

boy taking, as a matter of course, a quart bottle of water to bed with him and finishing it before the morning. Therefore a native always runs a greater risk than the European does. The only treatment which I found to be of any use was small doses of buchu and opium freely diluted. This seemed to allay the irritability of the bladder (which was the prominent symptom) better than anything else. The *non-parasitic* form of hæmaturia was always associated with a high temperature. The usual course of a typical case was as follows: First, a rise in temperature ranging from 103° to 105°; this would last for about two hours, by which time the patient had probably gone to bed. Secondly, a severe rigor, lasting perhaps twenty minutes; about an hour after the rigor the temperature falls to about 102° (probably influenced by antipyretics). Thirdly, a feeling of faintness comes on, marked by great pallor; the first quantity of urine which is passed after this will be absolutely black, and is found to contain a large quantity of grumous material, composed of disintegrated blood-cells. At this stage of the disease no actual blood-cells can be discovered by the microscope; but as the patient recovers, and the amount of blood passed is less in quantity, it becomes more like real blood in its appearance, and cells more or less altered can be readily made out. The hæmorrhage usually continues for about three days under treatment; perhaps it would last longer if not treated, but naturally one did not care to try. And then follows, fourthly, the stage of convalescence; the hæmorrhage has ceased, but there is still a temperature of about 102°, which may persist for a month or until the death of the patient. Probably the system, weakened by the great loss of blood, is unable to resist the malarial poison as it otherwise would; for an African fever is generally sudden both in its onset and in its retrocession; the man who has been moaning with pain and delirium, with temperature 106° one day, will in two days' time be out stalking antelopes. This, however, is not the case after an attack of hæmaturia; recovery is then always very slow and tedious. This disease is common amongst the Europeans, but rare amongst the natives, although they are frequently attacked by ordinary malarial fever. I have heard of another form of hæmaturia in this district (hæmoglobinuria), but as I have not had a case under my care I give no description of it.

Darfield, near Barnsley, Yorks.

TREATMENT OF ULCERATED SCARLET FEVER AND DIPHTHERITIC THROATS BY IRRIGATION.

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I HAVE used the following method of treatment in the ulcerated throats of scarlet fever and diphtheria in the Birmingham City Hospital for about two years and a half. The appliances necessary are a small indiarubber bag syringe, 4 or 6 oz., according to the size of the patient, two small basins, and a towel. The medicament used is boric acid dissolved in hot water (about 105° F.). In order to facilitate the solution of the boric acid, I have a saturated solution in glycerine, prepared by Messrs. P. Harris and Co., Edmund-street, Birmingham, of which the following are the proportions: Powdered boric acid, four parts; glycerine (sp. gr. 1260), three parts. The glycerine should be heated by steam, and the boric acid (best quality, carefully powdered) stirred in till the solution is perfect. Of this solution, a large tablespoonful is dissolved in about a pint of hot water. The method of procedure is as follows:—Place the patient sitting up, or, if too weak to sit up, place him on his side with his face over the edge of the pillow. Apply the towel round his neck to keep him dry if any water accidentally gets spilled; withdraw the nozzle from the syringe before filling it, and fill with the solution; replace the nozzle, and direct the patient to open his mouth; then put it into the mouth well over the back of the tongue, and forcibly empty the syringe; at the same time receive the water which rushes out of the mouth and nose into the empty basin. In this way the mouth, fauces, pharynx, and in some cases the posterior and anterior nares, are irrigated. The operation is repeated till the parts are washed quite clean. In cases of purulent discharge from the nose or nasal diphtheria, the same procedure is applied to the nostrils. The irrigation may be performed every two or four hours as circumstances require. In this hospital during

two years over 1500 cases of ulcerated scarlet fever and diphtheritic throats have been treated by this method. From this experience I can recommend it as superior to any other I have ever tried. I believe its efficacy is due to the fact that it is founded on the rational principle of washing away all septic discharges with a non-irritating, non-poisonous fluid. It is not in any way disagreeable to patients; on the contrary, when the mouth is dry or foul, it is most comforting. The solution is rendered sweet by the glycerine, so that only a small percentage of even very young children offer any objection to it. Occasionally children swallow some, but without any subsequent ill effects. It should be borne in mind that, in order to prevent any septic matter being sucked into the syringe, the nozzle should always be withdrawn when filling.

Birmingham.

A CASE OF AINHUM.

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SURGEON OF PRETORIA.

THIS complaint is commonly met with amongst the natives (Kaffirs) of South Africa, especially in Northern Transvaal, and is usually limited to the little toe; both feet are, however, generally attacked, though not simultaneously. The toe at its junction with the foot has the appearance of being gradually cut off by means of the continuous pressure of a ligature tied round the toe at that spot. The following is an example, extracted from my note-book, of the usual history attached to such cases.

Tozini, aged thirty-four, married. The little toe of his left foot is already gone. About a year ago the dorsum and outer side of his right foot swelled up to a considerable extent and gave him much pain of a burning character, the pain running down into the little toe. The swelling gradually subsided, leaving a small pustule on the inner and dorsal aspect of the metatarso-phalangeal joint of the little toe. This pustule, on evacuating the matter, assumed the appearance of a crack, which slowly extended round the toe, eating deeper and deeper through the tissues; all feeling gradually left the toe, though the foot remained very painful until the toe dropped off (or in some cases gets accidentally knocked off). The wound quickly healed and gave no more discomfort. The complaint appears to be one of nerve origin, and differs entirely from the "mutilans" form of leprosy. The only cure consists in amputating the toe.

Pretoria, S.A. Republic.

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.

MIDDLESEX HOSPITAL.

CASES OF INJURIES OF PERIPHERAL NERVES (*continued*).
(Under the care of MR. HULKE.)

WE continue below the interesting series of injuries to peripheral nerves which we commenced at page 877 of our last issue. The cases already brought forward include two of wound of the ulnar nerve, one of recovery of function after immediate suture of median, and one of division of the sciatic nerve within its sheath followed by very incomplete recovery of function.

In Case 5 the presence of small sensitive islands in the palm was singular, in presence of the fact that the divided ends of both median and ulnar nerves were separated by not inconsiderable intervals. The relatively early return of sensibility in the palmar distribution of the median nerve after suture, although the ends of this could not be brought into contact, imperfect as it was, and transitory as it proved in some branches, is a remarkable circumstance. In Case 6, the position of the smaller and posterior of the two scars in