SCARLATINA KNOWN IN INDIA.

By A. F. Bradshaw,

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In the issue of the *Indian Medical Gazette*, dated June 1st of the present year, appeared a leading article headed "Scarlatina unknown in India," the writer of which sets forth,—*firstly*, that scarlatina has not yet been met with in India; *secondly*, he impugns the accuracy of Dr. Maunsell's diagnosis of a case which was published in the *Indian Medical Gazette* for December 1st, 1870, under the name of scarlatina in the hills; and *thirdly*, he calls upon any one in possession of positive evidence of the existence of the disease in India, to submit it to the profession. He also quotes from the *Lancet* a paragraph referring to a family in Simla in which scarlatina was said to have lately spread.

The family in question was under my care, and I am satisfied that the disease was what I named it; and believing myself able to show that, excluding my own cases, scarlatina is known in India, I proceed to do so somewhat at length.

I have not access at present to the professional writings of former generations of Indian physicians, but I am inclined to think that our predecessors were not quite free from doubt as to the occasional occurrence of scarlatina. Dr. Gregory mentions a cautious remark by Dr. Jackson that he could not recollect any cases *deserving* the name of scarlatina in India. Dr. Murchison, who was formerly on the medical staff of the Bengal Army, states:—"In India, according to the testimony of Morehead and other writers, true scarlet fever is never met with, but epidemics of a closely allied, *if not indentical* affection, dengue *alias* scarlatina rheumatica, are observed from time to time." Dengue is defined to be scarlatina *plus* rheumatic fever, and Aitken reports of the last epidemic of it in Calcutta "that decided implication of the mucous membrane of the mouth and throat prevailed, with an *almost entire absence* of the articular pains," *ergo*, scarlatina *minus* rheumatic fever?

On referring to the series of annual blue books issued by the Army Medical Department, I find that scarlatina is by no means an unknown disease in India, at any rate to the medical officers who have held European charges.

The following table gives the number of cases that have been observed during the last decade among the English troops, and shows that it is incorrect to say that the disease has not been seen in this country—in the Bengal Presidency at least:—

Cases of scarlatina in		Bengal.		Madras.		Bombay.	
		Admitted.	Died.	Admitted.	Died.	Admitted.	Died.
Year	1860 ...	5	1	...	...	...	...
"	1861 ...	2	2	1	...	...	...
"	1863 ...	1	...	...	...	...	...
"	1865 ...	2	...	...	...	...	...
"	1868 ...	2	...	...	...	2	1
"							

It may be objected by those who have hitherto taken for a fact the rumour of scarlatina not having yet appeared in India, that the above table proves nothing, because the reports of the cases are not forthcoming for examination; but I cannot doubt the diagnoses, since the medical officers who treated the patients must have been familiar with the exanthem, having all of them been trained at home, where examples of it not unfrequently occur in every one's practice.

But, as it is only necessary for the purpose of the present paper to prove that one instance of scarlatina has been met with India, I will take a case related by Dr. Garden, of Saharunpore, in the *Indian Medical Gazette* for July 1st, 1870, under the name of erythema scarlatiniforme. He treated the complaint in 1869, and he mentioned his having seen "another exactly similar to it in all respects" in 1865, both patients having been children.

The symptoms observed were, in brief:—fever of five days' duration, eruption "itching, diffused, and not in defined patches, bright red and punctiform" which spread over face, body and extremities, and ended in general desquamation, leaving the skin temporarily rough and dry; tongue furred, white and with prominent red papillæ; considerable sore throat, tonsils swollen, the whole of the back of the mouth reddened with a dotted efflorescence, and lastly, enlarged and tender glands at the angles of the jaws.

Dr. Garden details and summarises his case with care, establishing quite clearly its character, and asks "in an epidemic of scarlatina, would not this case be accepted as a fairly typical case of the mild form?" The reply is—certainly, because it was undoubtedly a genuine example of scarlatina, and one not to be mistaken for erythema, roseola, measles, dengue, rötheln, rubella, or anything else, as any table of differential diagnosis will prove.

