

discrete herpetic vesicles on the right half of the tongue; vesicles also on the soft palate and cheek. The sublingual and submaxillary glands were swollen.

Dr. Fayer relates a very similar case in this journal for July 1870, under the title of "Impetiginous eruption of the face caused by peripheral irritation of the branches of the trigeminal nerve." The patient, a martyr to toothache for 10 years, caught cold, which was followed by neuralgia and feverishness, and an unilateral eruption on the face on next day. The eruption was confined to one side of the face, and extended from the ear forwards to the upper and lower lip and inside the cheek. The glands were swollen and engorged. On the sixth day of the eruption the carous teeth of the upper jaw were extracted, after which the eruption dried up.

Dr. Anstie (1) relates a rare and remarkable instance of this form of zoster, as it occurred in his own person. After suffering from intense neuralgia of the right ear and face for some nine or ten days he discovered herpetic vesicles "in the central folds of the pinna, and a little group of two or three at the external edge of the cartilage; the latter, being rubbed, ulcerated and became very painful." At the same time a small group of characteristic herpetic vesicles formed below the right angle of the mouth, and invaded the mucous membrane. They had all disappeared in seven days. After remarking how delusive in a case of this kind is the apparent advantage derived from quinine, he suggests that these cases are not so rare as they seem to be. The idea that has occurred to me is this: that a large proportion of cases of earache, which are generally set down as suppurative inflammation of the meatus auditorius, are in fact nothing but neuralgic herpes, affecting the auriculo-temporal branch of the trigeminal nerve. This suggestion is worthy of being kept in view, but amongst the large number of cases of suppurative inflammation of the ear that have come under my notice I have not as yet noticed one in which herpes was developed. I may remark that diseases of the ear are very common amongst natives. Neuralgia is frequently met with, and is curable with quinine, but I have never, as I stated above, seen any eruption.

One of my patients at the present time almost periodically at the same season every year suffers from intense neuralgia which invariably disappears after a few doses of quinine.

Zoster Perinolis of Neumann and Z. Sacro-ischiadicus of Barendsprung I have not seen.

Zoster, as a rule, leaves its victims in impaired health; but besides this, there are certain sequelæ that require mention. Obstinate neuralgia and ulceration are amongst the most common, as well as affections of the eye which have been already noticed when considering the cases of Ophthalmic Zoster. The neuralgia may last for weeks, months, or years, or even may end only with life, baffling all remedies and attempts at cure. This is most marked after Z. Capillitii. Obstinate ulceration is another troublesome indication of impaired nerve power, and the ulcers when healed leave scars which are never obliterated. Another nutritional change has been noticed by Mr. Paget, in his paper published in the *Medical Times and Gazette*, and quoted by Dr. Woakes (2) in a case of Z. Brachialis. After the eruption had disappeared neuralgia continued, and the fingers became thin and tapering, smooth, hairless, glossy, pink and blotched as if with permanent chilblains. These symptoms subsided slowly, being unaffected by the ordinary treatment of neuralgia. Dr. Woakes calls attention to the fact that these appearances are met with after injuries to nerves. Temporary atrophy also follows other affections of the nerves. Last year I treated a case of acute sciatica, apparently of malarious origin, in the course of which the limb below the knee rapidly shrunk to a degree that frightened the patient, to gradually regain its normal size after the cessation of the disease. In the same

paper of Mr. Paget's is related the well-known case in which necrosis of the jaw followed Z. facialis.

Motor paralysis is met with not only as a sequel but as a precursor of zoster. Bowman and Hutchinson both relate cases in which diplopia from paralysis of the third nerve followed Zoster Capillitii. Professor Oppolzer (1) mentions a case in which there was for a time all but complete hemiplegia. Dr. Duncan (2) of Edinburgh relates two most interesting cases in which partial hemiplegia preceded the appearance of the rash.

1. F., 65, pain in the right side of chest and partial right hemiplegia for three days before the eruption appeared. She was well in three weeks.

