

spread as plaster, a third that frequent analyses of "secret female pills" should be made and their vendors prosecuted, a fourth that druggists should be warned as to the use being made of diachylon and the danger of selling it indiscriminately, and a fifth that lead poisoning in women should be a notifiable disease. In regard to these suggestions, it may be remarked that even if the pharmacopoeial preparations of lead were scheduled as poisons persons who knew its properties could still buy it in other forms, such as white lead. Nevertheless I am of opinion that a considerable diminution in this practice would follow the scheduling of diachylon as a poison and that the evil is of sufficient magnitude to justify this step, unless, indeed, its sale were stopped altogether. The chief use of lead plaster in this district is to "sweal the milk out of the breasts." It can hardly be maintained that lead plaster is necessary for this or any other purpose. The scheduling or suppressing of diachylon need not involve the publishing to the public of the reasons that led thereto.

I brought the matter before the Nottingham and Notts Pharmaceutical Association and found that many of the leading druggists were quite unaware of the use to which diachylon sold in the lump was put. The council at once gave its kind consideration to the matter and issued a circular to the members recommending that diachylon should be labelled as a poison, "for external use only." I am told that within a fortnight the sale of the preparation had diminished. The question of the prosecution of vendors of "female pills" is one for careful consideration from the legal point of view, but I am decidedly of opinion that lead poisoning in women should be made a notifiable disease.

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RECURRENT HERPES GESTATIONIS.

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THE notes of the following case are interesting in that they describe a rare disease.

The patient, a woman, aged 36 years, came to consult me on Sept. 1st, 1903, for a rash on her arms. I found there an eruption consisting of erythema, papules, and vesicles of about the size of small peas; it was irritating and painful and was for the most part limited to the forearms, though there were a few patches without vesication on the thighs and body. The rash had been in evidence for about a fortnight. The patient was at this time about five months pregnant and foetal movements were present. Her general health was good and the urine was normal. The diagnosis of herpes gestationis was made.

Previous history.—The patient had had five previous pregnancies. The first four confinements were instrumental cases but the reason for this I cannot explain, as I did not then attend her. There was no evidence of pelvic contraction. The first child was stillborn, the other three are living. The fifth pregnancy, in May, 1901, ended in a miscarriage at the second month. The patient was very ill at the time, having lost an excessive quantity of blood before I was summoned, but she made a good recovery. Her catamenia have always been normal and regular. There is no history of syphilis. Her general health has been of quite an ordinary character, except that after each confinement she has been troubled with facial neuralgia lasting for several weeks. No other members of her family have been troubled with a like eruption.

Course and symptoms.—The rash gradually extended over the rest of the body, leaving only the palms and the soles free, though the face was only affected by one or two spots. When the pain and irritation were most severe the forearms became hot and swollen and the vesicles were continually bursting, the fluid from them giving a sensation of scalding to the arms, whilst fresh crops rapidly appeared. These symptoms produced a good deal of insomnia.

Treatment.—In the first place arsenic was given internally and lead ointment applied externally, but no relief was experienced. Later various other remedies were tried, such as resinol and thiol, but they gave no result.

After six weeks of the disease the foetal movements diminished and ceased altogether about Sept. 29th, 1903, when the death of the foetus was diagnosed. The rash gradually disappeared and the pain and irritation subsided. The patient was delivered on Oct. 9th of a stillborn foetus (breech presentation). The confinement was easy and the patient made satisfactory progress until the eighth day of the puerperium, when she developed a pulmonary embolism with the consequent pleuritic effusion from which she slowly recovered. The catamenia reappeared in January, 1904, and were regular every month, but a week before the flow commenced the patient experienced pain and irritation in the forearms; these became slightly swollen and red spots appeared on them. The spots and the pain subsided as soon as the flow ceased. In the following April the spots did not appear and the patient regained her usual health, which was only interfered with by a severe attack of facial neuralgia in June, which lasted about a month.

Second attack.—The patient became pregnant for the seventh time in September, 1904, and towards the end of October she was troubled with severe pain in the legs. There was nothing abnormal to be seen but the tibiae were painful on percussion. This lasted for about a fortnight, was not amenable to treatment, and disappeared on the appearance of the eruption at the beginning of November. The rash again commenced on the forearms, these being most affected, and it gradually spread over the rest of the body, leaving only the palms and the soles free. In appearance the rash consisted of erythematous raised patches and papules, reddish in colour, serpiginous and circinate. This was best seen on the body. The forearms did not have this distinctive marking, being completely covered by the eruption, and on parts of them were small semi-solid vesicles; these would occasionally burst and fresh ones appear. The rash was extremely irritating and there was pain of a boring character felt deep in the arms constantly present, but worse in the evening and night, when the forearms became swollen, red, and hot. The eruption was always at its worst when the patient should have had her usual monthly period, remaining at its height for about a week and then gradually subsiding but never disappearing.