In turn I inquire, why did Dr. Garden hesitate to call his case by the name that evidently seemed to him to be the proper one, *viz.*, scarlatina? Why did he not call his spade a spade, and what induced him to give to an ailment that he describes as having "all the characters of an eruptive febrile disease," and "more allied to scarlatina than to any other," the designation of *erythema scarlatiniforme* which has been already appropriated by nosologists to indicate an affection "which presents all the characters as regards the rash of scarlatina; but lacks its general throat symptons and the peculiar appearance of the tongue." (Tilbury Fox)?

The explanation apparently is that Dr. Garden permitted his judgment to be hampered by the theory that scarlatina is unknown in India, and that his diagnosis would be insufficiently supported in the absence of proof of traceable causative or resultant contagion. I trust, however, that he will be inclined to adopt the amendment that I propose as to the name of his case; and that with regard to the theories, he will come to consider the first as disproved, and the second as imperfect.

But it is not necessary to insist upon Dr. Garden's case being received as a true one of scarlatina. Dr. Maunsell's is, in my opinion, quite decisive, and upon it I will now make a few remarks.

The following symptoms are recorded:—quick pulse, frontal headache and general malaise; "throat very much inflamed, tonsils enlarged and of a bright red colour, soft palate and uvula also of a bright red colour and œdematous;" "rash well out over the trunk and extremities," and consisting "of small dots of of a bright scarlet colour, confluent by their margins, no skin of normal appearance between them, not elevated to the touch, completely disappearing under pressure, and rapidly re-appearing when the pressure is removed," the tongue furred, white and with bright red tip and edges. The rash lasted five days, desquamation followed, it was very marked on the hands, and the skin of the trunk generally was left very rough and dry.

To this assemblage of morbid phenomena, Dr. Maunsell with decision gives the obviously appropriate name of scarlatina, notwithstanding the denial by some medical men of the existence of the disease in India, and his own inability to trace contagion. I note, however, his mention of the fact that some servants in the adjacent compound had fever with sore throat.

But the writer of the leading article that I am now replying to, preferring hearsay to immediate evidence, concludes as the result of some inquiries that the case was not a genuine one of the alleged exanthem, although he does not "of course, for an instant question the circumstances related by Dr. Maunsell."

I observe with surprise that the critic does not offer a correction of the diagnosis he disputes, and does not give any good

reason for the incredulity he avows. He remarks—"supposing this were a genuine instance of the disease, medical men in this country must have over-looked its existence during the last century, an idea contrary to reason." I do not admit this inference. It does not follow that they have not had cases of scarlatina, because our writer has not seen them in print, and he cannot prove either that cases have not been recorded, or that any have not been noticed in practice. He goes on to say—"or else this case of scarlatina was an instance of the disease, springing up *de novo* in Simla," an alternative he dismisses as absolutely incredible. Does he believe then in Pandora's box? Or if he is not prepared to prove "that certain conditions or combinations of circumstances happened in remote ages, which are never repeated now," can he not adopt the compromise that there may have been some unsuspected or untraceable contagion? Why does he not see sense and probability in the *Lancet's* remarks? "It is very possible that the disease has been imported into India; the freer intercourse of late between that country and England, may have rendered this an easier matter than hitherto."

