

malaise, especially where the patient takes to bed from a sheer feeling of illness, whenever rash begins to show we suspect something grave, one of the acute specific diseases probably. However, amongst the occasional exceptions, acute lichen, erythema nodosum, secondary syphilis, acute eczema, pityriasis rubra, acute pemphigus, urticaria, herpes zoster, and erysipelas may be named. Secondary syphilis has been mistaken for the mottling of typhus and measles, acute lichen for measles, and herpes zoster for pleurisy, on account of the pain. It is merely necessary to be aware of these mistakes to avoid them. This test is then important as the rule. When symmetrical, the disease is due, usually, to a blood-poison; when unsymmetrical, to local causes or affections of the nervous trunks probably.

*Temperament.*—We guess at a glance whether our patient is of full habit and likely to have a loaded system, especially the case in women; whether there be organic disease, or if there be a dyspeptic habit, or an ill-fed system, that signifies debility. If *lymphatic*, we may expect eczema, impetigo, intertrigo, the pustular aspect of scabies, and ringworm; if *gouty*, the scaly diseases, chronic eczema, and lichen agrius; if *rheumatic*, erythema nodosum; if *strumous*, eczema, lupus; if *florid*, alphas especially. There is also the *cancerous* aspect, and in *nervous* subjects various hyperæsthesiæ engrafted upon ordinary eruptions, and so on. Red-haired subjects get pityriasis of the scalp.

We ask how long the disease has existed?

*Hereditary* diseases are—lepra, psoriasis, ichthyosis, lichen, eczema, and syphiloderma especially.

*Congenital* diseases are—syphilodermata, pemphigus, pigmentary, nævoid, and ichthyosis (scales).

*Chronicity.*—The more chronic a disease is the more does it tend to become a local disease; and this is the case with hereditary affections, hence in these cases *local* treatment is the most important.

Has the patient had the disease before?

*Recurrence.*—Lepra is essentially the disease which recurs, but syphilitic diseases also return.

*Occupation.*—Cooks get eczema and erythema, and lichen agrius about the backs of the hands, with bakers, grocers, and bricklayers; chimney-sweepers are liable to epithelioma of the scrotum; cotton-workers to urticaria; butchers and graziers to whitlow, boils and malignant pustule; dragoons and shoemakers to an inveterate form of eczema in the fork of the thighs; young women who come from the country and have the full diet fare of the London servants, get an overloaded system that shows itself as erythema papulatum, erythema nodosum, or impetigo.

When did the disease first appear?

*Age* is very important. During the first six weeks of life congenital syphilis develops itself; intertrigo, eczema of the scalp, and seborrhœa capilliti; the congenital diseases of course show also. Syphilitic pemphigus occurs, it is said, before the child is six months old, not afterwards; during the first few months and up to and through the period of dentition, strophulus and eczema. One need only mention important facts. Cancer (epithelioma) is a disease of late life—not before thirty, about sixty; and rodent ulcer about the age of sixty and beyond. Lupus is a disease which commences in early and young life, and the same may be said of syphilis. The parasitic diseases occur in the young, rarely after twenty-one years of age. Herpes circinatus (or, as I call it, tinea circinata) is the form seen in middle life. In old people, prurigo, ecthyma, cachecticum, pemphigus, and pruritus occur, with cancer and rodent ulcer.

Where did the disease first appear?

*Seat.*—On the *scalp* we have parasitic diseases, keelion, eczema, porrigo at the back of the head, sebaceous cysts, alopecia, and lepra; *ears*, eczema; *forehead*, lepra and herpes zoster; *near the eye*, chromidrosis, rodent ulcer, xanthelasma or vitiligoidea, molluscum; *face generally*, acne, impetigo contagiosa, erysipelas, lichen, syphilitic eruptions, erythema; *nose*, lupus, hypertrophy, acne rosacea; *cheeks*, lupus, malignant pustule, acne rosacea; *upper lip*, impetigo sycosiforme, herpes labialis; *lower lip*, epithelioma; *chin*, sycosis; *whiskers*, acne sycosiforme; *angle of mouth*, congenital syphilis; *chest*, chloasma and keloid; *under clavicle*, sudamina; *about the nipples*, in women, scabies; *in the side*, shingles; *outer and posterior aspects of trunk*, prurigo and lichen, as distinguished from eczema on the *inner and front* aspects; *elbows and knees*, lepra, psoriasis; *interdigs* and *about wrists*, scabies; *back of hands*, lichen and grocers' and bakers' itch; *palm of hands* alone, syphilitic lepra and erythema; *buttocks and feet of children*, scabies; *upper line of penis*, scabies; *scrotum*, eczema, psoriasis, and epithelioma in chimney-sweepers; *front of leg*,

erythema nodosum, and in old people, eczema rubrum; *about the anus in children*, congenital syphilis; *generally over the body*, pemphigus foliaceus and pityriasis rubra; *in the bend of joints and armpits*, eczema rubrum; and limited to the *hair follicles*, lichen and pityriasis pilaris; and to these and the *sebaceous glands*, lichen scrofulosis and lichen rubra.

