, two or more operations being required."

It is intelligible that the chief obstacle to union of the raw surfaces would be the accumulation of urine in the vagina tending either to irritate or to burst asunder these. To obviate this accident, and a repetition of the operation, I adopted a plan similar to that of puncture of the bladder per rectum in the male.

Operation (May 4th).—This consisted in dissecting off a thin layer of mucous membrane, at least an inch and a half in depth, of the outlet of the vagina, a large catheter being retained in the urethra, whilst the under surface of this was being pared. Quill sutures were used as in the operation for ruptured perineum. As soon as all bleeding had ceased, the recto-vaginal septum was penetrated just behind the raw surface, obliquely from before backwards with a trocar and cannula introduced per anum. The trocar was withdrawn, and a winged catheter having been passed through the cannula, the latter was removed, and the end of the catheter left in the vagina. The sutures were now twisted, and the operation was completed. Half a grain of opium was ordered to be taken night and morning.

May 7th.—Progress very favourable. The bed is perfectly dry, the urine flowing freely through the catheter, which projects at the anus. Removed the sutures.

9th.—This morning, the catheter having become accidentally plugged, the urine was retained, and the patient, instead of sending for Mr. Powles, sat on the pot de chambre and strained to make water, and with the effect of forcing apart the feebly united surfaces. On this day, at my usual visit in the afternoon, I had intended to remove the winged catheter, expecting to find that it was no longer required. I now determined to give up all idea of primary union, and to trust to healing by granulation. To secure this I deemed it desirable to reintroduce sutures and also to replace the soft by a metallic tube in the rectum. Accordingly, after giving the patient a few days' rest, and getting the bowels open, this was done on May 15th.

26th.—Removed the sutures.

30th.—The tube was removed early this morning, and the bowels were freely relieved by an aperient and an enema.—5 P.M.: The bladder has not been emptied since the morning, but the new septum is water-tight, although the desire to micturate is great. The water is to be drawn off periodically per meatum, and, if desirable, she will be taught to use the catheter herself.

Remarks.—A short silver tube (No. 14 cathetersize) answered the purpose of conducting the urine better than the smaller and soft instrument, as it never became plugged, although on removal there was a thick coating of phosphates on its interior. I was somewhat anxious lest a permanent fistula might result from the use of this tube, but there was at no time any evidence of the passage of urine into the rectum, neither has this occurred since the removal of the tube. With the hope of preventing this, I, on each occasion, perforated the recto-vaginal septum obliquely. I ought also to state that I introduced the silver tube through the septum by means of a Thompson's bivalve tracheotomy lancet. Throughout the treatment the patient experienced no inconvenience whatever from the tube in the rectum, and the position she was thus able to assume was a most independent and comfortable one.

P.S. June 3rd.—To-day I was informed that a few hours ago the patient found that her water again dripped from her. On inquiry it appeared that the nurse had used the catheter as usual, and soon after the patient noticed that she was wet. On examination I found a small opening large enough to transmit a No. 6 catheter leading into the vagina, just below the position of the meatus, and doubtless made by an improper use of the catheter. Notwithstanding the annoying circumstances connected with the case, I believe puncture per recto-vaginal septum will prove of great value.

Queen Anne-street.

ACUTE GENERAL HERPES.

By CLEMENT DUKES, M.B., B.S. LOND., M.R.C.P. LOND.,
MEDICAL OFFICER TO RUGBY SCHOOL.

As the above-named disease is exceedingly rare, the following clinical account of a well-marked case may not be without interest to many. Some authors do not even mention its existence; while Dr. Tilbury Fox remarks in passing that Dr. Coutagne, of Lyons, has recorded cases. The following notes are only those taken hurriedly at the bedside:—

Mr. B—, aged seventeen—subject to urticaria, and having a mitral systolic murmur,—while out in the rain on Oct. 17th, 1874, got wet, and stood in front of the fire, with his clothes on, to dry them. He says he was only wet up to his knees.

On Oct. 18th and the following days, had aching all over, but especially in the limbs; did not feel well; had no catarrhal symptoms.

Oct. 22nd.—Aching very much worse; so bad was it that I anticipated an attack of rheumatic fever. At 5 P.M., I was asked to see him again, and found him with a pulse of 120, and a temperature of 102°; skin hot and burning; acute pain in diaphragmatic region, which proved only neuralgic, and not inflammatory, as I expected it would have done. He had a hot bath, and went to bed.