Treatment.—This time evaporating and astringent lotions were tried but without success, though I think that vesication was to a certain extent prevented. Internally, potassium iodide (10 grains) and liquor hydrargyri perchloridi (30 minims) were administered but gave no result. During the latter six weeks of the pregnancy a draught of chloral hydras (30 grains) and liquor morphinae hydrochloridi (30 minims) was given at times, and nightly during the last fortnight, but this at the most only produced about three hours' sleep; other hypnotics signally failed. As the pain and consequent insomnia were telling on the patient's constitution premature labour was induced at the beginning of March, 1905, by means of bougies, the patient being delivered of a six months foetus which lived a week. The placenta was normal except for a yellow necrotic-looking patch about three inches in diameter situated near its margin. The patient passed a normal puerperium, the rash gradually disappearing. Her general health has remained quite satisfactory but the rash has not completely disappeared, there being still a few spots and some discolouration of those parts where the rash was most in evidence.

Comments.—The first fact that may be noted about this disease is its rarity; in most of the books at my disposal it is certainly mentioned and that is about all. In Clifford Allbutt's "System of Medicine" the best description that I can find is given, but here the writer is only speaking of a very limited number of cases that have come under his personal observation and the reports of a few others. I have only seen one other case but that did not conform to the above type, consisting only of large bullae on the forearms with some pain and irritation.

Causation.—Pregnancy without doubt is the all-important factor. If pregnancy gives only a predisposition to the disease, then there must perforce be an exciting cause. To make any suggestion as to this is exceedingly difficult unless the condition is looked upon as being of simple nerve origin and that when the nervous system becomes unstable, as in pregnancy, some obscure morbid process takes place, giving rise to the disease. But if this was the case

then in other conditions of the nervous system we should expect to find a like eruption, but it is not so, therefore I think that pregnancy must be taken as the exciting cause. It will then naturally be asked, "How does it act?" It is a recognised fact that during pregnancy toxins are frequently developed and I consider that some peculiar toxin is generated which acts upon the nervous system giving rise to the disease. This toxin, I think, is probably developed by some morbid change taking place in the ovaries during pregnancy, as instanced by the aggravation of the disease at the monthly epochs and also by its continuance for a short while after the cessation of pregnancy.

Distribution—As will be noticed, it was excessively wide; this fact alone points to the circulation of a toxin.

Treatment—To my mind the only rational treatment is the induction of premature labour as soon as the patient's health is beginning to be affected by the insomnia, &c., caused through pain and irritation. It is useless to delay when there is no prospect of giving relief by other means and the longer this mode of treatment is put off the weaker will be the patient and so less able to endure the consequent labour. As will be seen, various local and internal remedies were given a fair trial but without success, the treatment being mainly symptomatic and empirical, and it must be so until we arrive at a more definite causation of the disease.

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ACUTE HÆMORRHAGE INTO A GALL-BLADDER THE SEAT OF INFECTIVE CHOLECYSTITIS AND HUNDREDS OF GALL-STONES.

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HÆMORRHAGE into the gall-bladder as an acute symptom seems to be such a rare condition that the following history may be worth recording.

On the evening of July 30th, 1905, I (J. A. W. P.) received a message desiring me to send a bottle of medicine to relieve "spasms" occurring in an old patient of mine. I sent her a carminative mixture, but in half an hour a second message came urging me to come to see her quickly as she was worse. On arrival I found her seated on a chair in the kitchen, supported by two friends. Her face was blanched and she complained of thirst. She groaned with pain which she described as being round the navel. She rambled in her speech and did not recognise either her friends or me. I had her carried upstairs and placed in bed so that I might examine her more closely. The abdominal walls were soft and supple. There were pain on deep pressure and fulness in the region of the appendix. There was distinct tenderness at MacBurney's point. There was also pain on pressure at the right hypochondrium. The liver was not enlarged and the gall-bladder could not be felt. There was no jaundice. The rectum was empty and the vagina was normal. She had menstruated three weeks previously. She was regular. The temperature was normal and the pulse was 100. Ten grains of Dover's powder and a soap-and-water enema were given. I made out also her previous history to this extent, that she had for years suffered from spasms which were usually relieved by getting rid of flatulence from the stomach. On the night mentioned she thought that she had one of her old attacks; thinking that perhaps a good walk would do her good, she dressed and went out. Whilst out she felt that she must open her corsets, feeling so distended, and she had great difficulty in getting home. This feeling rapidly gave way to one of actual pain and collapse. She reached home, however, and was found lying on the floor.