Our next query ascertains whether the eruption be *persistent* or *evanescent* (urticaria), developed pretty much at once (acute specific diseases, herpes zoster, herpes), or *consecutive*, as in most cases, *uniform* or *multiform*: the latter being the character of scabies and syphilodermata especially, and also seen in the complication of scabies by impetigo contagiosa; urticaria, and scabies, or purpura; scabies and prurigo, eczema and scabies, eczema and lichen (eczema lichenodes), eczema and psoriasis, seen oftentimes in the fork of the thighs and about the bend and front of the elbow. This fact of the intermingling of diseases is one of the most important to remember; to forget it is to lay oneself open to one of the commonest sources of error.

To scrutinise closely the character of the eruption to ascertain the *primitive elementary lesion*, is our next duty. In acute cases we have no difficulty; but in chronic instances it is frequently difficult, because the disease is often modified by *secondary changes*—brought about by (1) abortive development; (2) by treatment; (3) by the intercurrent and intermingling with other diseases, as before mentioned. Most skin diseases employ the agency of inflammation in their operation; and this consists of redness (congestive), papulation (depositive), vesiculation (effusive), pustulation, &c. Now some diseases only need the aid of the minor, others of the greater, of these; hence by abortive development a vesicular disease (eczema) may only reach the erythematous or the papular stage. And we must remember that our guides to the correct interpretation must be the concomitants in each case. The intermingling of two or more diseases requires to be kept in mind; and the effect of treatment is oftentimes to check secretion, and to produce an unnatural scalliness and dryness, so that a chronic eczema looks like psoriasis (lepra). The history, however, shows it to have "run" or discharged in its early days. *Scratching*, too, always induces additional inflammation, and flannel very much so. In chronic cases, we necessarily go to the newly developed part of the eruption to ascertain the nature of the elementary lesion—that is to say, to newly affected parts where the eruption is scattered and discrete, and to the edge of patches. In many cases congestion is augmented by deficiency of elimination, especially in regard to the kidneys. I believe our omission to attend to this is greatly to be reprehended, and in elderly people the effect of gravitation and retarded circulation is most potent. Many a case of eczema rubrum is exaggerated by, if its visible presence be not dependent upon, a deficient kidney action.

I shall next summarise the features of the various eruptions.

## A SEDIMENT TUBE FOR THE MORE READILY COLLECTING FROM THE URINE TUBE CASTS AND OTHER OBJECTS FOR MICROSCOPIC EXAMINATION.

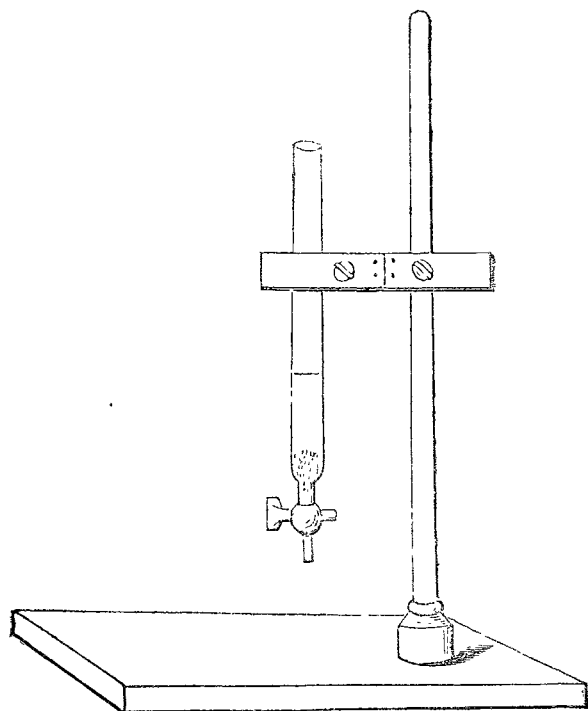
By W. R. BASHAM, M.D.,

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I HAVE frequently suffered so great a loss of time in searching for tube-casts and other objects of interest in the urine of those suffering from renal disease, that I venture to think that a very simple apparatus which I have adopted for obtaining the lowest portions of the sediment, without disturbance of the upper portion, and thus finding, without loss of much time, the objects sought for, may be found of service to the profession, and particularly to microscopic observers.