23rd.—Awake all night; very restless; pain at diaphragm continued.—At 2 P.M. a redness of the skin was seen, in raised patches, all over the body, somewhat like urticaria; face and hands swelled; skin very irritable, not itching, but sore and tingling; could scarcely bear the bedclothes to touch the skin anywhere. On looking more closely, the red inflamed patches were raised in small vesicles in clusters, not all over equally alike, but in certain parts, in characteristic crops of herpes vesicles filled with clear fluid, these occurring especially well-marked on the back of the hands, elbows, knees, feet, and several clusters of a dozen each on the walls of the thorax.

24th.—Many more of these vesicles in clusters all over the body in various parts; also on the face, beside the nose, but not on the lips, and occurring, too, all over the hairy scalp and forehead. Those vesicles seen yesterday are much more distended with clear fluid. There are no vesicles on the palms of the hands, but only red patches as large as a threepenny piece. The chest-walls are smothered with vesicles in small crops, but in no case do the crops seem to follow the distribution of nerves; they are most irregular in their situation. Isolated vesicles only on abdomen, back, and thighs, scattered here and there, but the redness, bright scarlet, is so extensive as to form almost one continuous red surface. On the soles of the feet are red patches only, but on the dorsum a great many vesicles. On the inside of the mouth, on the tongue, soft palate, and well into the pharynx, vesicles are seen.

25th.—Sweating profusely where the skin is not covered with the redness or crops of vesicles, but as this normal skin only exists as interstices between these patches (so full are they), it presents a very curious appearance. Therefore the skin presents the following character: red patches with crops of vesicles on them; red patches dry on surface; and normal skin threading its way between these, quite wet with perspiration. The redness is beginning to fade, and the vesicles are shrinking and several bursting, leaving no scab, but only the cuticle that had been filled with fluid, lying lax on the surface and dried.

26th.—Still more fading and absorption.

28th.—Most of the vesicles gone, and the redness become darker in colour. On the back, where there had been no vesicle detected—that is to say, well raised, bright and glistening from the fluid,—I could distinctly see and feel not only raised red patches, but on these patches small pimples but not blebs, doubtless owing to a small amount of fluid under the cuticle. The red patches have assumed such peculiar shapes that it is quite impossible to describe them, but they make the skin look anything but as it should.

29th.—There are fresh crops of vesicles on the chin and beside the nose, also some on the ear and inside the nose, not noticed before; some still visible on the soft palate and

tongue. There has also been a vesicle at the end of the penis, and there is now a crop of fresh-looking vesicles on the scrotum. The fluid from the vesicles is alkaline and clear. The red patches are becoming smaller and darker, and much resemble the fourth day of the rash of measles, so blotchy are they. On looking closely at what have been the larger red patches, they are disappearing in rings, exactly resembling the way that ringworm grows—that is, they become brownish-yellow in the centre, with a reddish ring encircling it.

30th.—A few fresh vesicles on the chin and nose, which resemble in appearance the ordinary herpes from cold, but no vesicles at all on the lips. Has severe pain again in abdomen.

Nov. 3rd.—Skin desquamating all over, more or less, in large and small scales. The patches with yellowish centre and red ring surrounding are very marked, but they are all manner of shapes and sizes. Fainted while at night-stool; slept much after.

6th.—Skin still peeling; convalescent.

His treatment was salines at first, with Dover's powder to relieve the pain; subsequently he had the mineral acids with bark, and then quinine. This illness, together with the mitral disease, was the cause of a very great debility, extending over some months.

CASE OF CLEFT HARD AND SOFT PALATE, OPERATED ON BY LANGENBECK'S METHOD; RESULT PERFECT.

By GEORGE BUCHANAN, M.A., M.D.,

PROFESSOR OF CLINICAL SURGERY, UNIVERSITY OF GLASGOW.

DAVID S—, aged twenty-two, was admitted to the Western Infirmary Nov. 26th, 1875. There was a congenital cleft in the palate involving the whole of the soft and half of the hard palate. The anterior end of the fissure was quite rounded, and the margins of cleft in the hard palate were three-quarters of an inch apart. The tips of the bifid uvula were drawn asunder by the palatine muscles.

The operation was performed after the method introduced by Langenbeck, closure of the hard and soft palate being accomplished simultaneously. The patient, not being put under the influence of chloroform, was able to give great assistance, by holding his head at a proper angle and occasionally stopping to rest and wash his mouth. From the help of the patient the proceedings were much more rapid and satisfactory than usual.