On the following morning I saw the patient at 8 o'clock. She had passed a restless night but the pain was not so violent. She complained of thirst. At 11.30 the pain was worse. The temperature was 99° F. and the pulse was 105. A saline aperient was given. This acted about 8 o'clock. The abdomen was then slightly distended on the right side.

Later in the evening I called in one of the surgeons of the hospital to see the case with me. On examining the patient Dr. Harris found a roundish tensile swelling in the right hypogastrium which was exceedingly tender to the touch. Its lower border could be traced to the ligament and anterior-superior spine of the ilium and backwards to the crest; its upper border could not be made out so distinctly. The respirations being shallow no vertical movement could be detected. As the acuteness of the attack was out of proportion with the temperature it was decided to wait still a little time and to see her together the next morning. As a ruptured tube gestation could not be dismissed as an alternative diagnosis it was ascertained that she had been regular every three weeks but had not had any coloured discharge between the times. She had felt poorly for the last few weeks. If asked where the worst pain was she placed her hand over the hypogastrium. On seeing her the next day together we decided that as the pain and other symptoms had increased an operation was called for and this was done on August 1st at the Royal Devon and Exeter Hospital. Whilst under the anæsthetic it was observed that the lump seemed higher up than it appeared before and although the case seemed to be one of appendicitis it was recognised that a misplaced kidney or renal tumour might be the cause of such symptoms. On cutting down over the most prominent portion of the tumour, about midway between the ribs and Poupart's ligament, in the line of the external border of the right rectus, a tumour presented itself which proved to be the gall-bladder greatly thickened and tightly distended. This was tapped and four ounces of bile-stained but bloody fluid were evacuated. The gall-bladder was now stitched to the abdominal walls and the remainder of the wound was closed. Three days later under an anæsthetic the gall-bladder was opened and found to be filled with a thick, glairy, raspberry-jam-coloured mucus, with almost innumerable gall-stones, some as large as Spanish nuts, some of the size of orange pips, and some still smaller. Between 200 and 300 were removed and many extruded in the dressings subsequently. A large drainage-tube was kept in for eight days when it was removed, the wound subsequently healing with no untoward symptom. The raspberry-jam-coloured contents were not clotted or offensive.

In the light of what was found at the operation it seems difficult not to think that the initial feeling of poorliness was a commencing infectious cholecystitis, that the pain and feeling of flatulence for which the patient tried a walk was a passive hæmorrhage which was increased by the walk, and that the collapse and fainting condition were due to the actual loss of blood, and the pain when her friends found her on the floor was due to the acute stretching of the walls of the gall-bladder.

It is noticeable that in acute cases of infectious cholecystitis in which the gall-bladder has dark, or mucopurulent, purulent, or hæmorrhagic contents the diagnosis is by no means easy. Osler says: "The symptoms may not indicate the section of the abdomen involved." Appendicitis is often diagnosed. Acute intestinal obstruction and other abdominal ills have also been diagnosed by some of the ablest men. Had we known more of our patient and had the symptoms occurred after typhoid fever or pneumonia, or had we waited longer, a correct diagnosis might have been made. But the patient was relieved, made an excellent recovery, and six months after was still quite well.

Exeter.

A CASE OF DOUBLE VAGINAL CYSTS.

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IN *La Ginecologia* for December, 1905, Dr. Santi, who has made a special study of vaginal cysts, subdivides the various origins of these cysts thus: (1) Edema and extravasation into the connective tissue; (2) lymphatic effusion; (3) introflexion and closure of vaginal folds; (4) vaginal glands; (5) abnormal evolution of, and formation in, Müller's tract; (6) remains of the Wolffian duct; and (7) partial closure of the pouch of Douglas. Mr. W. Roger Williams has written more fully on these cystic formations than any other British observer and classifies them thus: (1) Wolffian; (2) Müllerian; (3) "rests" of the secretory structure in the Wolffian body, in the cervical and vulvar