

nerve. The eruptions were all vesicular, containing a clear, watery fluid, except a few in front of the thorax which were just beginning to dry up. There was diminution of cutaneous sensibility of the affected part as when compared with the healthy side. The patient felt the sharp prick of a needle as a blunt point. He complained of a burning sensation and numbness all over the affected part, and tingling in and below the right ear, with occasional sharp shooting pain in it. The eruptions varied in size from a pin's head to a small pea. They were all distinct and had no tendency to run into each other. Whilst the patient was telling his history it was quite apparent that he had marked facial paralysis, but curiously he was quite unconscious of it until his attention was drawn to the fact. He had more or less complete paralysis of the right side of the face. He was unable to close his right eye when told to do so. The right half of the skin of the forehead was smooth and shining. He was unable to knit the forehead or raise the eyebrows of the affected side. When he smiled or talked one side of the face remained expressionless, and the mouth could not be pursed up to whistle. He was unable to blow or spit properly, and the cheek puffed out on forcible expiration. There was marked diminution of cutaneous sensibility on the affected side of the chest, neck, and face. There was no flattening of the arch of the palate or any deviation of the uvula. The patient complained of tingling pain in and about the ear, but there was no disturbance in hearing. On examination the ear was found to be healthy, though the skin about the external meatus was slightly swollen. The right half of the face was swollen and looked bigger than the left side. The sense of taste was impaired, everything tasting insipid. Food collected between the teeth and the right cheek, and he was obliged to remove the collected food with his fingers. No exact date of the paralysis could be fixed, as he was quite unconscious of it until now, but he said that food had been collecting in the mouth for the last three days, and as the eruptions came out eight days before and attacked the face on the fourth day it is probable that the paralysis came on the day after the eruption appeared on the face.

Jan. 6th (i.e., on the tenth day): The whole of the eruptions on the chest and some on the neck and face have dried up.—12th: The scales have all dropped off. The facial paralysis is improving. He was able to close his eye to some extent, but still unable to whistle, and food still collects in the mouth. He is able to raise his eyebrows to some extent.—19th: The patient is much better. He is able to whistle, and food does not collect in the mouth. The eyes could be closed, but the skin over the eyelids could not be thrown into folds on strongly closing the eyes. There is still tingling in the ear, but no shooting pain.—24th: The patient has wholly recovered, and there is no sign of his former paralysis. He can firmly close both his eyes and can work all the muscles of his face with ease. There is no pain in the ear. The eruptions have all disappeared, leaving no cicatrices or scars, but deeply pigmented marks in place of the vesicles. There is still slight anæsthesia over the pigmented area, though not so marked as before.

Facial paralysis rarely follows an attack of herpes zoster of the face. There is one similar case quoted by Dr. Fagge, where it came on twenty-four hours after an attack of herpes zoster, the patient recovering after a lapse of several months. My case is of interest from the fact that though paralysis was complete he recovered from it perfectly within twenty-eight days from the commencement of the herpes. There was no history of exposure to cold, and he never suffered from ear disease. The pain in and below the ear was, I think, in the root of the facial nerve rather than in the ear itself. The pain was increased by deep pressure behind the ramus and the angle of the lower jaw, but the movement of the ear itself did not cause any pain. The paralysis may be of a reflex origin, but I should think it was a kind of neuritis from the nature of the pain. It is said that when herpes zoster affects the face it is more liable to leave permanent scars behind it. There were no marks left in the above case except the pigmented spots where the eruptions first appeared.

Bombay.

## Clinical Notes:

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### AN UNUSUAL CAUSE OF COMPOUND FRACTURE OF THE LEG.

BY H. E. WRIGHT, L.R.C.P. EDIN., M.R.C.S. ENG., J.P.,  
DISTRICT SURGEON, UMVOTI COUNTY, NATAL.

I HAVE recently met with a case of severe compound fracture of the tibia and fibula caused in such an uncommon manner that I have thought it worthy of record.

A man twenty-four years of age, of good physique and weighing about ten stone, was riding a bad-tempered horse on Jan 10th last. On arriving at the edge of a precipitous hill the animal commenced to buck, at the same time rushing madly down the decline of the hill, which, to use the patient's own words, was "nearly as perpendicular as a wall." The rider was thrown violently on to his feet, and still retained hold of the reins. No sooner had he alighted on his feet than he fell down, and he became aware that his right leg was broken. He had on a pair of thick moleskin trousers, through which the tibia protruded for a good two inches. The patient said he alighted fairly on his feet and never struck any stone or other obstacle in his fall. I saw him about four hours after the accident, when he had been removed to his home and placed in bed. I found the right foot twisted outwards and a lacerated wound bleeding freely on the antero-internal aspect two inches above the inner malleolus. Through this wound two inches of the tibia protruded. The bone was broken transversely, and was not splintered. Under chloroform I carefully washed the end of the bone and the wound with hyd. perchlor. lotion, reduced the fracture, and put in a couple of sutures to make the wound less extensive and gaping, covered all with iodoform, and dressed and put up the limb in a back splint with foot-piece and two side splints, the inner one being bracketed. The wound healed in six weeks with little traumatic fever, and with the exception of a piece of necrosed bone in the lower fragment repair went on uninterruptedly. The patient has been up and about with the limb encased in plaster of Paris for the past three weeks, and I am only waiting for the sequestrum to become loose in order to remove it. I think the case worthy of record on account of the rarity of the cause.

