

better than I. One while I have comforted myself with the thought that the late Dr. Symonds did not think the subject of Headache too trivial for your thoughts; but again I reflected how much the more must be the talent of the speaker the less striking his subject, and how great the interval between him and me. That I have said nothing new to you I am painfully aware; and that my words may not have fallen below the authority of this chair is my single hope.

CASES OF FACIAL ERYSIPELAS WITH LOW TEMPERATURE.¹

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THERE is probably no disease which presents so great a variety as erysipelas, in the extent, severity, and character of the inflammation of the skin, which forms its essential symptom; and accordingly an extensive nomenclature has been devised in which some attempt has been made by authors to define the different forms of the disease. Thus we meet with the terms erysipelas erythematosum, and e. phlegmonosum, distinguishing the depth of tissue affected; e. glabrum, diffusum, and marginatum, according to the character of the surface and edge of the inflamed part; the presence of vesicles, bullae, pustules, and crusts, is denoted by the terms e. vesiculosum, bullosum, pustulosum, etc.; while the name e. gangrenosum points to what is fortunately a rare termination. Again, if the affection remain limited to the parts first attacked, it is called e. fixum; while if it extend to fresh tissue, the term e. migrans marks this character; lastly, the names e. multiplex and erraticum signify the simultaneous or successive implication of distant parts of the skin.

It may be doubted whether much is gained by the employment of so many names to designate varieties of what is essentially the same disease; no light is thereby thrown on the nature of the erysipelatous process, and variability, although very striking in erysipelas, is at least equally so in many other diseases; but it may perhaps be admitted that the particular character of the affection is emphasised by the adoption of these diverse appellations, and that an important clinical fact is thereby stamped more firmly on the memory.

Be this, however, as it may, it is not only in aspect and extent of cutaneous inflammation that erysipelas varies widely, but also in the severity and character of the fever which accompanies such inflammation. Cases may be preceded by a rigor or rigors, and the temperature may rise to 104° or more in the first twenty-four hours, or it may reach this point gradually, in the course of two or three days; it may be maintained at a high pitch, with very slight remissions, or the remissions may be as marked as in enteric fever; and there may even be cases of an intermittent type, a morning temperature of normal height being followed by an evening rise to 104° or more, for several days in succession. It may be said that, as a general rule, the fever is directly proportional to the skin-affection, any extension of the process being accompanied by a rise, while quiescence, or temporary diminution of the inflammation, is expressed by a more or less marked fall. Defervescence usually takes place by crisis, a fall to normal or subnormal occurring as suddenly as the rise; or, more rarely, there is a gradual subsidence, extending over several days.

But, although the above-mentioned varieties may be said to include the majority of cases, instances of still greater divergence may be not unfrequently met with. Thus, there may be no initial rigor; the fever may precede the skin-affection by one or two days, or it may follow the inflammation; the remissions or intermissions may last several days; there may be high fever with comparatively slight inflammation; and lastly, the fever may be very slight throughout, and there may be an extension of the inflammatory process in the skin during defervescence, even when a normal temperature has already been reached.

I have had recently a few cases of the latter mild type under my care in St. George's Hospital, which seem to me not without interest in some particulars, and I have therefore thought that a condensed account of them might be worth a little attention.

CASE I.—A man, aged 65, admitted on September 28th, 1883, had had two previous attacks of erysipelas; the first, and severest, five years ago; the second, two years ago. In the afternoon of the day before admission, while feeling quite well, he noticed that the bridge of the nose was slightly swollen and red. The same evening, the swelling extended to the left cheek, and during the night to the right cheek, with slight burning pain; no rigor. On admission (second day), there was

circumscribed swelling and redness over the bridge of the nose, and on both cheeks below the eyes; the affected parts were tense, tender, and slightly painful; evening temperature, 100°. The temperatures were September 29th, morning, 99°; evening, 101°; September 30th, morning, 99°; evening, 100°. October 1st, morning, normal; evening, 100.2°. October 2nd, morning, normal; evening, 99.5°. October 3rd, morning, normal; evening, 99.5°. October 4th, morning, normal; evening, 99°. October 5th (ninth day), morning and evening, normal, and continued so. There was no extension, and the swelling and redness steadily subsided.

