very bad cases, generally cures the worst cases in the course of a week. During the last five years, I have used no other method of treatment. The explanation of its success is as follows. Common spirit of turpentine is a powerful germicide; but it is a still more powerful solvent of the sebaceous or greasy matter of the scalp, and it rapidly penetrates into all the epithelial structures of the scalp, the affected hairs included, and clears the way for the application of a still more powerful germicide, namely, tincture of iodine.

It is an interesting chemical fact that spirit of turpentine, or, more correctly, oil of turpentine, is a powerful solvent of iodine. This solution of iodine in turpentine is a most powerful germicide, and quickly destroys the fungus of ringworm. If tincture of iodine be applied to the spots which have been treated, as above, first with the spirit of turpentine, and then washed with carbolic acid soap and water, it finds its way down into the epithelial tissues, and into the hair-follicles, following the course which the spirit of turpentine has taken. It is of no use to apply watery solutions of germicides, until the greasy or sebaceous matter of the scalp has been first removed.

In some severe cases, I have applied a solution of iodine in turpentine, ten grains to the ounce, instead of the tincture of iodine, after the head has been washed and cleaned; but in most cases, the application of tincture of iodine, after the part has been acted on by the spirit of turpentine as above described, is quite sufficient to destroy the disease.

Ringworm on other parts of the body may be treated with spirit of turpentine and tincture of iodine in exactly the same way. One great advantage of this treatment is that it may be applied to the head of the youngest child, and causes little or no distress at any time.

James Foulis, M.D., Edinburgh.

CUCAINE IN NEURALGIA.

When the medical journals are full of the varied uses to which the new anæsthetic, cucaine, has been applied, it would seem superfluous to seek publication for the following case, illustrating its anodyne properties, which follow, as a matter of course, from its recognised anæsthetic action.

D. B., aged 24, single, waiter in a London restaurant, consulted me for neuralgic head- and face-ache, lasting for over six weeks. The pain was agonising, constant, but always aggravated at night. He had been under the treatment of two other medical men, and had besides tried, without obtaining any relief, various remedies, much in the same way as Mark Twain treated his cold. I prescribed the usual bromides, quinine and iron, belladonna, spirits of chloroform, etc., but to no purpose. It occurred to me to try the effect of the local application of cucaine. A 2 per cent. solution was applied to the forehead and cheeks. The application was attended with a smarting sensation, like the "pricking of pins," to use the patient's words, and the neuralgic pain seemed, if anything, worse after it. The lotion was ordered to be diluted with as much water, and was rubbed over the points where the sensory nerves of the head become cutaneous, with the effect of shifting the pain from the forehead and face, to the vertex and occiput. A third application, however, completely cured him, and for the last week he has been free from any return.

I may add that the condition of the bowels and pupils contraindicated opium; the only administration of the drug being in the form of Ferrier's snuff combined with ordinary snuff, which he has been using since the cessation of the pain. To give tonicity to his nervous system, I have now put him on small doses of Easton's syrup.

Philip S. Brito, M.B.,
Late Demonstrator of Anatomy, Aberdeen University.

CLINICAL MEMORANDA.

FOREIGN BODY IN THE ALIMENTARY CANAL OF AN INFANT TEN MONTHS OLD: PASSAGE IN THIRTY-SIX DAYS: RECOVERY.

On January 15th, I received an urgent message to go and see a baby, who, the messenger said, had swallowed a toy, and was choking. On my arrival at the house, the father of the child told me that, just after the messenger had started, the child became so bad that he thought it would die; he therefore passed his finger into its mouth, and, feeling something hard and sharp, and not being able to remove it, he pushed it down. The little one was at once relieved, and, when I saw it a few minutes afterwards, was quietly taking the breast, as if nothing unusual had happened. I kept the child under observation for a day or two, and gave directions that the motions should be watched and examined. No bad symptoms whatever occurred, the child taking the breast and sleeping as usual. The circumstance had nearly passed from my memory, when, on February 20th, thirty-six days after the infant had swallowed the foreign body, the father came to my surgery, and said that the baby had just passed it. The baby seemed in a little pain as the motion, which was semisolid, came away, and the diaper was slightly stained with blood. The foreign body proved to be half a brass toy locket, with sharp cutting edges, measuring in its long axis seven-eighths of an inch, and from side to side nearly three-fourths of an inch. The colour of the brass was very little altered.