#### ENTERIC FEVER COMPLICATED WITH DIPHTHERIA; TRACHEOTOMY; RECOVERY.

BY WILLIAM GAYTON, M.D., M.R.C.P. EDIN.,  
MEDICAL SUPERINTENDENT, NORTH-WESTERN FEVER HOSPITAL,  
HAVERSTOCK-HILL, N.W.

A BOY eight years of age was admitted to the North-Western Fever Hospital on Feb. 7th, 1894. He had then been ill five days, complaining of pain in the abdomen and head. On admission the temperature was 104° F. The abdomen was distended, but not tender, and there were no spots. The tongue was dry and fissured; a few râles only were to be heard over the lungs. The temperature kept high, having a distinctly remittent type, and reached its highest point on the evening of Feb. 14th, when it was 104.6°. Spots first appeared on the 10th. The bowels throughout were rather confined and the abdomen at one time was considerably distended and tender. On Feb. 20th a harsh cough and hoarseness were observed, the temperature still being raised and oscillating between 101.6° and 103.6°. On the 21st, as there was marked stridor, the patient was put into a steam tent and poultices were applied to the throat. Two days later the lower ribs were slightly retracted. The fauces were inflamed, but no membrane could be seen. As the breathing and retraction became rapidly worse, on the 24th tracheotomy was performed. No membrane was seen at the time, but the dyspnoea was very much relieved. There was a trace of albumen in the urine. The next day some exudation was removed by feathering and on the 26th a large cast of the trachea came away, the wound being very septic, with a foul-smelling discharge. A large mass and several smaller pieces of membrane were removed during the next two days. On March 1st the wound was cleaner, no more membrane was

#### SANITARY INSTITUTE CONGRESS AT LIVERPOOL.—

Dr. Thomas Stevenson, F.R.C.P., Scientific Analyst to the Home Office, has consented to act as president to Section III., Chemistry, Meteorology, and Geology. Dr. Edward Klein, F.R.S., has consented to act as president to Section I., Sanitary Science and Preventive Medicine.

ejected, and as the trachea showed the natural pink colour the tube was removed for six hours. The temperature now began to decrease and the abdominal symptoms improved, but fine crepitations were heard at the base of the right lung. On the 2nd the tracheotomy tube was finally removed. A week later the albuminuria had disappeared and uninterrupted improvement ensued. On April 20th the patient left the hospital for a seaside convalescent home. The incidence of diphtheria during the course of enteric fever must be extremely rare, Sir William Jenner, Murchison and others who have written on the subject not mentioning its occurrence. The above case is interesting in the fact that there was recovery even though tracheotomy was necessary.

#### ANASARCA IN THE PUERPERAL STATE DUE TO PRIMARY SYPHILIS.

BY ALFRED KEBBELL, M.R.C.S. ENG.