CASE II.—A man, aged 39, admitted on September 29th; no previous attack of erysipelas. On the day before admission he felt quite well until the evening, when there was some heat and tingling of the left cheek; on the following morning swelling and redness had appeared, and extended to the nose; no rigor. On admission (2nd day), circumscribed redness and swelling of left side of nose, and neighbouring left cheek, on which are two bullae near the nose; no pain evening temperature, 99°. September 30th, temperatures: morning, normal; evening 99.2°. October 1st (4th day), morning and evening, normal, and continued so. No extension, but slow subsidence, with much branny desquamation.

CASE III.—A woman, aged 32, admitted on October 1st. About six previous attacks of erysipelas during the last seven years; the last nine months before the present one. On the day before admission she had slight shivering and headache, with smarting and tingling of the face, which began to swell; the swelling had increased and extended next day. On admission (2nd day), circumscribed redness and swelling of both cheeks and bridge of nose, most marked on left side, where it extends to the margin of lower jaw; a good deal of aching pain. Temperatures, morning and evening, normal. October 2nd, morning, subnormal; evening, 99°. No change in face. October 3rd (fourth day), morning and evening subnormal, and continued so. On this day, however, the redness and swelling extended over the upper and inner two thirds of the left concha, where it lasted three days before subsidence, the temperature never rising above 98°. All swelling and redness afterwards steadily diminished, with branny desquamation.

CASE IV.—A girl, aged 12, admitted on October 11th. Three previous attacks of erysipelas. Two days before admission she had a fit of shivering, and the face and nose swelled. On admission (third day), swelling and pale redness of nose and neighbouring cheeks margin not very sharply marked; very slight sensation of pain and heat. Temperature, morning, 29°; evening, 99.6°. October 12th, morning, 99.7°; evening, 99°. October 13th, morning, normal evening, 99°. October 14th, morning, normal; evening, 99.5°. October 15th, morning, normal; evening, 99.7°. October 16th (eighth day), morning and evening, normal, and continued so. Steady subsidence throughout; very slight branny desquamation.

CASE V.—A woman, aged 35, admitted on November 22nd. A month ago, having had no previous attack of erysipelas, the right ear became swollen, red, and painful; this subsided in a few days. Eight days ago swelling and redness of right eyelids, increasing so as to close eye; this subsided completely in four days, when she had a rigor, followed by redness and swelling of left side of nose and cheek, with much pain.

On admission (fifth day of relapse), slight branny desquamation of right eyelids and cheek; bright redness and swelling of left side of nose, both left eyelids, and cheek, sharply circumscribed downwards and inwards, more diffused over outer side of cheek. Temperatures evening, normal. November 23rd, morning and evening, normal. November 24th, morning, 99.5°; evening, 100.2°. Headache; fresh patch of redness and swelling at back of left ear; bulla on cheek. November 25th (eighth day), morning and evening temperatures were normal, and on following day subnormal, and continued so. But, on November 26th, there was an extension of redness and swelling to left side of forehead and temple. From this time steady subsidence, with desquamation.

Such are the cases which I have observed, and probably many will think that there is not much to be said about them; they are simply mild or abortive attacks of erysipelas, and there is an end of the matter. If this view be held, it still seems to me not without interest that in one of them (Case v) a rigor, and in two others (Cases III and IV) slighter fits of shivering, preceded so mild an attack; further, that two (Cases II and V) were first attacks, which are usually severe; and, lastly, that in two (Cases III and V) an extension took place while the temperature was subnormal.

But another view of these cases may be taken. It may be doubted whether they are to be considered examples of true erysipelas, and some may prefer to rank them as instances of spurious erysipelas, or-

¹ Read before the Medical Society of London.