2. F., 68, left Z. femoralis preceded for two days by slight left hemiplegia, which increased with and after the appearance of the eruption.

Dr. Broadbent (3) reports the case of a woman aged 74, in which right Z. Brachialis was followed by temporary paralysis of the right arm which lasted a week.

Dr. Greenough of Boston, U. S., relates a case of a weakly man, aged 33, in whom left zoster collaris was followed in ten days by numbness of the left side of the face. He could not close his left eye, his mouth was drawn to the right side and he was much troubled by his food getting between his gums and left cheek. He gradually recovered.

Dr. Sichel mentions that Z. Capillitii is usually followed by anæsthesia, and that falling of the hair, a nutritional change, is not unfrequent. Temporary, complete or partial anæsthesia is commonly met with after severe zoster of any region, particularly that in which the severity has been marked by great nutritional changes.

Dr. M. Singer records a case of zoster of the three divisions of the fifth in which the sense of taste and touch in the tongue were lost and regained together.

Hutchinson and others have noted an acne like rash amongst the sequelæ.

In the *Medical Times and Gazette* for October 21st, 1865, a case is related in which the eruption was preceded for a week by intense neuralgia. The neuralgia recommenced after the cessation of the eruption, and affected also the brachial nerves. The seat of the eruption then became red, and this redness had not disappeared ten months afterwards. This patient was much out of health and another case is mentioned at the same time as occurring in a cachectic boy subject to epilepsy.

(To be continued.)

INDIAN FEVERS.

By THOMAS O'FARBELL, M.A., M.D. Surgeon, A. M. D.

THE pyrexial diseases of this country have engrossed a large share of our attention, and to a certain extent our efforts in this field of enquiry have been attended by success. Unhappily much still remains to be done, but let us hope that the constant efforts of the *Indian Medical Gazette*, to keep this important subject before its readers, may in the end succeed in accumulating such a heap of evidence, and in bringing to light such a number of facts, that we may at no distant period sit down to the work of generalization and classification with every reasonable probability of accuracy.

As an humble contribution to the history of Indian Fevers I beg to lay the following considerations before the profession, and first of all I would solicit the readers' kind attention to Dr. Aitken's division of diseases due to malaria as the one most generally received, and best illustrating the remarks I am about to make. He divides the malarial group into: I. Ague

(1) Practitioner, Vol. VII, 198, and seq.
(2) Journal of Cutaneous Medicine, Vol. I, p. 252.

(1) Journal of Cutaneous Medicine, Vol. III, p. 193.
(2) Ditto ditto, Vol. II, p. 241.
(3) British Medical Journal, 27th October 1866.

or Intermittent Fever. II. Remittent Fever. III. Malarial Yellow Fever. Now the history of the agues is happily so well known, and the course, symptoms, and diagnosis so thoroughly made out, that we may dismiss them from further consideration. Far differently however is it with remittent fever: here, most of the discussions of the disease are scanty and bald, in some cases ambiguous, generally unsatisfactory; and there can be little doubt if ever we hope to unravel the tangled skein of Indian fevers, we must bring all the powers of mind and the instruments of modern research to bear upon the diseases grouped under this head. That there are fevers, of a well marked remittent character, met with in this country, no one can deny, and I could bring forward cases proving their occurrence. The kind of fever alluded to is best described by saying—“If you can imagine a quotidian ague, where the cold stage is badly marked, where the fever lasts over 24 hours, and where there is no special distinction between the hot and sweating stages, then you have what we call a remittent fever,” I had almost said “mild remittent fever,” for they are seldom fatal. It is however the great class of mortal remittents that call loudest for elucidation; unfortunately it is here also that our information is scantiest.

In most recognized class books we hear a lot about “lulls” alternating with “tempestuous” action, and we are constantly warned not to let the “golden opportunities” of remission pass through our fingers, yet where is the thermometric proof of these hurricanes and calms? Do we not look in vain for a single history of a fatal case with an uninterrupted bed-side account of the fever from its outset until it terminates in death? Are we not entitled to reliable information on the subjects of temperature, pulse, respiration, and character of the excreta? Above all where are the *post-mortem* examinations (in which all important organs are examined) which prove, beyond the possibility of doubt, that no other known disease could have killed the patient?