A WOMAN twenty-four years of age, married about six months, five months pregnant, was first seen by my assistant on Nov. 2nd, 1893. He diagnosed pregnancy with albuminuria, and gave a careful prognosis. She was ordered seven minims of tincture of iron, three times a day. On the 4th the patient was in the same condition, but the anasarca had increased. On the 6th I was asked to see her. I found her in the following condition: the anasarca was extreme, the face puffy, and the arms and hands swollen. The legs and thighs were so swollen that it was almost impossible for her to walk. She hardly dared to lay down. She had never been well since she married. She had suffered from sore-throat and headache, and rash on the skin. Her hair, which was very abundant, was all falling off. Her appetite was bad; the urine was scanty and highly albuminous. On seeing the woman I remembered that I had attended her husband during a severe attack of syphilis ten months previously. The throat was still sore, the hair nearly all fallen off, and there were scattered over the body the remains of a syphilitic rash. I had never seen such a case before, and was in doubt as to the best treatment to be pursued. Mention of syphilitic puerperal anasarca does not appear in any published work that I have examined. Mr. Pridgin Teale, to whom I afterwards mentioned the case, kindly drew my attention to the article of the Paris correspondent of THE LANCET of Dec. 23rd, 1893: "At a meeting of the Société de Dermatologie et Syphiligraphie, M. Gastou exhibited a patient upon whose abdomen a sore, diagnosed as a hard chancre, had appeared in July, 1893, the infection being alleged to have been due to contact of a pustule (from pediculosis) with soiled sheets. The sore was situated about two centimetres above and to the left of the umbilicus, and had the appearance of an elliptical cherry-red ulceration covered with granulation, with raised hard edges, and measured six centimetres long by four broad. The axillary glands were enlarged. About mid-November, with the roseola there appeared anasarca involving the whole body, the face excepted; the urine was scanty, thick, and high coloured, and contained albumen in the proportion of one gramme eighty-seven centigrammes to the litre. Under the influence of an exclusive milk diet and iodide of potassium the cedema disappeared. M. Gastou rejects the theory of albuminuria *a frigore* or of mercurial origin, the patient having only taken mercury for six days. Although the man was addicted to alcohol, M. Gastou believes the albuminuria to be an unusually early manifestation of the action on the kidneys of the syphilitic virus." In my case the albuminuria could not have been of mercurial origin, because the patient had not then taken any mercury. The interest in the case centres in the pregnancy. I ordered a milk diet, complete rest, and warmth, and the following mixture was given: pot. iodid., two scruples; spt. am. ar., four drachms; tinct. cinch. co., half an ounce; aqua to eight ounces; two tablespoonfuls to be taken three times a day. A one-grain mercury and chalk pill to be taken three times a day. On the 8th there was decided improvement in all the symptoms. On the 11th the patient was still improving; she could walk much more easily. She said that she began to improve after taking the first dose of the medicine. From this date she continued to improve, and by Nov. 20th was practically well and able to attend to her household duties, but she continued under my care until Dec. 4th, when she left the neighbourhood. I saw her husband in March last, and he said his wife was quite well.

Flaxton, Yorks.

## 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 prop. ias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Prooemium.

#### HOSPITAL FOR SICK CHILDREN, GREAT ORMOND-STREET.

TWO CASES OF "SUPPURATIVE EPIPHYSITIS OF INFANTS," IN WHICH UNCOMMON LESIONS WERE FOUND.

(Under the care of Mr. OWEN and Mr. PITTS.)

THE following two cases present points of considerable clinical interest. In each case the ends of the diaphyses of several ribs, and in one case both clavicles, were affected. In both cases the disease followed closely after suppuration in certain cutaneous sores. We do not purpose adding more to the remarks on these cases than will suffice to give Mr. Battle's other reasons for regarding these cases as not pyæmic, as a rule, in their typical examples. The patients usually die from exhaustion, and if there is any internal inflammation, such as pneumonia, it does not present the character of inflammation due to pyæmic infarcts. The percentage of recoveries is much higher under appropriate treatment than that obtaining in pyæmia. For the notes of the cases we are indebted to Dr. C. F. Marshall, surgical registrar.

CASE 1.—An infant aged four weeks was admitted to hospital on Feb. 7th, under the care of Mr. Edmund Owen. An acute abscess involved the lower third of the left thigh, and another was present above the ankle of the same limb. There were also two small subcutaneous abscesses in the palm and little finger of the left hand. These abscesses developed a few days later, suppuration occurring in cutaneous sores on the arm. The abscesses were opened, flushed, and drained, but the child died two days afterwards. The post-mortem examination showed that the abscess above the knee led to bare bone at the diaphysal surface of the lower epiphysal cartilage of the femur, and the end of the diaphysis was in a condition of acute osteo-myelitis. There was no actual cavity in the bone, and the knee-joint was not involved. The abscess above the ankle led to bare bone at the tibial diaphysis, which was partially necrosed and surrounded by a good deal of new bone. The ankle-joint was not involved. There was a similar condition of the sternal ends of the third right and fourth left ribs and of the spinal ends of the seventh and eighth ribs, in each case the end of the rib being necrosed. There was also in this case purulent meningitis affecting the convexity of the brain, but no other sign of pyæmia was present.

CASE 2.—An infant aged six weeks was admitted to hospital on Jan. 5th, under the care of Mr. Pitts. In this case, also, the disease followed a few days after inflammation and suppuration in some cutaneous sores. There was an acute abscess above the left clavicle, and another above the left knee. On opening the former abscess the entire diaphysis of the clavicle came away as a sequestrum, which lay loose in the abscess cavity. The femoral abscess led to a cavity in the region of the epiphysal cartilage, which contained a small sequestrum. The knee-joint and shoulder-joint were not involved. The child died five days afterwards. The necropsy revealed necrosis of the acromial end of the right clavicle, suppuration in the acromio-clavicular joint, and necrosis of the sternal end of the fourth rib on the right side and of the spinal end of the eighth rib on the same side. Subpleural abscesses were found in each case.

Remarks by Dr. MARSHALL.—The affection first described by Mr. Thomas Smith as "acute arthritis of infants," afterwards called "acute suppurative epiphysitis," and more recently considered to be a diaphysitis, has in many cases been regarded as of a pyæmic nature, although in most instances it is difficult to trace any pyæmic origin of infection. In the two cases described above the origin of infection was apparently due to the septic