

punctiform, exactly resembling that of a mild case of scarlet fever. Similar epidemics have been described by Filatow and Kramsztyk. In two of the cases described by the latter there had been previous attacks of scarlet fever attended by himself; one later had a typical attack of the ordinary type of r  theln, and another true measles. The attacks began suddenly with fever, headache, and sometimes vomiting, with a red rash. The fever, which ranged from 101   to 103  , lasted from two to four days, and the rash about the same time. The rash was general except on the face, and indistinguishable from scarlet fever; there was hardly any tonsillitis. The headache and malaise usually lasted only one day, and so by the second or third the child was practically well but the rash remained visible. In one case there was swelling of the cervical glands.

Desquamation is mostly absent. Difficulty in diagnosis principally occurs in isolated cases, or in the first case or two coming under notice. When other cases occur the long period of incubation of rubella would be a valuable aid. The author raises the question whether rubella, when it assumes the scarlatinal type, has a shorter incubation than in the other form.

Surgical scarlatina, he believes, is in most cases scarlatina occurring in a subject under the care of a surgeon, but in cases in which there is an excessive amount of suppuration there may be a red rash due to septic  mia. It occurs in cases of scarlet fever where there is much suppuration about the neck and fauces, the rash looking at first sight like a second scarlet eruption, but it is apt to be more patchy and of a duskier hue. A similar rash may be seen in empyema with much pus-formation. The rash seen in severe cases of diphtheria is no doubt also septic, though it is now a well-recognized fact that a membranous exudation exactly resembling true diphtheria may be present on the fauces in scarlet fever, but the Loeffler bacillus is absent. The inflammatory form of diphtheria is sometimes exceedingly like scarlet fever, beginning with vomiting and high fever; especially if there were a dusky septic rash present the likeness would be still more close.

Among the drugs, belladonna is the only one that produces an erythema liable to be mistaken for scarlet fever. Antipyrine certainly at times produces a rash, but it is more of the measles or nettlerash type.

The question of desquamation, which is apt to follow all diffuse rashes, especially where there has been fever, is of great importance. The author believes that as indisputable evidence of scarlatina desquamation is greatly overrated. Mild cases of scarlatina often do not desquamate at all, or differ in no way from other febrile attacks, such as influenza, pneumonia, or typhoid.

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#### TREATMENT OF DOUBLE EMPYEMA IN CHILDREN.

G. A. SUTHERLAND (*Lancet*, June 9, 1894, p. 1439) reports four cases of this interesting and rather rare affection, and tabulates the leading facts in 17 cases collected from the literature. As regards etiology, 14 (67 per cent.) were secondary to lobar pneumonia, one was preceded by influenza, one by broncho-pneumonia, two are described as primary, and in three the history of previous illness is indefinite. This corresponds very closely with the statistics of unilateral empyema given by ADAM (*Archiv f. Kinderheilk.*, Bd. xv., Hefte 5 u. 6), who found that in 32 cases, 23 (71 per cent.) were preceded by lobar

pneumonia. In the four cases reported by the author, occurring in children from two and a half to six years of age, the treatment adopted was double resection, irrigation, and drainage. After resection the pleural cavity was explored with the finger to break up adhesious and estimate the size of the cavity, and a short drainage-tube inserted, which was removed usually within a week. To this practice of temporary drainage he attributes the rapid recovery, the average duration of drainage in his four cases being seven days, as contrasted with seven weeks in the other cases published. This fact has especial bearing on the treatment of cases of double empyema, where, if one side is speedily cured, the other can then be treated without danger in the same radical manner, aspiration having been performed, if necessary, in the meantime. This would seem to be the most satisfactory method, for in the reported cases of "simultaneous drainage" the collapse has frequently been alarming, and the signs of cardiac and respiratory embarrassment very marked. As regards the side to be operated on first, the greatest relief will probably be obtained by selecting the side on which there appears to be the larger amount of fluid. After the operation-wounds have healed, an important part of the treatment is the employment of forced respiratory movements and chest-expanding exercises.

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#### A CASE OF PARALYSIS FOLLOWING DIPHTHERIA OF THE GENITALS ONLY.

W. GAYTON (*Lancet*, May 26, 1894, p. 1301) reports a case of purely genital diphtheria in a girl of four years, who was admitted to the Northwestern Fever Hospital. The skin of the groins, labia, and vulva was excoriated from a very offensive, copious vaginal discharge. On separating the genitals the parts were found to be extremely swollen and covered with a membranous exudate of true diphtheritic character, which had also crept along the vagina as far as could be seen. The temperature was 96°, the countenance very pallid, and the pulse feeble and slow. The vulvitis had existed for a fortnight, but the throat was not, nor had it been previously, affected.

Twenty-two days later, under tonic treatment, together with local use of a perchloride of mercury solution, the parts were nearly healed and the vaginal discharge had ceased; but the urine still continued slightly albuminous, and the temperature and pulse subnormal. Four days later marked strabismus was observed, also palate paralysis, with regurgitation of fluids through the nostrils and an irritating, noiseless cough. In three days more the muscles of visual accommodation were impaired and the paralysis continued to increase until, ten days later, death occurred, apparently from direct toxic action of the diphtheritic poison on the bulbar centres. The chief point in view in recording the case, the author says, is to qualify a statement recently made, that diphtheritic paralysis does not follow except when the fauces have been previously affected.

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#### A CASE OF URTICARIA PRODUCED BY SANTONIN.

G. STEWART ABRAM (*Lancet*, May 12, 1894, p. 1186) relates the following case: A child seven years of age was brought to him suffering from thread-worms, which had been present for three years. She had been under treatment once before for this cause, but had not taken santonin. The child was