The truth of the matter appears to be, that there are very few fevers of the class described in books, which are supposed to kill so many of our soldiers so insidiously that no traces of their past visit can be found in the body after death, except perhaps engorgements of the liver and spleen, conditions by the way common to most pyrexial states. And there seems strong grounds for believing that most of the diseases heretofore known in India as “Adynamic Remittents” and “Pernicious Paludal Fevers” are in reality the same as those which we now know by the name of Enteric Fever. In fact that they are all synonymous terms expressive of one and the same pathological state. Perhaps as well as being synonymous they may to a certain extent be convertible expressions, and we may with equal justice say that most of the enteric fever cases in this country are paludal remittents, claiming however for these paludal remittents the constant presence of an affection of the intestinal, solitary and agminated glands, and it must be conceded that there are unequivocal reasons for saying that some at least of our enteric fever cases have a paludal origin.

That enteric fever as we see it is pretty much the same as the so-called mortal remittents, and that no very appreciable difference exists between them is apparent whenever an attempt is made to lay down diagnostic rules for our guidance. It is said that gastric and duodenal disturbance are present in all remittent fevers, absent in enteric. To this we answer,—we don't know about the duodenal, but certainly gastric irritability is so common as to be almost constant in the enteric fevers of this country. The distinction grounded on the fact, that remittent fever stools are dark and bilious, while those of enteric are yellow-coloured, &c., is not of such value in our eyes, especially as we have seen cases run their course to a fatal termination, where the motions were brown, black, or many tinted, the autopsy demonstrating the anatomical sign of

enteric. We feel very much inclined to doubt that apart from the epigastric and hepatic regions, abdominal tenderness is generally absent in remittent fever. It is laid down that “if a hæmorrhagic tendency evinces itself in the course of a remittent, the blood proceeds from the mouth, nose, urinary organs or bowels, while in enteric fever it is from the intestines only, at an advanced stage, during the separation of the glandular sloughs:” now one of the most constant symptoms met with in Enteric Fever, as we see it, is epistaxis, occurring sometimes three or four times daily, and frequently to an alarming extent; it is usually early in the fever, but not always so, and bleeding from the throat, lips and tongue are by no means unusual. It is said that in India the spots are more frequently absent than present in enteric fever; all we can say is, this does not accord with our experience. While admitting that the face in enteric fever is generally flushed over the malar bones, it is not always so; we have seen the countenance as “muddy” as that of typhus, therefore the expression cannot always be depended upon as a satisfactory distinction. It is given as a distinctive character of remittent that the fever is more or less paroxysmal, while it is continued in enteric; we altogether doubt the truth of this, and we think a glance at any thermometric chart will show the fever of enteric to be every bit as paroxysmal as that of remittent; and, in conclusion, from our knowledge of how the disease occurs in this country we fear that “a careful examination into the history with an eye to causation” will do very little to help us out of our difficulty. It may however be advanced that you never find disease of the intestinal glands in cases of remittent fever. We answer,—prove it. When you show us some fatal cases of some duration (and Dr. Maclean says they seldom terminate before the seventh day) displaying the characteristic symptoms claimed for remittent fever, and with no other *post-mortem* signs than engorgement of the liver and spleen and other obscure congestions, then and only then can we admit the truth of what you advance. It is worthy of note that Dr. Maclean, when giving the diagnosis in India between the two diseases, makes no mention of the absence of intestinal disease in remittent.