Br Med J: first published as 10.1136/bmj.1.1243.599 on 29 March 1884. Downloaded from http://www.bmj.com/ on 13 April 2024 by guest. Protected by copyright.

erythema, or non-specialised dermatitis. As the contagiousness of true erysipelas has been placed beyond question by the experiments of Koch, Tillmanns ("Erysipelas," *Deutsche Chirurgie*, p. 9), and especially Fehleisen (*Deutsche Med. Wochenschrift*, 1882, p. 553), as well as by many clinical facts, an accurate diagnosis is obviously of importance. It has been shown that the virus of erysipelas may be collected, cultivated by appropriate methods, and transmitted to animals and to man by inoculation, the resulting disease being often of great severity. The question then arises, can the virus, when inoculated, give rise to a mild affection similar to that under consideration? The experiments of Tillmanns (*loc. cit.*, pp. 14, 18) seem to show that it can. Out of twenty-five inoculations on dogs and rabbits, five were followed by marked erysipelas with high fever; in two there was erysipelatous redness and swelling, but only a slight rise of temperature, while in several others (the number is not stated) the inoculation was followed by spreading redness and swelling, which resembled erysipelas in every particular, but ran their course without fever. Now Tillmanns considers that as these cases were apyretic they were not genuine erysipelas, but I must admit that I fail to see the force of his reasoning. The selection of high fever as the pathognomonic sign of the true disease seems to me altogether arbitrary, and, even if it be accepted, impossible to apply with accuracy. It is surely true that the cases with the highest fever and those with the lowest, or even with none, are connected by transitional forms which establish an insensible gradation between the two extremes, and I am quite unable to see where the line should be drawn, on one side of which we are to place all the genuine cases, and, on the other, all the spurious ones.

If, then, we admit that true erysipelas may occasionally run a mild course, practically without fever, and if we also recognise the fact that some forms of erythema, and even urticaria (*e.g.*, the "acute circumscribed cutaneous oedema" of Quincke), may have a close resemblance to erysipelas, we have to inquire by what means we may distinguish between these affections. I think there is one character of importance which is present in erysipelas and not in the others, and that is rapid spreading at the margins. Mr. Jonathan Hutchinson, in an able paper on Certain Diseases allied to Erysipelas (*Medical Times and Gazette*, January 1883), insists strongly on this point. After pointing out that erysipelas may be often wanting in vesication, in abrupt margin, and even in hyperemia, he defines as erysipelatous any inflammation which *travels* and is attended by oedema. But, even if we pay attention to this valuable sign, I think we shall still meet with instances in which diagnosis must remain uncertain. Tillmanns, referring to such cases (*loc. cit.*, p. 196), says that it must remain a question how far they are true erysipelas; and, further, that a correct diagnosis has no practical importance; but I do not think it would be wise to accept this view without reserve. Erysipelas is unquestionably contagious; and, although this may not be equally true of all cases, the severe ones being probably far more dangerous in this respect than mild examples, we cannot do wrong in taking all necessary measures to avoid communication of the disease to others. The severe cases shade off into the mild and doubtful ones by such gentle transitions, that it is certainly not always an easy matter to decide as to the rank which should be occupied by any particular case under notice. The difficulty is, perhaps, best solved by Mr. Hutchinson, who concludes that there is a family of erysipelatous affections, rather than a single disease erysipelas—some closely, others remotely, connected with the typical complaint. He holds that, in all, a virus is probably produced, which enables the disease to spread by contagion; and, whenever transmission to another person occurs, the disease, he believes, is intensified.

If these views are correct (and we shall at least be on the safe side if we adopt them), it is plain that there may be a danger of infection from any case, however mild; and caution will be always desirable. This possible danger of infection should, I think, be specially guarded against by those who are engaged in the practice of midwifery, and in the performance of vaccination and other trivial operations. The close relation of erysipelas to a grave form of puerperal fever is well established, and the slightest wound may become the starting-point of erysipelatous inflammation; indeed, it is nearly certain that some breach of surface, however trifling, is a necessary antecedent of all erysipelas. Under these circumstances, I have no doubt whatever that he will be the best practitioner who takes the minutest precautions against the possible conveyance of infection, however remote and improbable such a contingency may appear.

THE Duke of Devonshire has been elected President of the Chesterfield and North Derbyshire Hospital for the ensuing year.

AMONG the candidates for the *externat* of the Paris hospitals, M. Mathieu, a negress, has competed with success.