The above case seemed to me to be interesting on account of the length of time the foreign body remained in the alimentary canal, no untoward symptoms occurring during its passage. In an adult, we can administer opiates, keep the patient at rest, and order him constipating food, so as to form a coating or a vehicle for the foreign matter swallowed; but this treatment is impossible in an infant ten months old, subsisting, as my little patient does, only on its mother's milk.

Mr. Erichsen relates an interesting case, in which he succeeded in getting a gold plate with three molar teeth to pass in four days after it was swallowed by a gentleman 25 years old; but I think, in contrasting the two cases, that of my little patient is of greater interest.

F. W. E. Kinneir, M.R.C.S., L.S.A., Horsham.

REPORTS
OF
HOSPITAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN, IRELAND, AND THE COLONIES.

NORFOLK AND NORWICH HOSPITAL.

SUBSPINOUS DISLOCATION OF THE SHOULDER.

(Under the care of Mr. Cadge.)

[Reported by Mr. Donald D. Day, House-Surgeon.]

On July 14th, J. C., aged 44, who had been thrown out of a cart less than an hour previously, was brought to the hospital complaining of pain in the right shoulder. All underhand movements were performed well, but abduction was extremely limited and very painful. The arm hung down almost vertically, the elbow being close to the side, though not touching it; the forearm, semiflexed across the abdomen, was supported by the left hand. There was marked flattening of the deltoid, with increased prominence of the acromion. A swelling beneath the spine of the scapula proved to be the head of the humerus, which lay at the posterior edge of the deltoid, just under the middle of the spine.

Reduction of the dislocation was effected with very little trouble, the man being faint, and his muscles flabby. The patient being seated, while steady traction was made horizontally outwards by an assistant, Mr. Day, with his knee in the axilla, and his fingers on the acromion, and thumbs on the head of the bone, steered it into its natural position in less than a minute. A sling for the wrist and circular bandages kept the arm to the side. As the patient left Norwich the next day, he was not seen again.

Remarks by Mr. Day.—The rarity of this dislocation seems to be due to the strong protection afforded to the posterior part of the joint by the supraspinatus and infraspinatus muscles, which are extremely tendinous, and intimately blended with the capsular ligament; in fact, from the coraco-humeral ligament to the inferior edge of the infraspinatus muscle, there is one strong musculo-tendinous plane. through which escape of the head is impossible without such an extreme degree of violence as to rupture it; and this is prevented as a rule by the force expending itself in breaking the clavicle. Hence the only point of escape lies at the lower part of the joint which is unprotected save by the long head of the triceps, on which the bone falls in the subglenoid dislocation. Now, in consequence of the plane of the scapula inclining slightly forwards, the smooth round head is apt to slip off it forwards, and be drawn up under the coracoid process (the usual position), unless the greater tuberosity catch against the under lip of the glenoid cavity. If, however, the arm be rotated inwards as the head slips out of the socket, the tendency is for the head to slip backwards off the triceps; and then, as the arm descends from the elevated position, which seems necessary for the production of any dislocation, the head of the humerus is levered up towards the spine of the scapula, stretching and probably tearing the infraspinatus from its origin. In this process, a strong analogy exists to

the dislocation of the femur on to the dorsum ilii, the part played by Professor Bigelow's Y-ligament being here taken by the coraco-humeral ligament and the supraspinatus, with which it is intimately blended. The subspinous position is, in my opinion, always a secondary one, and not that originally occupied by the head of the bone. The vertical position of the arm, though differing from that described by Erichsen, entirely agrees with the account given of it in Callaway's Jacksonian Essay, 1846. The slight pain experienced, except during abduction, is evidently due to the absence of pressure on or stretching of the large axillary nerve-trunk, which would take place in the subcoracoid or subglenoid positions. The rarity of the accident is shown by the fact that Sir Astley Cooper only saw two cases.

