

from below the double vagina to a small anal orifice. A complete septum appeared to exist between the vaginal canals, and another between them and the rectum. The four inferior extremities were normal.

The placenta, which was readily extracted, was large and single. From the centre of the mass sprang an umbilical cord, which about two inches from the origin divided into two branches, one passing to each umbilicus. The other cord was inserted on the lateral edge. In the membranes there was one large compartment in which the double foetus was contained, and a second smaller which held the last born foetus. The double foetus weighed 6 lbs. 13 ozs., the single 4 lbs.

In the after progress of the case it soon became evident that the malformed children were not likely to survive. Their cry became more feeble, and, though carefully tended and fed, they vomited their food and atrophied. Meconium continued to pass, though I could not ascertain that any urine was discharged. They died at 8 P.M. on Saturday, September 24th.

It is worthy of note that the mother's parents were first cousins; one of the mother's sisters is the inmate of an asylum on account of congenital idiocy; another sister is of weak intellect. The mother herself is of a nervous temperament, and in her first pregnancy suffered from puerperal convulsions. She herself alleges that she sustained a shock in early pregnancy by seeing a collision between two carts. She was unusually large during the latter period of gestation, and for three weeks before labour set in suffered much grinding pain and bearing down.

The double foetus and the placenta are in the hands of the Curator of the College of Surgeons for preparation and addition to the Museum. The College Museum possesses a wooden model of a similar malformation, but no actual specimen. The third child was born alive, and still survives.

## THERAPEUTIC MEMORANDA.

### DIPHTHERIA.

RECENTLY published memoranda suggest the following notes. Gargling in diphtheria, as in all acutely inflamed conditions of the throat, is surely to be avoided if possible. Physiological rest for inflamed parts is usually regarded as a cardinal point in therapeutics; the art of gargling involves violent exertion of the muscular apparatus of the fauces and palate; the routine prescription of a gargle frequently causes patients great suffering, and may, I believe, do absolute harm. There are few if any cases in which all the benefits of topical application are not obtainable by either painting, inhaling, or spray.

There is nothing new or original in my ordinary treatment of diphtheria; but as it has been very successful, I may be excused for describing it. Upon first seeing a case I order salicylic acid, ten to twenty grains, suspended by means of mucilage in half an ounce or an ounce of water, to be taken every two to four hours; if there is much pain, I combine five to ten minims of succus belladonnae with each dose. In severe cases I give also a mixture of perchloride of iron and quinine, usually one dose after every two of salicylic acid. The acid has answered better than salicylate of soda, especially because, being suspended in mucilage, it adheres to the inflamed surface as it is swallowed, and in mild cases serves all the requirements of a topical application; there is often a little vomiting after the first dose or two, but that soon passes off.

In all cases, except the mildest, one of the following applications has always served me well, namely: 1. Inhalation of eucalyptus oil, ten drops to half a pint of hot water, inhaled for five minutes every hour or two. 2. Spray of sulphurous acid, diluted with about twice its bulk of water; the acid should be freshly prepared, as evidenced by its pungency. 3. Spray of chlorinated soda solution; one part of the B.P. solution, with three or four of water.

Whichever spray is used should be applied most assiduously, as often as every hour at first, and it is essential that its administration should be supervised by a thoroughly skilled person; in cases where the upper part of the fauces or the nares are involved the spray should be separately applied to both throat and nostrils.

With young or intractable children, inhaling may be managed by means of a bronchitis kettle, and spraying by a large spray-producer—a steam spray answers best—placed at a sufficient distance to ensure its saturating the child's immediate atmosphere.

The remarkable restorative properties of Warburg's tincture were well shown in one case of severe nasal diphtheria, in a child about 4 years old; the acute inflammatory condition had subsided, there was not much membrane left, the temperature had dropped, the heart's power was decidedly flagging; in fact, the child appeared to be dying from

blood-poisoning and exhaustion. He was given ten drops of Warburg's tincture every two hours; he soon began to mend, and, after about six doses, rallied so much as to be pronounced practically out of danger.

Finally, I think that diphtheria, perhaps more than any other acute disease, calls for free alcoholic stimulation, and the most nutritious possible diet from the very first.

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## TOXICOLOGICAL MEMORANDA.