The following analysis of the casualty reports of the 63rd (West Suffolk) Regiment since its arrival in India will show how few victims can be claimed by remittent fever:—

The 63rd Regiment landed in India on the 9th November 1870, and from that time up to the present date, 1st July 1874, or about three years and eight months, forty men of the rank and file have died. Fifteen of the deaths belonged to the febrile group, and twenty-five to all other diseases. There are however two cases classed with all other diseases which would seem more deserving of a place among the fevers. One was returned as a case of acute dysentery, the other as acute asthenic bronchitis. A careful study of the symptoms and the condition of the intestines disclosed by the *post-mortem* dissection casts grave doubt on the accuracy of the diagnosis in both cases, and it would seem that, in the first case, the bloody stools and abdominal symptoms were rather connected with disease of the agminated and solitary glands than with the separation of dysenteric sloughs, and, in the second case, it would appear that the diseased condition of the lung was subsequent to and consequent upon a pyrexia which was associated with ulceration of the glandular apparatus of the intestines; in fact that it was a case of concurrent broncho-pneumonia, a condition of the respiratory organs very frequently met with in enteric fever cases.

However, leaving these two cases out of the question, merely noting what a ready channel certain kinds of dysentery and bronchitis offer for a mistake in diagnosis, we will say that the febrile group caused 15 deaths. Now in 13 out of the 15 (or nearly $\frac{2}{3}$ of the total deaths due to all causes) there was disease of the solitary and agminated glands of the ileum, and a glance

at the accession, course, symptoms, termination and necroscopy would convince the most sceptical that they were genuine cases of enteric or typhoid fever.

In the other two the intestines were free from any very appreciable change, and they were seemingly quite different diseases from one another and from the thirteen enteric cases. That they cannot be claimed as belonging to the remittent group I think the history will satisfactorily prove, that is, if we take the account by the standard authors as giving a fair description of the mortal remittents.

I now proceed to describe the only two pyrexial diseases which caused death in our ranks while the intestines were unaffected. I would merely premise that I am well aware how faulty they are in some respects; all I claim for them is, that they are the conscientious description of the symptoms as they seemed most important to humble observers whose sole object was a search for truth.

The first case was under the care of my friend Dr. Hanna, A.M.D., and this account is derived from our combined notes taken at the time and independently of each another.

Private W. E., aged 35 years, service 14 years, came out from England with the regiment, and was admitted into the Regimental Hospital, Hazareebaugh, 3rd October 1871. He was under observation on the 2nd, and was reported to have been ailing some nine days previous, though he only became bad on the 1st October. On the 2nd he had intense pain in the head and vomiting; at noon he felt very cold and shivered; all the thermometric readings are given in one table at the end.

October 3rd or 11th day.—He complained of fever and general pyrexial symptoms; appeared in a very depressed state; his tongue was covered with brown fur; pulse 120, soft and compressible; bowels rather constipated; stools light-coloured, like white clay; considerable pain in the head and vomiting. He had 15 grs. of quinine, and was ordered sedatives to check vomiting.

4th or 12th day.—No improvement; he was jaundiced; tongue covered with a yellowish-brown fur; respirations 32; pulse (reclining) 128; had pain at times in the belly, especially over the liver, with gurgling and tenderness in the right iliac fossa; he had quinine by the rectum, as vomiting precluded its being given by the mouth.

Tespere—Was in an exceedingly depressed state; there was evidently an exacerbation of the fever coming on; occasional hiccough; skin exceedingly yellow; sordes on the teeth and

gums; the stimulants were increased and the quinine enema repeated; only vomited three times.

5th or 13th day.—Tongue brown; has had hiccough for the last 24 hours; did not pass much water, apparently from suppression rather than retention; vomited three times; his pulse counted 128, and he was slightly delirious at night; he had twenty grains of quinine, and was at the stool three times.

6th or 14th day.—The hiccough was intermittent all the day of the 5th, but for the last six or eight hours has been continuous. Bowels were opened once, stools white and solid; pain in the hepatic region on pressure. He vomited twice, the vomited matters inky black in color; there was a tendency to hæmorrhage, as exemplified by petechiæ on the forehead; pulse 100, compressible; complained of cramps in the legs on moving them. There was a cold moisture on the forehead; he does not otherwise sweat. Quinine was repeated, and he got podophylline pills every third hour. The skin was exceedingly yellow.