It frequently happens, in using the ordinary conical-shaped urine glass for collecting the sediment in urines, that in pouring off the upper stratum the sediment is so disturbed and the objects so diffused, that drop after drop is placed on the microscope stage with a negative result. It requires a large amount of patience to go through some eight or ten sample drops and find nothing, and still to persevere till rewarded by finding an object typical of the stage or form of disease from which the patient is suffering. I have for some time used a sediment tube of glass constructed with a tap, by turning

which only the lowest portion of the sediment, and that which is richest in microscopic objects, is permitted to fall on the glass stage of the microscope. By this means no disturbance of the sediment can occur from pouring off, and the minutest sized drops can be brought into view. The accompanying woodcut will best illustrate the simplicity of this method. The



tube should be about three quarters of an inch in internal diameter, and, including tap and orifice, ten inches long. It may be kept in perpendicular position by any ordinary tube support. The most advantageous mode of using this sediment tube, if the quantity of urine to be examined microscopically be six or eight ounces, is to pour this into an ordinary conical-shaped urine glass, and allowing this to rest for an hour or more, carefully to decant off to within about two ounces, and pour this into the sediment tube. The sediment in an hour or two will have collected sufficiently, and by turning the tap a minute drop may be allowed to descend on to the microscope stage, and being covered with a slip, will be found to exhibit whatever microscopic objects of importance may be contained in the urine. A great saving of time is thus gained, and where formerly I have spent an hour or more in, perhaps, fruitlessly searching through samples of urines from different patients, I now can satisfactorily complete the examination in a few minutes. Messrs. Griffin and Sons, of Garlick-street, Long-acre, have made these tubes for me, and they can be supplied by them for a few shillings.

Chester-street, Grosvenor-place, Feb. 1867.

## A Mirror OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

*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.

### MIDDLESEX HOSPITAL.

#### A CASE OF HYSTERICAL CHOREA.

(Under the care of Dr. MURCHISON.)

WE had the opportunity lately of observing the following case, which was of curious character, and of some little importance, especially in reference to prognosis, which would probably be more favourable in hysterical than in true chorea.

Jane N—, a cook, and unmarried, was admitted on the

24th of December, 1866. She had frequently been the subject of rheumatic pains, and twelve years before had suffered from an attack of rheumatic fever, which lasted for eight weeks. There was a history of consumption on her mother's side, but no family history of fits. She had long suffered from menorrhagia and leucorrhœa. Her aspect was hysterical, and not very anæmic.

Her present illness commenced about six weeks before admission, without any apparent cause, and consisted in severe convulsive movements, chiefly on the left side of the body. For the first three weeks the attacks came on only during the night, but subsequently they became more severe, and occurred in the daytime as well as at night.

After the patient's admission these fits were found to present the following characters. They commenced with a choking sensation like globus hystericus, and successive efforts at deglutition. These were soon followed by violent muscular agitation, confined for the most part to the head and the left side of the body, and interrupted occasionally by severe spasmodic rigidity of certain muscles, as the result of which the head was drawn sometimes to one side and sometimes to another, and occasionally there was a condition approaching to opisthotonos. The movements were so violent that the patient must have hurt herself if she had not been in bed. Any attempt to restrain them only made them worse. The attack was not preceded by any scream, or accompanied by any loss of consciousness or pain. The patient would converse freely while the movements were going on, and with her right hand endeavour to restrain the movements of the left; and what was more remarkable was that the movements were to some extent under the control of the will. In the midst of a fit she could pick up a pin or a card and hold it with her left hand, which went directly at the object and grasped it, the movements being for a few moments suspended. Sometimes she had to wait a few seconds before trying to seize the object. The duration of the fits varied from a few minutes to several hours. She had five, six, or more during the day, and often they appeared to be induced by excitement, as at the hour of visit. There were no movements during sleep, and never any in the intervals of the fits.

As regards her other symptoms: the pulse was 84 and regular; the physical signs of the heart and lungs were normal; the tongue was clean and moist; the appetite was capricious, but there was no symptom of indigestion; the bowels were regular. There was no headache; but there was slight strabismus, the left eyeball, when she looked upwards, being drawn upwards and outwards more than the right. The left pupil was also about one-third larger than the right. The patient stated, however, that ever since she had been a child there had been something peculiar about her eyes.

The patient was ordered a pill containing a grain of valerianate of zinc, a grain of sulphate of iron, and three grains of extract of gentian, three times a day; and, on January 7th, 1867, she was up and greatly better, the fits consisting of little more than slight muscular twitchings.

Although occurring in a rheumatic patient, Dr. Murchison pointed out that the symptoms in this case differed in two particulars from true chorea—viz.: 1. In the complete intermission of the movements during the intervals of the paroxysms. 2. In the patient's ability during the paroxysms to control to some extent the movements, and at once to seize a small object and to hold it. The case was evidently one of those which had been well described by Trousseau under the designation of "hysterical chorea." In one of the cases recorded by Trousseau, the movements were equally violent as in the case now recorded; and also confined for the most part to the head and the left side of the body. But if the patient was placed in front of a piano, the movements at once ceased, and she could play for hours without failing in a single note.

### ST. BARTHOLOMEW'S HOSPITAL.

#### FRACTURE OF THE OS CALCIS FROM MUSCULAR ACTION.

(Under the care of Mr. HOLMES COOTE.)

THE possibility of a fracture of the os calcis as the result of violent contraction of the muscles of the calf has been long established. In the museum of St. Bartholomew's Hospital (No. 9, Series iii.) is exhibited an os calcis fractured transversely through its posterior part. The plane of fracture extends from the posterior border of the upper articular surface to the middle of the posterior surface of the tuberosity.