

rectum and administered chloroform and injected pilocarpine hypodermically. This treatment benefited the patient, especially the administration of chloroform, which kept the seizures well under control. She had no convulsive seizures for about a couple of hours after the administration of chloroform had been stopped. I then left her to see another urgent case and returned just in time to see the patient in a violent general convulsion in which she died (probably asphyxiated).

Certain points are worthy of note in these cases: (1) the disregard the majority of patients pay to the premonitory symptoms, sending for medical aid only when the eclamptic seizures come on; (2) the value of instrumental delivery and the induction of premature labour in certain cases of puerperal eclampsia; (3) the value of chloroform in controlling the fits; (4) the appearance of albumin in the urine of all four patients and its complete disappearance three or four days after delivery in the first three cases; and (5) the fact that all four patients were primiparae.

#### A CASE OF SPASMODIC DYSPNOEA.

By J. E. S. BARNETT, F.R.C.S. ENG.

THE patient in the present instance was a male child who soon after birth began to suffer from attacks described by his mother as "grunting and blue all over." When he was three and a half months old I saw him and learned that the fits were becoming more frequent and enduring. His breathing was laboured, with suprasternal and subcostal recession during respiration, locomotion of the larynx, and action of the nares. During an attack these symptoms were intensified and in addition cyanosis became marked in the lips, face, and finger-nails. In the intervals there was free but noisy entrance of air into both lungs. The temperature was 97.8° F. in the groin, the heart sounds were normal, and the apex was in the natural position. The child was unusually fat and big for his age and he took his mother's breast well. The fits became more severe, threatening dissolution, and the mother was anxious that something should be done. Treatment by hot fomentations and by a steam-kettle under a tent proved useless. Papilloma and spasmodic catarrhal laryngitis were thought of as possible conditions. Tracheotomy was performed on March 17th, 1898, the infant being then four months old. No difficulty was experienced except in the introduction of the tube; the smallest vulcanite was used. There was no marked immediate relief, but next day the breathing was less laboured, and although the fits persisted the cyanosis was lessened and for the next day or two was absent. No oedema, emphysema, or suppuration occurred about the wound and the child's condition improved; his temperature remained normal throughout except for a rise to 100° on one evening. When the vulcanite tube was removed it was replaced first by a Parker's and afterwards by a Marrant Baker's rubber tube. Three weeks after the tracheotomy the child suffered from a prolonged attack of dyspnoea, became gradually more and more cyanosed, and eventually died. At the post-mortem examination it was found that the thymus gland was enlarged and that outlying lobules of gland tissue extended well into the root of the neck. Perhaps the recurrent laryngeal nerves were irritated and set up spasm of the larynx which the tracheotomy relieved, but the gland still growing caused direct and fatal pressure on the trachea. From the appearance of the parts when the deep fascia was divided this pressure must have been considerable. There was neither ulceration of the trachea nor papilloma of the larynx.

Paddington.

#### A CASE OF SHINGLES OCCURRING PRINCIPALLY ON THE SCAR OF A BURN.

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THE patient in this case was a boy, nine years of age, who came under my care on Dec. 6th, 1897, for well-developed shingles on the left side of the trunk. On Nov. 22nd, 1893, he had an extensive burn on the left thoracic and abdominal regions, owing to his nightshirt catching fire. He was treated as an in-patient at St. Mary's Hospital for eight

weeks. When I first saw the patient I was informed that twelve hours previously—i.e., about 9 P.M. on the previous evening—he had suffered from great pain in his left side which was so severe as to make him scream and to keep him awake during the early part of the night. On examination I found that he was a well-nourished boy with an extensive scar on his left chest, side, and abdomen. The skin was puckered and reddish in colour, with bands of thick fibrous tissue running in all directions. He was suffering from typical shingles on the left side. The rash started from the tips of the eleventh and twelfth dorsal and the first lumbar vertebrae and was continued round the left side in a band varying in breadth from 1½ in. to 3½ in. The greater part of the rash was on the site of the scar, though several groups of vesicles were present on the otherwise healthy skin. Two or three spots were on the right side of the middle line both in front and on the back. The rash presented nothing atypical; it was confluent in places and pain of a neuralgic character was present with considerable intensity. The child seemed to be poorly and his appetite was bad. His mother told me that he had been "out of sorts" for the last few days. During the nights of Dec. 6th, 7th, and 8th he could only sleep lying on the left side—the side of the lesion. The treatment consisted in protecting the side with absorbent wool and in giving tincture of perchloride of iron internally; 3 grains of calomel were given on the nights of the 6th and 7th, followed for a week afterwards by 3-grain powders of mercury with chalk at bedtime. The disease ran the usual course and recovery took place without any unusual symptoms. The neuralgic pain disappeared completely on the 10th.

The interest of the case seems to lie in the following points. It is not often that one comes across a case of shingles occurring on the site of such an extensive burn. Personally I have never seen one before, nor have any of my medical friends to whom I have detailed the case. From the nature of the scar it is evident that the skin over the burnt area must have been pretty thoroughly destroyed down to the deeper layers of the dermis and consequently the nerve terminations must have been destroyed too. The few spots occurring on the right side of the median line both on the back and front demonstrate very prettily the overlapping of the nerve-supply in those regions. This point is noted by Fagge,<sup>1</sup> but the case negatives his assertion that "pain of a neuralgic character is entirely absent in young patients." The mother put the child to bed herself and is certain that no spots were present—in fact, until the morning she thought the pain was due to pleurisy.

Queen's Park, W.

### A Mirror OF

## HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

### SEAMEN'S HOSPITAL, GREENWICH.

A CASE OF TRAUMATIC TETANUS TREATED BY ANTITOXIN ON THE SEVENTH DAY AFTER INJURY; DEATH.

(Under the care of Dr. CURNOW.)

ON several recent occasions we have published in "The Mirror of Hospital Practice" reports of cases of tetanus in which the antitoxin has been employed and we gladly print the following cases as it is advisable that as many of these cases as possible should be put on record, for the value of tetanus antitoxin is still debateable. We would not suggest that the antitoxin has no controlling power over the disease for its efficacy in this respect has been abundantly established, but it cannot be said that at present we are in any degree certain of the frequency with which the antitoxin should be given or even of the most suitable dose for any given case. Cases of tetanus vary

<sup>1</sup> Fagge and Pye-Smith: Text-book of the Principles and Practice of Medicine, third edition, vol. ii., p. 939.