BATH GENERAL OR MINERAL WATER HOSPITAL.

A CASE OF IRREGULAR SUPPRESSED GOUT.

(Reported by Mr. JAMES MERCES, Resident Medical Officer.)

W. C., AGED 37, a farm-labourer, was admitted on September 15th, 1884, for articular gout. At the age of 22, he had some acute febrile affection, probably acute rheumatism. Six years before admission, he had the first indication of gout. He complained of irregular pains, with acute exacerbations of swelling and inflammation in his knee, ankle, and toe-joints. There were large irregular deposits of urate of soda at the terminal joints of all the phalanges. The movements of the joints were impaired, and gave rise to a fine crepitant feeling on passive movement. The condition of the feet was very characteristic of gout; there was no actual enlargement, but the feet on the inner side were in a straight line from ankle to great toe, with no depression anywhere. The ankles and knees gave rise to the same fine crepitant feeling. Deposits of urate of soda were formed in the helices of the ears, in the bursæ over the patellæ, the elbow, and the outer side of the ankles; softer deposits, presenting microscopically fine acicular crystals of urate of soda, were found in the palpebral conjunctivæ. The conjunctivæ were somewhat chemosed. The apex-beat was in the sixth intercostal space, two inches below, and in the nipple-line. There was a loud blowing systolic murmur heard, also, at the angle of the scapula. The second aortic sound was accentuated. The pulse at the wrist was 108, small, regular, and somewhat tense. Large quantities of urine, of specific gravity 1010, pale acid, containing a quarter albumen, and a few granular casts, were passed. Sight had been failing for a year. There was double optic neuritis, with small hæmorrhages close to the disc.

September 16th. He was ordered the baths at a temperature of 98° Fahr., with the wet douche thrice weekly. He was placed on a diet of meat, vegetables, and milk; no stimulants were given, but he drank a small tumbler of mineral water twice daily.

On September 30th, he was ordered the hot bath (103° Fahr.), and the douche to the joints.

On October 17th, he complained of severe pain in the head and symptoms of a "cold." The temperature was 99° Fahr.; the skin moist; the pulse 100.

On the following day, he complained of severe pain in the epigastrium, extending to the right iliac fossa, with constant vomiting of bilious matter. The tongue was dry, and covered with dark yellowish-brown fur. Dysphagia was the most troublesome symptom. As there was constipation, he was ordered a pill containing three grains of euonymin.

October 20th. The vomiting had ceased. He was slightly jaundiced. The tongue continued furred, though the bowels had acted freely. Dysphagia was exceedingly troublesome. The urine was of specific gravity 1035, and contained abundant lithates. Far above the normal amount of urea was excreted in the twenty-four hours. He was ordered a mixture containing colchicum.

On the following day, he began to improve, and left the hospital on October 25th.

REMARKS BY MR. MERCES.—The points of interest in this case are: 1, the undoubted existence of rheumatism, as indicated by the old mitral regurgitant murmur; 2, the hypertrophied heart and contracted granular kidney commonly met with in long standing gout; 3, the sudden appearance of "suppressed gout," while the joints were quite well; 4, the value of colchicum even in cases of suppressed gout, with suitable treatment for special symptoms as they arise.

PRESENTATION.—Dr. Atkinson, late assistant medical officer to the Kensington Infirmary and Workhouse, has been presented, on the occasion of his retirement from the post, with a handsome clock and bronzes, accompanied by an illuminated address, expressing the good wishes of his friends for success in his new sphere of labour.

REPORTS OF SOCIETIES.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

TUESDAY, MARCH 10TH, 1885.

GEORGE JOHNSON, M.D., F.R.S., President, in the Chair.