Examination of urine—Morning.—Urine not fresh, very scanty, of a yellow brown color and sickly disagreeable odour; specific gravity 1014. Boiling and nitric acid when used separately caused no precipitate, conjointly they effected a well defined albuminous precepsitate when the fluid was slightly acid. Simon's and Pettenkofer's tests did not prove the presence of bile. The urine sediment put under the microscope showed crystal of oxalate of lime, but no tube casts.

Evening.—Eight ounces of urine were drawn off by catheter; reaction acid; specific gravity 1010. Boiling caused a ppt. insoluble in excess of nitric acid. Nitric acid by itself caused no ppt., and its presence prevented precipitation by heat.

7th or 15th day.—He was three times at the stool; motions offensive, thin, of a green brown color, darker since the podophylline has been used. Pulse 122, intermitting; black sordes on the teeth; scales on the tongue quite black; he moans constantly, hiccough less, is much weaker, jaundice not so bright. There was well marked prominence of all the external veins all over the body; there were no bronchitic rales heard when the chest was examined. Urine.—There was little or no urine in the stools passed during the night, and only two ounces and a quarter could be drawn off by catheter. It was not very high coloured; specific gravity 1012. The soluble albumen in the urine was affected by reagents in exactly the same manner as last evening. Simon's test failed to show the presence of bile. He died at 7:30 P.M.; death apparently beginning at the heart.

Case I.—Pte. Wm. E.

Died 7th October 1871.

DATE.	HOURS A.M.												HOURS P.M.												HOURS A.M.				
	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5					
October 1871.																													
2nd October ...						102°					103.1			102.2															
3rd ditto ...	98.3				100.1°			101.4					102.4°		103.1														
4th ditto ..	103°			104°			104.4		104.2				103.3		101.3														
5th ditto ..	99.1				99.4		100						99.4		99.4														
6th ditto ..	100.2			101			101.4					103.4			103.1														
7th ditto ..	102.4					102.4					103.1						Died												

Post-mortem appearances 13 hours after death.

Body, in a fair condition, skin bright yellow in colour. Rigor mortis complete; a large quantity of mucus in mouth and œsophagus.

Brain.—Small quantity of fluid in the calvarium. Longitudinal sinus empty; vessels of the dura and pia mater very well marked, enlarged and full of blood; there was a small quantity

of fluid in the lateral ventricles; choroid plexus healthy; vessels of the convolutions congested; substance of brain firm and natural. Weight 3lbs. 8oz.

Thorax.—Extensive old and recent adhesions on the anterior surface and base of right lung. The lower lobe of the right lung was perfectly hepatized, except a small portion anteriorly; in the lower portion this has reached the stage of grey hepati-

zation. The upper portion of right lung stuffed with tubercles, and about two inches from the apex a cavity, the size of a walnut, existed. The reflection of the pulmonary pleura between the middle and lower lobes of the right lung inflamed, and on separating these lobes about two ounces of serous looking fluid escaped; the weight of this lung 2lbs. 8oz. *Left lung* congested slightly posteriorly and at the base; it was otherwise healthy.

Heart.—External surface of the pericardium inflamed with recent and also old lymph deposit, internally it is so closely adherent to the visceral layer that it can only be separated with difficulty. Walls of left ventricle thin, pale and flabby. There was a large yellow fibrinous clot adhering to and hanging loosely from the border of the mitral valve. Wall of the right ventricle extremely thin, only one-eighth of an inch thick; fibrinous masses on the tricuspid valve, atheromatous deposit on two of the aortic valves, preventing their closure also in the arch of the aorta, innominate, subclavian, and carotid arteries. The heart weighed 14 oz.

Abdomen.—*Liver* enlarged, the external surface of a brownish-yellow colour. Gall bladder immensely distended with bile. On pressing the liver a large quantity of frothy, thin, sanious fluid escapes from the portal vein. On section of the liver this fluid can be squeezed out from the branches of that vessel. The whole structure is somewhat friable and of an intensely yellowish green colour; no reaction with iodine.