But, where is his difficulty in Dr. Maunsell's case? Was the disease an example of measles? But epiphora, coryza and flea-bitten red patchy rash were wanting. Was it the hybrid rötheln? But catarrh and separate aggregations of crimson red stigmata were not present. Was it roseola? But that is "characterised either by transient patches of redness, of small size and irregular form, distributed over more or less of the surface of the body, or by the formation of numerous small isolated rose-coloured dots" (Tanner.) Could it have been erythema? But that is known by slight red and often bumpy patches, and is seldom preceded or accompanied by febrile symptoms (Meadows.) Could it have been dengue? But there was no rheumatic complication. Finally, was it a new complaint? But the appearances related correspond so closely with the following standard symptoms of scarlatina, that the two diseases *must* be identical:—"A febrile disease of definite course, associated with sore throat and swelling of the maxillary glands, and with a scarlet efflorescence which commences about the second day of the fever, spreads over the pharynx and fauces and over the whole body, and terminates in desquamation after a duration of about five days. The tongue is peculiarly furred, resembling a strawberry, and the skin is harsh and dry" (Flint, Aitken, Tanner, Hooper and others.)

I refer now to my own cases as supplying corroborative proof of the existence in Hindoostan of the exanthem in question, and I proceed to summarise them concisely.

During November 1870 and the three subsequent months, seven members of one family, the mother and six children, came successively under my care, all with symptoms the same in each, but varied in degree.

The first patient was one of the elder girls, and the ingress of the complaint was attended with vomiting and disturbance of the bowels; fever ensued, and then a scarlet rash appeared on the chest and extended over the neck, face, whole body and extremities. At first it consisted of innumerable minute dots, which soon coalesced into a deep red, uniformly diffused efflorescence. The eruption lasted about five days, and ended in general desquamation, rendered less apparent by the inunction of lard employed. The palate, pharynx and tonsils were a little sore and very red, and the latter also were swelled together with the adjacent glands. The tongue was furred white, and its papillæ prominent, producing the usual strawberry appearance.

The baby's turn came next, but although he looked very *peakish*, the objective symptoms were all so slight as not to need further remark.

In the third case, the fever, diffused rash, peculiar tongue, faucial redness, and swelling of the tonsils and maxillary glands were more marked than in any of the others.

The fourth patient had a uniform, vividly red rash, but less throat affection, and less disturbance of the system, than the rest of the children.

The mother now fell ill after three weeks of very close and constant attendance in the sick rooms. She had high fever and much prostration; throat sore, very red, and tonsils much enlarged. The eruption was abortive, transient and patchy.

About a month after the beginning of the last case, the sixth appeared. It was ushered in with gastro-enteric derangement; the rash, throat affection, &c., were typical, and desquamation of scurfy character followed freely.

Six weeks later, the eldest girl came on the list as the seventh and last case of the series. Her most prominent symptom was universally distributed efflorescence; the throat redness being slight, the soreness less, the tonsillar and glandular swelling merely perceptible, the feverishness trifling, but the tongue distinctively furred.

In the first case only was a sequela feared, and the convalescence slow. The remainder recovered rapidly and well.

It is likely enough that the author of the leading article, now being controverted, may be as disinclined to accept my cases, or perhaps any that he has not himself seen, for examples of scarlatina as he is to admit Dr. Maunsell's under that heading. But I am not disposed to allow that there was any error in my diagnosis, which of the children's disease was scarlatina simplex and of the mother's scarlatina latens.

I was well aware, while the cases were under observation, that the existence in India of this particular eruptive fever, is denied by some members of the profession, and accordingly took care to satisfy myself completely of the correctness of my diagnosis, by frequent comparison of the clinical facts with the accepted descriptions of the several complaints, resembling the cases in any respect. I was unable, it must be admitted, to to trace contagion in the first instance of the disease, but that difficulty could not be permitted to disentitle a malady to its proper name. It is not improbable, however, that a clue has been obtained to the origin of the ailment in the family. One of the servants, observing the children's symptoms, informed his mistress that it was common to see the same appearances among the hill-natives; and a communication of similar nature was made to Dr. Maunsell. (I have noted the subject for investigation.)

It must not be supposed that Dr. Maunsell and myself have monopolised all the cases of scarlatina in Simla. I am authorised by Dr. Thorp, Civil Surgeon of the station, to mention that he met last year with two examples of true scarlatina in the Punjab Girls' School. And to these may, perhaps, be added the many cases "*exactly similar* to" Dr. Maunsell's quoted by him in his report, as vouched for by one of the civil surgeons of the time.