The Treatment of Acute Peritonitis by Abdominal Section. By FREDERICK TREVES, F.R.C.S.—The extreme fatality of acute diffused peritonitis—especially of that form due to perforation—and the acknowledged futility of the modes of treatment that are at present employed, give some support to the proposal that acute peritoneal inflammations should be treated by the same methods that are successfully applied to other acute inflammations, namely, by free incision and drainage. This common and general surgical procedure has been already applied for the relief of inflammations of certain of the serous membranes. It was at first adopted in connection with the smaller serous cavities, as those of the joints. It has been gradually and with increasing freedom applied in the treatment of inflammatory conditions involving the pleura. It has finally become a recognised means of treatment in certain forms of localised and chronic peritonitis, especially when purulent collections have formed. Mr. Treves urged the adoption of this principle in treatment in connection with acute and diffused forms of peritonitis. A female, aged 21, was admitted into the London Hospital on January 21st, suffering from chronic pelvic peritonitis following severe gonorrhœa. On February 25th, three months after the commencement of the chronic peritonitis, she suddenly developed the symptoms of acute diffused peritoneal inflammation. The sequel showed that a large chronic purulent collection, containing very offensive matter, had formed near the left pelvic brim. The walls of the abscess were formed partly by the pelvic peritoneum and partly by many coils of small intestine that had become matted together. The acute symptoms were due to the bursting of this abscess, and the extravasation of its contents into the general peritoneal cavity. On February 26th, the abdomen was opened under antiseptic precautions, the patient being at the time apparently in a very critical condition. The general surface of the peritoneum showed the ordinary appearances of acute peritonitis. The intestines, where in contact, were lightly glued together. A quantity of semi-opaque fluid, mixed with flakes of lymph and pus, escaped. The whole peritoneal cavity was washed out with many quarts of water, and a drain introduced. The patient made a good recovery, and was allowed in the garden on the fortieth day. Mr. Treves alluded to several cases in which operations involving laparotomy have been performed with success during the progress of acute peritonitis, the cases having been in most instances the subjects of error in diagnosis. Allusion was also made to the recent experiments of Dr. Parkes, of Chicago, as to the treatment of penetrating gun-shot wounds of the abdomen, with perforation. Mr. Treves ventured to suggest the use of abdominal section in the treatment of certain cases of acute general peritonitis, such as that following injury, gun-shot wound, the bursting of an abscess, and specified forms of perforation.—Mr. HOWARD MARSH read the notes of a case which had many points in common with that of Mr. Treves. The patient was a medical student, of the age of 19, who was attacked with symptoms of sudden and acute peritonitis, and admitted under the care of Dr. Andrew and Mr. Howard Marsh into St. Bartholomew's Hospital. There was no hernia, and nothing abnormal could be felt by the rectum; a little to the left of the umbilicus the skin was slightly raised and flushed, and there was deep fluctuation, with dulness on percussion. A diagnosis of circumscribed peritonitis was arrived at, and operation determined upon; the state of the patient was very critical, the vomiting violent. An incision about two inches in length was made along the linea semilunaris, and about two pints of fœtid pus evacuated. The intestine was found to be much distended, but no cause of obstruction was discovered. The abdomen was thoroughly washed out with a solution of carbolic acid, of the strength of one part in 60, a drainage-tube introduced, and the upper and lower ends of the wound closed by deep sutures; carbolic dressings were applied as dressings for the wound. For two hours the patient was cold and collapsed, and he vomited much, probably from the ether; then he began to revive, and the vomited matter had no feculent odour, but was merely the contents of his stomach. Morphia was given, and he was fed by the bowel for several days; the sickness ceased entirely in twelve hours, and it became possible to take food by the mouth. The temperature was slightly raised, but did not reach 101; the discharge from the incision was profuse, and at first very offensive, but after a week it lost its odour, and recovery was steady, with one trifling intermission, when the discharge increased. The peritoneum, in the later stages, was washed out with a solution of