Spleen very much enlarged and friable. Weight 1lb 1oz.

Kidneys—*Right* very much enlarged; on section both cortical and tubular portion tinged with the colour of bile; otherwise healthy. Weight 8½oz. *Left* also much enlarged and of a peculiar lobulated shape; yellow on section. Weight 9oz.

Pancreas.—Weight four ounces. Normal.

Stomach very much distended with a large quantity of dark-yellow, grumous-looking fluid; mucous surface healthy.

Intestines.—A few patches of congestion along the ileum, in some parts this is very marked; Peyer's patches perfectly natural, no sign of ulceration or disease, either in large or small intestines. No entozoa.

CASE II.—No. 1406, Private Henry B., aged 22 years, was admitted with pyrexia of two days' standing on the 23rd August 1872. He had then a dull depressed appearance, his tongue was furred, his skin was hot, and his bowels were loose, and his temperature was as low as 100° F. for some hours.

August 25th.—Pyrexia still continued, there was a tendency to delirium, bowels open twice.

26th or 5th day.—He was delirious all last night; there was a great deal of gurgling, but no pain in the right iliac region. Temperature 7 a.m. 100°, 4 p.m. 104°. He got 15 grs. of quinine in the morning.

27th or 6th day.—He had restless delirium all the night of the 26th, and early this morning he was rather purged; stools of a dark dirty brown colour; there was pain and gurgling in the iliac fossa; continued the quinine. Pulse 96. Temperature 6 a.m. 103.4°, 10 a.m. 101°, noon 101.4°, 4 p.m. 101.4°, 8 p.m. 104°.

28th.—He was noisy and delirious all the night before; the tongue though moist was covered with a white fur; the pupils were dilated and not much affected by light; bowels not opened since yesterday morning; he had a blister to the head. Temperature 6 a.m. 101.4°, 4 p.m. 102°, 8 p.m. 104.4°; morning pulse 96, evening 80

29th or 8th day.—He was very much worse; he was affected by convulsions, opisthotonos and strabismus; he passed yesterday twice the ordinary amount of urine for a man in health; his head symptoms were unrelieved; there was evidently inflammation and effusion on the brain. Temperature 6 a.m. 100.4°. He died at 12 noon on the eighth day of the sickness and sixth in hospital. Temperature immediately before death 104.4° F.

Post-mortem examination four and a half hours after death.

External appearances.—Body in good condition; no external marks except an ecchymosis on the left arm; this was not of a *post-mortem* character.

Head.—*Brain,* no fluid was found on taking off the calvarium; vessels of the posterior lobes very much injected. On removing the brain there is found extending from the optic commissure over the medulla oblongata for some little distance down the cord and over the cerebellum a layer of organized lymph of some thickness, especially so over the medulla oblongata; vessels of cerebellum and the base of the brain intensely congested. The *lateral ventricle* on the right side contains 3vi of opaque serum, having several small flakes of lymph floating about in it. The left ventricle also contains a similar quantity, but of a bloody appearance; flakes of lymph are found in this also. The choroid plexus very pale, but the vessels of the optic thalamus very much injected. In the floor of the fourth ventricle there is a patch of inflammation. *Puncta vasculosa* in white substance rather well marked; the pia mater at the base very much congested. Weight of brain 3lbs. 6oz.

Neck and thorax.—*Œsophagus* healthy; larynx and trachea healthy; bronchi filled with frothy mucus. Lungs healthy; no tubercle; right weighed 1lb. 8oz., left 1lb. 8oz.

Heart—Both sides filled with dark fluid blood; a large white fibrinous clot in the right auriculo-ventricular orifice; also a similar one in the pulmonary artery; heart's structure and valves perfectly healthy. Weight 10oz.

Abdomen.—*Liver*—weight 3lbs. 4oz., health.

Spleen—Healthy, weight 12oz. *Pancreas*, weight 4oz, healthy.

Intestines healthy.