ON THE YELLOW PIGMENTS FOUND IN THE VISCERA IN CASES OF ARSENICAL POISONING.

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IN an interesting communication on the above subject (*BRITISH MEDICAL JOURNAL*, 1884, vol. i, page 506), Dr. Campbell Brown and Mr. Davies record their examination of a bright yellow pigment, met with in three bodies exhumed after death from arsenical poisoning; and conclude that the pigment resembled one of the products of decomposition of bile-pigment. They, moreover, state that "no proof has ever been adduced, so far as we are aware, that the yellow substance" observed in such cases "is really sulphide of arsenic."

This novel and valuable observation accords with what is known of the occasional yellow discharges from the bowels, during the course of cases of arsenical poisoning, referred to in Dr. A. S. Taylor's *Principles and Practice of Medical Jurisprudence* (third edition, edited by myself, vol. i, page 257), where it is stated that "the matters discharged from the stomach and bowels have had in some instances a yellowish colour, as it was supposed, from a partial conversion of the poison into sulphide, but more probably from an admixture of bile."

The authors of the paper in question go too far, however, when they assert that no proof has been adduced that the yellow substance, met with in exhumed bodies, is sulphide of arsenic. Christison (*Poisons*), in speaking of the solid particles of arsenic found in the stomach, speaks of the brilliant yellowness of the surface of these particles, and adduces four cases of this character which came under his own notice; and adds that, in all these, he found the oxide as well as the sulphuret of arsenic. In one of these cases, besides the oxide and sulphide, he found sulphuretted hydrogen gas in the stomach. In the case of Margaret Warden, yellow arsenical solid particles floated in the stomach fluid. In the case of Regina v. Jennings (Berkshire Lent Assizes, 1845), Dr. Taylor describes how, in a case of exhumation, he obtained abundant evidence of the arsenical nature of the yellow substance, by means of general reactions, which are given in detail. (*Guy's Hospital Reports*, 1845, page 187.) In another case, Regina v. Garner and Garner, tried at Lincoln in 1863, Dr. Taylor found, in a case of exhumation, arsenic "partly in a soluble and partly in an insoluble form—that is, as orpiment, or yellow arsenic," the quantity of which he put as six or eight grains. (*Pharmaceutical Journal*, 1862-3, page 377.) I well remember seeing these yellow powdery masses of yellow arsenic in one of Dr. Taylor's cases.

To these, I may add an observation of my own on the body of Elizabeth Kittle, exhumed in 1872, six months after burial (Regina v. Kittle, Chelmsford Summer and Autumn Assizes, 1872), where there was extensive yellow staining of the stomach, orange-coloured staining of the duodenum, and also a considerable amount of solid yellow matter in the stomach, gritty to the touch. The yellow portion of this was insoluble in water, and could be seen coating the surface of pigments of white arsenic. The yellow matter was conclusively proved by chemical tests to be sulphide of arsenic.

I think there can be no doubt that gritty yellow sulphide of arsenic is not very rarely formed from arsenious oxide in the viscera after death; but this must not be confounded with the yellow substance described by Dr. Brown and Mr. Davies.

EPIDEMIC OF FOLLICULAR TONSILLITIS DUE TO DEFECTIVE SANITARY ARRANGEMENTS.¹

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THE following are a few notes on an epidemic of sore-throats which occurred at the Cheltenham Training College (male department) during May and June 1882.

The first man attacked complained of a sore-throat, and stated that the previous day he had a shivering fit and a splitting headache, and, on awaking the following morning, found he had a sore-throat. He had never before suffered from any such affection. The following notes I took of his condition, progress, and treatment, and they are typical of most of the other cases which followed.

He complained of a severe throbbing headache, sore-throat, great thirst, and inability to sleep. The temperature on the second day was 103° Fahr., with a pulse of 130 per minute. The whole of the pharynx, tonsils, soft palate, and uvula were intensely congested. On the tonsils were three white looking ulcers, as large as threepenny-pieces, of an irregular shape, covered with a white membranous material, which

¹ Read before the Gloucestershire Branch.