### POISONOUS FUNGI.

ON August 16th, about 10 A.M., three of my Chinese servants partook of a dish of supposed mushrooms. A. and B. ate them with rice, but C., not feeling hungry, ate only the fungi, and also drank the water in which they were cooked. In about half an hour the three were seized with violent vomiting, purging, and pain in stomach. A mustard emetic was administered. In about an hour's time I saw them and found them all greatly depressed, complaining of giddiness, pain in the stomach, violent vomiting and purging, skin covered with a profuse cold perspiration, pupils contracted, markedly so in C.'s case. Brandy and stimulants were given, and hot bottles were applied to the feet and stomach. A. and B. rallied quickly, and were soon out of danger; but C. continued in a collapsed state, pulse very weak, violent vomiting and purging, profuse salivation, and cold perspiration, feet and hands were cold, and the pupils pin-point; he complained of blindness. A hypodermic injection of ether and a mustard blister were followed by slight rallying. Medication by the mouth failed, owing to the violent sickness. Sp. chlorof. and other sedatives were all rejected. The vomiting continued till the afternoon, when champagne was given and retained. A hypodermic injection of atropine was also given (B.P. solution,  $\pi$ ijj), but as the hypodermic syringe gave way at the mounting, it was rendered useless after the first injection. Towards the evening there was slight improvement, but the pupils still remained contracted, and difficulty of swallowing and dryness of throat were complained of. Pulse slow, 60, and firmer. In the morning he rallied considerably, purging had ceased, and sickness was only occasional. The champagne had been continued in tablespoonful doses all night. Swallowing was improved, and during the day he took egg, brandy and milk, milk and soda, and rice water. This improvement continued till the afternoon, when difficulty of breathing, weakness of pulse, cold perspirations, and vomiting returned. An enema of brandy and beef-tea was given, but rejected. Champagne was rejected, and he gradually sank, death resulting from asthenia about 8 P.M. The pupils remained contracted to the very last; the urine also was completely suppressed. Liq. atrop. was given by the mouth during the day, and once or twice when marked collapse manifested itself occasional enemata of brandy and beef-tea were administered with temporary improvement.

On examining the fungi they resembled small mushrooms, with black and white mottling on the upper surface. The gills were not pink-tinted. They had no unpleasant smell, and were found in the jungle close by under a large tree. When cooked they were said to have had a sweetish taste.

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### UNUSUAL CAUSE OF STAINING OF THE SKIN BY NITRATE OF SILVER.

SOME time ago an old woman came under my care at the throat department of the Bristol General Hospital for chronic granular pharyngitis. I noticed that her skin was most characteristically stained by silver. On questioning her, she told me that, whilst she did not remark any discoloration of the skin of her face until her friends had repeatedly called her attention to it, as it got darker she became aware of it, and had watched the colour deepening. She remembered that, some time before the skin became affected, she had had a bad throat, was under the care of a medical man for some time, and had had some "burning stuff" frequently applied. This "burning stuff" was, no doubt, nitrate of silver in solution.

I asked her if she had had stomach troubles, epileptic fits, or other diseases in which the drug might have been used; but she did not appear to have suffered from anything of the sort, and I believe that the swabbing of the throat with a solution of the silver salt, as is done by some practitioners in many throat affections, caused her to absorb a sufficient quantity to tinge the skin.

I do not know of any observation similar to my own, and it appears to me that, whilst she may have swallowed some of the drug and

have taken it into her system in that way, on the other hand it is probably one more fact which bears out the modern theory that the tonsils have a good deal to do as absorbent glands; and it is, I think, of interest on that account. Also, no one can fail to see the importance of remembering that the free use of strong solutions of lunar caustics may, although very rarely, cause the lamentable result of producing a permanent discoloration of the face.

Clifton.

BARCLAY J. BARON, M.B., C.M.E.D.

### CLINICAL MEMORANDA.

#### ENTERIC FEVER AS SEEN IN INDIA.

IN 1882 I described in the JOURNAL a fever possessing certain characteristics of its own, akin to malarial and also to enteric fever. This is the fever which Dr. Macartney calls "foreign enteric fever," a name which I submit makes confusion worse confounded. It is this difference of opinion over a name which causes returns to be useless and unreliable. Far be it from my intention to suggest that Dr. Macartney is in error, but the same fever which he would return under the heading of enteric fever merits, in my opinion, a separate classification, if not a distinct name. I consider the term enteric fever implies the presence of certain recognised symptoms and lesions, and that in the absence of them it is misleading to call the disease by that name. I admit, first, the indisputable existence of specific enteric fever; secondly, the existence of specific fever associated with malaria. I am inclined to believe in the *de novo* origin of enteric fever, though I admit the data in my possession have not as yet satisfactorily established the fact. I entirely disbelieve in the miasmatic origin, though the typical symptoms and course of home specific enteric fever may be masked by a malarial complication. I believe, however, a careful observer will be able to peer through or else draw aside the veil, and form a correct and accurate diagnosis.

The differences between this fever and home specific enteric fever are:

1. The disease is sporadic.
2. It has originated when the drinking water was analytically pure, the drainage engineeringly perfect, and the surrounding sanitation vouched for by the sanitary and medical authorities as being good.
3. The absence of lenticular spots.
4. The existence of constipation throughout the disease. When looseness of the bowels is present, it is caused by the irritation set up by the presence of the accumulation.
5. The absence of enlargement of the spleen, unless that organ is specially affected.
6. The abdominal lesions are more diffused and scattered, involving ileum, jejunum, duodenum, and stomach. Ulceration is also sometimes found in the colon.
7. The abdominal organs may be quite free from disease.

The theory which is advanced that the *materies morbi* of enteric fever exists in India in many gradations of intensity agrees with the views I have already expressed with reference not only to enteric fever, but also to cholera, dysentery, and all those diseases the development of which is dependent on a specific virus. I am of opinion this disease is due to a chill caused by a sudden atmospheric change of temperature acting on an overheated system.