There may yet remain unbelievers of the fact that scarlatina *is* known in India, who will require still further evidence on the subject, and to them I offer a model proof, one combining the three essentials, namely, existence, contagion, and importation.

During the first quarter of the present year, scarlatina appeared on board a troopship bringing to India a number of detachments. Of these, one proceeded in March to join the 92nd at Jullundur, and another to reinforce the 58th at Sealkote. In both regiments, scarlatina broke out in about a month afterwards among the children and some of them died; and in the 58th numerous cases of peculiar sore throat were observed at the same time among the men.

It would not, I imagine, be very difficult to trace previous instances of the importation of scarlatina into India. In the statistical abstract No. 29, given in the Army Medical blue book for 1868, I notice an admission into hospital for the disease from among the troops proceeding to this country *viâ* Egypt from England, and elsewhere I see some reason for believing

that sailing vessels may have in former years conveyed a contagion which is so subtle and enduring.

I conclude this paper with a few remarks upon a point which the critic of Himalayan diognoses apparently considers one of his strong ones, namely, that scarlatina has never been seen in Calcutta at all events. In his quotation from the *Lancet* this sentence occurs:—"Some of the Calcutta physicians, moreover, are of opinion that they have lately had cases of scarlatina." He comments thereon thus:—"We think the *Lancet* mistaken * * * especially with reference to scarlatina occurring in Calcutta."

I meet his comment with the assertion that many cases of very typical character *have* been met with in Calcutta, and my authority for the statement is the most experienced physician in the city, the head of the General Hospital, Dr. Brougham, in whose practice the examples occurred. And I do not suppose that he alone has seen cases of the kind in the metropolis.

It appears, therefore, that the critic, while intent upon reviewing the eye-witnessing of *confrères* practising in hills so distant from his own arena, has been unaware of the medical events that have gone on around him, and in consequence has unwarily denied the existence of adverse facts, that he might have ascertained. Truly there must be darkness under the lamp.

Simla, 14th July, 1871.

A MIRROR OF HOSPITAL PRACTICE.

INTRAMURAL FIBROID TUMOUR, PROBABLY OF ELEVEN YEARS' STANDING; REMOVAL BY LACERATION AND ENUCLEATION; RECOVERY.

By Dr. J. Ewart,

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Mrs. G.——, aged 35, East Indian, was admitted into the General Hospital, under my charge, on the 2nd May, 1871. She is the mother of six children. Her youngest child is almost twelve years of age. Ever since the birth of this child she has been a constant sufferer from dysmenorrhœa, and, during the past five or six years, profuse menorrhagia has been frequent. Partly from the pain experienced, during menstuation, but chiefly, however, from repeated large losses of blood, occurring lately as often as twice a month, her general health has become seriously impaired. So that she is now very anæmic, with a feeble heart, and excitable circulation: the nervous, muscular, and digestive systems have participated in the general low condition superinduced by oft recurring pain and hœmorrhage from the uterus. Her appetite is poor and depraved; pulse small and easily compressible; impulse of heart feeble, and cardiac sounds sharp, short and distinct; fatigue is induced by moderate exertion; giddiness and faintness are complained of.

She states that, during the past ten years, she has experienced difficulty in defœcation and micturation, but that these symptoms have been less, during the past year. On examining the region of the uterus, a distinct oval swelling can be observed occupying the median line, and reaching as high up as the umbilicus, or thereabouts. By palpation this swelling can be well defined through the thin and attenuated abdominal parietes. Its surface is even and devoid of irregularity. On percussion it is dull throughout.

Before, however, subjecting the patient to a vaginal examination, the bowels were thoroughly cleared out and the urine drawn off from the bladder.