Kidneys enlarged and slightly congested; weight of right 8oz., left 8oz.; no entozoa.

The intense headache, bright yellow skin, the inky or black vomit, the partially suppressed and albumenuric urine, stool deficient in bile, cramps in the legs, persistent hiccup, hemorrhagic tendency and irregular pulse, taken in connection with the state of the pericardium, stomach and other abdominal viscera, would suggest that the first case was one of Dr. Aitken's third class "Malarious yellow fever." Indeed, except that it did not appear to be at all infectious, it corresponds in many important particulars with the best descriptions of specific yellow fever (*vide* Dr. J. D. Macdonald's article in Reynolds). I look on the tubercle found in the upper lobe of the right lung as in no way accounting for the death or symptoms, and it probably existed previous to the last illness.

With respect to the second case, if we compare the symptoms during life (especially those immediately before death) and the *post-mortem* examination with the accounts of cerebro-spinal fever, we cannot fail to be struck with the resemblance. The opisthotonos, strabismus, and delirium are common to both, the fever, the purging, the dulness of aspect and blunting of the senses are very similar, and though in this case no petechiæ or vibices were seen during life, an ante-mortem ecchymosis was detected after death. The appearance of the nervous system in cerebro-spinal fever is given in a variety of ways, but most agree in finding "membranous lymph about the pons and upper part of the medulla oblongata, and great congestion of the membranes at the base of the brain, a deposit of lymph on the brain, and a drachm of fluid in the ventricles" Then again, "opacity of the arachnoid in patches the congestion most intense at the base of the brain, accompanied by lymph and traces of purulent matter about the pons and upper part of medulla." The man had received no injury of the head or spine.

In pointing out how like the first case is to malarial yellow fever and the second to cerebro-spinal fever, it has by no means been my intention to say they were more than like those

diseases; in fact I decline to diagnose them as such, but I trust by thus bringing prominently forward the salient symptoms, they may be better impressed on our memories.

In the foregoing considerations we have been dealing solely with cases, where the *post-mortem* dissections allowed us in most cases to "clinch" the diagnosis, in fact we may say to a certain extent, we were dealing with known quantities or certainties. When, however, we review the large number of grave fever cases which have recovered since the arrival of the regiment in this country, referring especially to those with a fatal tendency we find the same broad proportions obtaining. The great majority were cases of well marked enteric fever, and a good many others appeared to be the same disease in a milder form where some of the diagnostic symptoms (the diarrhoea for instance*) were badly marked or even entirely absent. The resemblance was, however, in other respects so perfect, one could not fail to see the relationship. On the other hand, I cannot positively say I have seen a true case of remittent fever that tended towards a fatal issue since we came to India.

And when I call to mind the number of patients in whom the seeds of destructive lung disease must have been laid by the pulmonary complications of enteric, I have no hesitation in saying,—“That of all the diseases which cause death and sickness and otherwise deteriorate the mental and bodily health of our European Army, enteric fever in my experience is far and away the most potential.” The effects of dysentery, hepatitis, &c., compared with enteric, dwindle into insignificance. Remove enteric fever and the dangers of Indian service would be wonderfully reduced. Now with respect to this removing or stamping out of enteric fever we can offer no suggestion. But while recognizing the comparatively non-contagious nature of the disease, I think the theory, stating that the disease is in no way communicable from the sick to the healthy, either through the medium of the discharges, fresh, decomposed, or otherwise, is by no means proven and is a very dangerous one to act upon while our information is so scanty.

JHANSI, BUNDLECUND, 1st July 1874.

THE "UMRIT SAGUR."

By Surgeon T. H. HENDLEY, *Jeypore Agency.*

(Continued from page 172.)

Jaundice.—Of this disease there are five forms; four arising in the different temperaments and a fifth from eating mud.

The humours and the blood are spoilt by overwork, too much sleep, overeating, taking too stimulating and acid food, and so the skin becomes yellow.

The skin cracks; the limbs become painful; a wish to eat mud is formed; the eyes are swollen; the fæces and urine are yellow; and there is indigestion.