Dover.

G. SHERMAN BIGG, M.R.C.S., Surgeon M.S.

A DAKOTA PRACTITIONER.—The *New York Medical Record* is responsible for the following: The Board of Health of Dakota publishes the results of an examination of an applicant for a licence to practise medicine. He had been practising medicine for years in a populous district of South Dakota. Here are some questions and answers: What medical journal do you take, Doctor? Well, they have all run out.—Don't you intend to take any of them again? Well, I can get along without them.—What books have you in your library? *Gunn's Family Physician and Common-sense Home Doctor*.—What is an element? Oh, anything.—Is that bed an element? Yes.—Name the three great cavities of the body. The head, the belly, and the diaphragm.—Mention the contents of the cranium. The brain and three skins.—Name contents of abdominal cavity. Kidneys and the prostate gland.—Does the prostate gland ever become enlarged? Yes.—Have you treated any cases of enlarged prostate? Lots of them.—With what success? Tip-top! never lost a case.—Did you ever treat any female for enlarged prostate? Oh, yes; numbers of them.

DR. HARRIS, the Medical Officer for Sunderland, says that his figures go to show that 75 per cent. of the children who died from diarrhoea were fed on the bottle.

## REPORTS

OF

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

#### ST. MARY'S HOSPITAL.

CLINICAL NOTES OF VARIOUS CASES.<sup>1</sup>

(Under the care of Mr. PAGE.)

CASE IV. *Fæcal Umbilical Fistula, following Pelvic Cellulitis*.—The following case was an example of one of the more unusual endings of pelvic cellulitis and suppuration. Admitted as a case of fæcal fistula, the diagnosis was at first obscure, and was only rendered certain after examination under an anæsthetic. There had been no trouble at any previous time in connection with the umbilicus, and we were, therefore, definitely able to exclude the existence of a patent intestinal diverticulum, which, if it occurs at all, probably shows fæcal leakage quite early in life, and it became necessary to search for some acute condition as the real cause of the opening into the bowel. And this was forthcoming in a history of "much pain and a sense of heaviness across the abdomen" after her first confinement three months before, with much feverishness and increasing weakness, and with the formation, after seven weeks, of a lump at the navel, which soon broke, and gave exit to offensive discharge. An examination, moreover, by Dr. Montagu Handfield-Jones revealed thickening in the anterior *cul-de-sac*, giving the impression that the inflammatory effusion had been once much larger in amount, and was now undergoing absorption. A delicate girl, aged 19, with high temperature, 104° F., hectic flush, very rapid pulse, and constant cough, with profuse muco-purulent expectoration, looking like a person soon to die of phthisis, was admitted to hospital in December, with distinctly fæcal discharge from a small orifice at the umbilicus. Pus in considerable quantity was also being passed with her motions. Under anæsthetic, a probe, and then the fingers, went into a large cavity, running in the direction of the left side of the pelvis, and, the orifice having been enlarged, exit was given to three or four pints of highly offensive pus. Drainage being impossible under these conditions, a counter opening was made above Poupart's ligament, a large tube was passed through, and by this means it was easy to keep the cavity drained and sweet. The condition of the patient instantly improved, and she rapidly assumed the aspect of returning health. As a matter of fact the discharge ceased to be fæcal in less than three weeks, the cavity gradually contracted, and the only trouble in the after treatment—which, indeed, kept her in the hospital till April 1st—was in getting the cavity perfectly empty. There was some tendency to collection of semi-purulent fluid if the drainage tube was removed, and early in March the expedient was adopted of making her lie upon her face, which very soon had the desired effect, and for fifteen days before her discharge the tube had been out, and there was no sign of further collection of matter. The opening into the bowel had probably been very small, and was early occluded, as the peritoneum was restored to its natural contact with the abdominal wall.

CASE V. *Abdominal Fæcal Abscess, probably the result of Perityphlytis from Injury*.—Singularly like the preceding case was that of a woman in hospital at the same time, but in whom it seems probable that the original cause of the abscess was an inflammation started by injury in the neighbourhood of the cæcum. A Pole, aged 24, was admitted on January 3rd, extremely ill and emaciated, with a temperature of 104° F., and pulse of 156. Just about the posterior superior spine of the right ilium was a fluctuant swelling, which seemed to be on the point of bursting, and from which, by aspiration, Mr. Lloyd drew off eight ounces of dark, most offensive purulent fluid. This relieved her but slightly, and, two days afterwards, the abscess was laid freely open, when the finger could be passed into a large cavity in the region of the cæcum, but not, as far as could be made out, extending into the pelvis. The pus evacuated was distinctly fæcal, and pus was also being passed *per rectum*. The cavity was thoroughly washed out, and large drainage tubes inserted. The general condition soon improved, though, as in the last case, considerable trouble was experienced in getting the cavity perfectly drained, more especially as it was impossible to make a counter opening. However, when she left the hospital on May 16th, the wound and cavity had been closed for some time, and in herself she was perfectly well. The history of her case indubitably pointed to injury as the cause of the original mis-

<sup>1</sup> Continued from p. 879, vol. i, 1887.