I first carefully made raw the entire edges of the gap by cutting off a thin slice of tissue from the hard palate, to the tips of the uvula, on both sides, taking care that the raw edge was continuous throughout. I then made an incision down to the bone, in the roof of the mouth, close within the alveolar process, extending from the hamular process forward to near the incisive foramen. Then with a blunt periosteal elevator of a hooked form I stripped the soft tissues, including the periosteum, from the palate processes of the maxillary and palate bones, and the flap so separated hung down like a curtain from the roof of the mouth, but of course supported by its attachment in front and behind. This was done on each side. The posterior part of the cleft, however, still remained too far apart to allow of approximation without considerable tension, so I relieved this by making incisions through the soft palate on each side, as in Dieffenbach's operation. The edges of the cleft could now be drawn together throughout the whole extent. Six silk threads were introduced by the ingenious method introduced by Sir William Fergusson, and finally by these, fine silver wires were drawn through and tied. At the end of the operation the gap was seen to be closed throughout in a most satisfactory manner.

On the eighth day the silver sutures were removed, and the edges found to be firmly adherent.

The patient was kept in the hospital for some time longer in order to see that the granulation of the side wounds should not reopen the cleft.

Two months after the operation the palate was firmly

closed throughout its whole extent. Already patient felt the difference in swallowing, and the improvement in his articulation was manifest. In fact, when he paid proper attention he could speak in such a way that his former deficiency was scarcely recognisable, and there is no doubt that by a little practice he will still further improve.

The operation, so far as regards the union of the cleft, and the result, both on swallowing and speech, is the most successful in my experience, and leaves little to be desired.

Glasgow.

ON

THE ORIGIN OF INFANTILE SYPHILIS.

By ROBERT CORY, M.B.,

ASSISTANT OBSTETRIC PHYSICIAN TO ST. THOMAS'S HOSPITAL.

IN THE LANCET of March 25th, I saw, by the report of Dr. Greenfield's speech at the Pathological Society, that he had generously mentioned my name in reference to a suggestion I had made to him in conversation upon infantile syphilis. I should not at present have ventured to give greater publicity to this theory if my name had not been mentioned in connexion with it, because for substantiation it requires more accurately recorded facts than I am as yet able to bring forward.

When infantile syphilis was first recognised, it was very naturally attributed to direct inoculation at the time of birth. Afterwards, however, when it was found that, except in a few instances, the mother was not suffering from local sores at the time of birth, another explanation was offered, which is still very generally held—namely, that the disease was inherited like other hereditary diseases, and that consequently it was communicated to the offspring at the time of conception. A corollary followed from this—namely, that the diseased foetus might indirectly convey to the mother the disease of the father. Now, looking at the facts and arguments in support of these views, they seem only partially to support it.

Let us consider the cases adduced first. They may be divided into two classes:—1st. Those where, the father having had syphilis, the mother gives birth to a child which afterwards suffers from the disease, but she herself remains absolutely free. 2nd. Cases where the mother, during pregnancy, without any discovered primary inoculation, suffers from syphilitic symptoms. In some of these cases the woman is said to suffer during each pregnancy, but remains well in the interval.

The alleged cases of the first class are the most important, for, if true, they are conclusively in favour of the received theory. M. Diday mentions several of these in his work on "Infantile Syphilis," but one which he details is sufficient to throw suspicion on all, for it indicates how a fallacy may arise, and also shows how facts may be bent to theories. The case is this. "The wife of a syphilitic man gave birth to a child which became syphilitic. The woman, however, suffered from no symptom whatever, unless a small patch of granular redness on the fore part of the neck could be said to be such. This woman becoming a widow, married a healthy man, but again by him gave birth to a syphilitic child." M. Diday supposes in this case that an impression was left behind on the woman by her first husband, which was capable of infecting her subsequent children, in some such way, I suppose, as the subsequent foals of a mare once covered by a zebra are sometimes impressed with the markings of the zebra. He does not, however, admit that she had herself contracted syphilis, because she presented no symptoms, and he argues against the small patch of redness being such. Here he thinks that it was possible for a woman to be free from syphilis herself, yet to give birth to a syphilitic child, the result of a former husband's impression, the real father being healthy. This assumption is directly contrary to the fact observed and stated by Mr. Hutchinson, "that he has never known a mother infected by suckling her syphilitic child;" evidently *because* she is protected by a previous attack of the disease. We see, therefore, of how little value the first class of cases become.