the presence of compression. The fact that the symptoms of this continued uninterruptedly from the very first pointed to a depressed fracture, while their early severity indicated the presence of blood extravasation, and the fact that both existed was rendered obvious in the course of the operation. Again, with reference to the matter of treatment, the case was an excellent illustration of the advantages of early operation in the event of a simple depressed fracture of the skull *with* cerebral compression. Many a life has been sacrificed to delays on the part of patient's friends in allowing the sufferers to be submitted to operative treatment, or to hesitation on the part of the surgeon in undertaking such a step at the right time. Temporising methods may have their advantage in certain cases of fracture of the skull, but when signs of cerebral compression exist and persist, there appears to be no reason whatever why the surgeon should not deal with the case by operative methods at the most suitable early opportunity, first to examine the state of the skull, and next to relieve the compression by the use of the trephine and by the removal of intracranial accumulations. The risks of expectant treatment are greater by far than any connected with opening the skull, provided the surgeon secures asepsis and uses ordinary care in the employment of the trephine. Still another point of interest is one associated with the symptoms that were present in the case under review. I have mentioned the motor paralysis of the upper and lower extremities that followed the injury, persisted for some days, and disappeared shortly after the operation, and I have drawn attention to the fact that this condition manifested itself in connection with the *right* side, the same as that on which both the injury to the head and the facial paralysis occurred. The explanation of this feature in the case is not easy to give, unless it is taken for granted that injury to the brain was, by counter-stroke, produced in the left cerebral hemisphere, that is, opposite to the side of the head that had struck the ground. If such was the case, the presumption is that with the relief of tension due to the trephining, and the rest in bed, aided with bromides and such favourable circumstances as the youth and previous good health of the patient and the fact that the injury to the left cerebral hemisphere was at its upper and anterior part, and limited in extent, a rapid return took place to the normal condition of things. But even this explanation does not show why, with a depressed fracture of the right parietal bone and a large clot pressing on the *right* side of the brain, there should have been no hemiplegia on the *left* side of the body. I give an exact account of the clinical features of the case as very carefully observed by me, and I shall be glad of an elucidation on this irregular point in the symptomatology. In all classical accounts of similar cases it is usual to read of injury of this kind to one side of the head, being followed with face and eye symptoms on the same side and paralysis of the extremities on the opposite side. The feature as it existed in this case gives it an additional interest for the very reason of its being difficult of explanation.

AN IODIDE ERUPTION.

By A. B. FRY, M.B. (Lond.),
Captain, I.M.S.

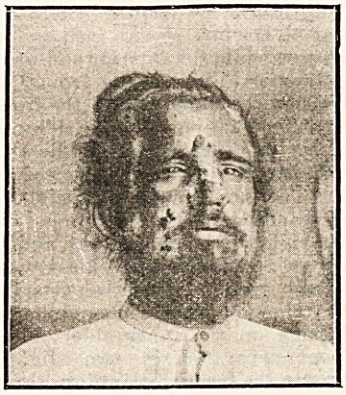
Asa Singh, age 29, a Sikh sepoy of 34th Pioneers, was readmitted to the Depôt Hospital with very severe sciatica. He had been away on sick leave, and I found by his medical history sheet that he had been seven weeks in hospital with a fever, diagnosed as a 'doubtful Malta fever.' He was wasted and the left leg was kept flexed, and he had most excruciating pain on movement.

Local applications even tried for a week without benefit, and I then ordered him Iodide of Potassium. Departing from my usual routine, I ordered the hospital assistant to give him a mixture containing 15 gr. of Pot. Iodide twice a day.

On the evening of the second day when the hospital assistant was about to give him the fourth dose, the man complained of burning sensations in the face and the hospital assistant noticed a red papular eruption and very wisely withheld the medicine. I saw the patient the following morning and was horrified at his appearance. The whole face was swollen and the nose, cheeks, forehead and angles of the mouth were covered with large granulomatous masses exuding pus. The photograph which was taken the next day gives a fair idea of his appearance though the general œdema had subsided. There was no rash on the body and no constitutional disturbance and the sciatic pain had gone. In fact, instead of groaning on the bed, the patient scrambled up into a chair and took a keen interest in his photograph.

The eruption dried up and faded away very quickly, but he still (two weeks later) has pigmented patches at the site of the biggest lesions.

The case is interesting as a severe one after a total of 45 grains of Iodide and also from the



complete absence of iodism; there was no redness of conjunctiva, lachrymation, coryza nor inflammation of respiratory tract.

A case like this happening in private practice with a lady patient would be ruinous, and it has warned me to be content with a commencing dose of five grains.

LARGE STONES IN THE BULBOUS PORTION OF THE URETHRA.

By T. S. BEAUCHAMP WILLIAMS,
Capt., I.M.S.,
Residency Surgeon in the Persian Gulf.

The patient, a fairly well developed Persian boy, aged seven years, was admitted into the Residency Dispensary, Bushire, on January 1st, 1907,