On now passing the finger up the vagina, the cervix was found to be hard and elongated, and high up, with the os pointing towards the posterior wall of the vagina. The anterior lip of the os was considerably enlarged and thickened. The posterior lip was also large, thick, and patulous. The tip of the fore-finger entered the external os, but further penetration was resisted by the canal of the cervix and the internal os. By pressing the finger against the upper part of the vagina anterior to the cervix, and exercising counter-pressure above the pubis with the fingers of the right hand, a thick, hard, and unyielding mass was easily distinguished. By placing the left fore-finger firmly against the wall of the vagina behind the cervix, and continuing external abdominal pressure, a large mass occupying the site of the uterus was clearly identified.

The patient declared that she had been recently informed that she was pregnant. But the enlargement was recognised more than two years ago, and she had, during that period, menstruated upwards of twice a month. The flow was painful and profuse, and she had just completed an act of menstruation prior to admission. She had—the uterine enlargement excepted—not a single objective or subjective symptom or sign of pregnancy. Simpson's uterine sound was, therefore, passed into the cavity of the uterus. It passed up fully six inches, and could be carried round the posterior part of the dilated cavity. Its progress was arrested about the middle of the anterior wall, and here the interference with the progress of the sound was such as to induce me to conclude that the base or pedicle of the tumour was broad. The descent, however, of the growth towards the site of the internal os, and its intramural character, were noted.

She was kept on nutritious diet, with a liberal allowance of wine, and full doses of bromide of potassium, citrate of iron and quinine. Under this regimen and treatment, the general health improved.

On the 13th, a sea-tangle tent was passed into the canal of the cervix. The vagina was plugged with cotton wool soaked in a weak solution of carbolic acid, to retain the tent in position.

The cotton and tent were removed on the 16th. The index finger could now be passed through the internal os into the cavity of the uterus. By steadying the organ with the right hand, and pressing it downwards into the pelvic cavity, the left index finger could be made to pass round the lower portion of the tumour, which felt soft and velvetty, and, as if it were attached to the anterior wall of the uterus. Its point of attachment could not, however, be reached with the finger. But its dimensions, point of attachment, and the size of the pedicle were approximatively determined by the use of the uterine sound.

By this aid, the growth was calculated to be almost three and a half inches in length, and two and a half in breadth, with a broad base, probably not less than two inches in diameter.

The urine was carefully examined by Dr. MacDonnell. Quantity normal; re-action slightly acid; rendered slightly opalescent, on standing, by a deposit of amorphous urates; free from albumen; sp. gr. 1018.

The general health has now improved by tonics, wine and good food. The conclusion of the next menstruation was seized upon for preparing the way for the removal of the growth. On the 27th of May, the os, after the introduction of successive seatangle tents previously, was sufficiently dilated to admit the entrance of three fingers.

Operation at 9 a. m.

Present: Dr. Lyons, Dr. Mackenzie, Dr. Lewis, and Mr. Grassby. The patient was put under chloroform by Dr. Lyons.

The large intestine having been emptied by castor oil, given on the evening of the 26th, followed by a morning enema, and the urine having been drawn off, the duck-bill speculum was introduced, and the posterior lip of the os seized with a strong pair of vulsellum forceps.

The os was then drawn down to the vulva and firmly retained there by Dr. Mackenzie, while steady external pressure was applied to the fundus. The attachment of the tumour to the anterior wall of the uterus by a broad base, and its size and shape were now easily diagnosed by the finger.

The uterine polypus forceps were introduced and locked on the tumour. But on using traction with a view to pull it through the os, and to apply the ecraseur, the structure gave way. The attempt was repeated several times, with the same result. The growth was, however, considerably mutilated, and I determined to enucleate it by means of my finger and a scoop. In this way, the greater part of the tumour was removed piece-meal, as much in the aggregate as the size of a medium sized Seville orange.

One portion, as large as of a small apple, and of a somewhat pyriform shape, was seized between the fore and middle finger and thus removed. The remainder was detached in small fragments, varying in size from a kidney bean to that of a hazel nut. It seemed to me that some of the growth still