

tracheotomy. With special reference to the emphysema of the neck which sometimes occurs during labour and during violent expiratory efforts, he says: "The mediastinal emphysema of tracheotomy is *inspiratory*; the mediastinal emphysema of violent expiratory efforts is *expiratory*..... This emphysema is essentially *expiratory* in its nature and due to a cause entirely opposite to that which is answerable for emphysema of the mediastinum after tracheotomy. In saying this it is conceivably possible that expiratory emphysema might occur after tracheotomy, though the conditions under which the operation is performed are well known to obstruct inspiration rather than expiration. In this case the operation would have nothing to do with the emphysema." The occurrence which Dr. Champneys regards as conceivable was observed in this instance as a separate event; but it may have been partly brought about as a result of the slight surgical emphysema originally due to the tracheotomy, which by loosening the pleural fold<sup>3</sup> at the root of the lung may have deprived some of the alveoli of their normal support, and this may have led to their rupture under excessive distension during expiratory effort. Artificial respiration had been applied for so brief a period after the occurrence of apparent death that it can hardly be held responsible for the production of the emphysema, which, moreover, was noticed in the neck before artificial respiration was performed.

In the absence of any known means of relieving its results or of checking its progress a recognition of this serious complication of diphtheria is a guide to prognosis rather than to treatment. The leak of air in this form of emphysema is beyond the reach of any local measures. An obvious indication would be to allay the tendency to cough, but in carrying this out too completely we might deprive the patients of the only means of clearing the tubes of their obstruction by diphtheritic products.

The continuous inhalation of oxygen through the tracheotomy tube, inasmuch as it favours a diminution of the respiratory efforts and a relative apnoea, would seem to be the most appropriate form of respiratory treatment.

## ANATOMICAL AND AGE DISTRIBUTION OF THE TINEÆ OF SOUTHERN ASSAM.<sup>1</sup>

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It is a remarkable fact that in 11 years' practice in Assam, where almost every individual at some time or other suffers from "dhobi's itch"—tinea of the body—I have never met with a single case of ringworm of the scalp. Tinea of the nails is very common here, but in England it is so rare that a single case is considered worth showing as a curiosity in our dermatological societies. In the past few months I have taken note of all cases of ringworm coming to my hospitals. They were 1407 in number. In all the body was attacked; in 211 the nails were attacked; but in none was the scalp affected. I have collected for comparison the figures given for Britain by McCall Anderson,<sup>2</sup> Adamson,<sup>3</sup> and Pernet.<sup>4</sup> Of their 633 cases 142 were of the body, none were of the nails, and 491 were of the scalp—a very striking contrast.

In the district of Kalain the anatomical distribution of tinea seems to be mainly influenced by the form of dress worn by the patient. When the European sweats the first parts of his clothing to become soddened and "fuggy" are the armpits

of the vest or shirt and the fork of the trousers. The European is most frequently attacked by "dhobi's itch" on the inner aspect of the thighs and axillæ, which are in contact with the sweat-soddened clothes. The male coolie and Bengali generally wear a loin-cloth tied tightly round the waist, and when they are hardest at work they "gird up their loins," drawing the loin-cloth firmly into the fork. The rest of the clothing is loose and flowing. The native male suffers almost always from a girdle of ringworm where the tightened cloth soaks up the sweat, as it trickles from the upper parts of his body and also in the fork. The women, Bengalis, both Mussulmani and Hindu, coolies, certain hill tribes, Kukis, and Mikirs, wear a "sari," a cloth some 20 feet in length, of which the first folds are tied firmly round the waist, the remainder being draped loosely over the rest of the body. The profuse sweat which the "perpetual vapour bath" of this climate produces keeps the skin and the cloth in contact with it continually sodden. Hence whatever portion of the skin of a woman of the above castes may be the seat of ringworm there is almost invariably a belt of the eruption found round the waist. On the other hand, Manipuri and Cachari women wear the clothes suspended from above the breasts, there being no belt or constriction round the waist. Ringworm in these women shows no special predilection for the waist.

*Age incidence.*—While in Europe the vast majority of ringworm patients are infants and children, here the disease is very rare before puberty. The youngest of my 1407 cases was a lad aged 13 years.

*The fungus.*—The fungus would be classed by Sabouraud as the megalosporon. Both spores and mycelia are scanty as compared with the growth in tinea tonsurans. The spores when stained and mounted in balsam measure from 2.5  $\mu$  to 5.5  $\mu$ , varying greatly in the same specimen. When examined in glycerine or in a solution of potash the spores seem still larger. On Sabouraud's *milieu d'épreuve* the fungus from the same case often gave rise to growths of varied appearance. The rule was a fawn-coloured dust-patch, sometimes of a target-like appearance, from different shades of brown in concentric rings.

I am quite unable to associate any definite clinical appearances with variations in the size of the spores or the character of the cultures. I at one time thought that in the scaly annular or gyrate variety the larger spores predominated, while the spores were smaller and the mycelium more scanty in a variety characterised by large continuous patches and the frequent occurrence of a pustular folliculitis. Lately I have not unfrequently found the conditions reversed. The latter variety is the harder to cure and more liable to relapse, probably owing to the survival of spores in the depths of the follicles.

*Tinea versicolor.*—It was with a feeling akin to shock that I read in the *British Journal of Dermatology* for October, 1899, Dr. Bosanquet's statement that tinea versicolor never occurs on the face. I find that McCall Anderson at page 592 of his "Treatise on Diseases of the Skin" says that "it is very rarely seen on the face," and on the next page he uses the words "never on the face." Living<sup>5</sup> says: "It is hardly ever seen on the face." In this district it is very commonly situated on the face. Of patients whom I have seen this day no fewer than seven had tinea versicolor on the cheeks and chin. I verified my diagnosis with the microscope in all seven cases. The fungus differs in no way from the microsporon proper of Europe. The reason for the frequency of facial tinea versicolor in Assam and its rarity in England seems to me to be that soap is an excellent cure and preventive of the disease. In England the lower classes wash the face with soap and water probably once a day. A complete bath is perhaps a rarity; I am over-stating the average if I estimate it at as once a week. The skin of the body is in England heavily handicapped in this respect. The native in Assam, however, shows no favouritism to his face in the matter of ablution. When he bathes he gets into a river or tank and washes the whole body. He, however, very rarely uses soap. The only European whom I have seen with tinea versicolor of the face was a patient who was advised not to use soap when bathing in India as it was "a cause of malaria." Tinea imbricata I have never seen in this district.

Kalain, Cachar, India.

<sup>3</sup> As regards the probable seat of rupture in these cases, observations which I have made as to the local differences in the strength, thickness, and adaptation of the pleural investment of the lung have led me to believe, in agreement with Dr. Champneys's experimental observations, that the bursting of the lung takes place at the pulmonary root either anteriorly, as he thinks, or, as I am inclined to believe, at the back, close to the reflexion of the pleura over the bronchus. In this situation it finds a ready escape forwards into the root of the lung and into the anterior mediastinum, upwards into the neck, and backwards into the posterior mediastinum.—W. R.

<sup>1</sup> An abstract of a paper read before the Surma Valley Medical Society.

<sup>2</sup> Treatise on Diseases of the Skin.

<sup>3</sup> Transactions of the Third International Congress of Dermatology.

<sup>4</sup> THE LANCET, Oct. 1st, 1898, p. 868.

<sup>5</sup> Handbook of Skin Diseases.