Jaundice of the windy humour.—The skin and conjunctivæ are dry and black or red; the urine also is highly colored; shivering, pain, swelling, and delirium are observed.

Bilious Jaundice.—Fæces, urine, and conjunctivæ yellow; there is thirst with much heat of body; the skin also becomes yellow, and the fæces are fluid.

Phlegmonous Jaundice.—The body is cold and swells; phlegm pours from the mouth; weariness and weight are felt; the skin, urine and fæces are yellow.

Sanipât Jaundice.—This arises from eating tasteless or very sweet mud, which dries up the seven secretions, or food undergoing digestion, spoiling the stomach; the members lose power

and the body becomes weak. This mud makes the skin and fæces yellow; digestion is destroyed; coldness, weariness, breathlessness, cough, pain, piles, loathing for food, swelling of the limbs and upper abdomen, worms, dysentery are noticed.

When much blood is passed the gums and eyes become very yellow, and the body is much swollen; there is no hope.

Kámala.—A very bad form of jaundice.

When a man suffering from jaundice eats too stimulating food, the bile, blood and flesh become scorched up; the eyes, skin, nails and mouth are coloured like turmeric; the fæces and urine are bloody; there is much emaciation with loathing for food, indigestion and inflammation.

Haimak disease.—In jaundice air and bile increase; the skin is green, yellow or black; all strength and pleasure depart; coldness, slow digestion, delirium, loss of love for women, and pain in the limbs are observed.

Remedies for Jaundice.—Iron, which has been macerated seven days in cow's urine, must be given in water fifteen days. Preparations of iron are especially useful, also bitters and aromatics.

The sufferer from jaundice may take wheat, rice and the milder kinds of dâl (pulse).

CHAPTER IV.

Rakt pitt रक्त पित्त.—From long exposure to the sun, hard work, overwalking, excessive venery, care, eating acrid or hot food, &c., the bile becomes calcined and afterwards the blood. There is then bleeding from above or below, that is, from the nose, eyes, ears and mouth or the penis, vulva, and anus. In bad cases even from the hair.

At first there may be vomiting, pain in the limbs, and smell of blood in the nose; then blood pours out accompanied with different signs according to the temperament. In the sanipât variety blood comes from all the orifices.

If the blood come from the mouth, eyes, &c., the disease is curable; if from the penis, anus or vulva, remedied with difficulty; if from all parts, incurable.

When there are much weariness and breathlessness, and the body loses in weight, the patient sees the sky as if red, and much thirst and indigestion set in, the case is hopeless.

Remedies.—If the blood be lost from above, purge; if from below, give emetics.

Use snuffs of dhub grass, pomegranate flowers, *Cassia fistula* juice.

Powder Emblic myrobalam and apply to the forehead or nose. Use snuffs of onion juice, ghee, washed a hundred times.

Tabâshir, &c.

Raj Rog—Consumption.

There are four forms arising in the different temperaments, and a fifth from blows.

Shosh Rog.—Six kinds. (1) arising from excessive venery. (2) care; (3) blows; (4) overwalking; (5) too much labor; and (6) old age.

Consumption arises from not passing fæces, urine, and flatus when necessary, poorness of semen, too rapid breathing, working beyond the powers, eating too much at wrong times, &c.; too much semen is secreted, and so also too much phlegm, and from too much venereal excitement, all the secretions are spoilt, and the body dries up day by day.

Symptoms.—Breathing becomes rapid, pain in the limbs, cough with spitting phlegm, dryness of the fæces, vomiting, slow digestion, nasal discharge, sleepiness, white and pearly conjunctivæ, eating meat, and much sexual desire, pains in the ribs and shoulders, heat of the extremities and of the body, loathing for food, closure of the nasal passages, and blood appearing in the mouth.

Air Raj Rog.—Altered voice, pain and drawing in of the shoulders and ribs.

*. Sir Wm. Gull says the presence or absence of diarrhoea is dependent on the presence or absence of disease of the large gut.