carminative drinks, change of posture, &c. Such cases are very common; they are especially frequent at night, perhaps because some posture during sleep favours pressure of the liver on the pylorus, duodenum, or upper coils of the jejunum; perhaps because lessened peristalsis allows an accumulation of solid and liquid intestinal contents, so that a trap is formed in the intestine. Whether the closure above is entirely spastic—and one would scarcely consider sleep to favour the development of spasm—or due to the pressure of the liver on the œsophagus, it is difficult to say; but there is no question that gastric distension is favoured by lying on the left side.

"Nightmare" is frequently due to this cause, and one can only decide by the state of the pulse and the heart sounds in any particular case whether the sense of cardiac interference is mainly genuine or due to the "nightmare." Most of these cases are relieved spontaneously or by domestic treatment; and apart from the passage of the stomach-tube to relieve gas-pressure the treatment is prophylactic, to prevent the formation of gas, a subject which has been dealt with in the course of this paper. Having passed, in somewhat sketchy review, the various theories of gas formation in the stomach, I would, in conclusion, enter a strong plea for the more careful investigation of these cases, so often recurring in general practice, and instead of routine mixtures for "wind" so often prescribed I would substitute a minute and searching inquiry into primary causes—their removal resulting in credit to ourselves and service to our patients.

MEDICINE.

JAUNDICE IN SECONDARY SYPHILIS.

SOMETIMES the results of secondary syphilitic hepatitis are very obscure, and are associated with severe intra-abdominal pain and with pyrexia and general ill-health. Laparotomy has more than once been resorted to on their account under the belief that the symptoms pointed to leakage from a gastric or duodenal ulcer or an abscess in connection with the liver. That jaundice should sometimes result from secondary syphilitic inflammation in the liver is not surprising, therefore, and sometimes the changes in the bile pigments are such that, although they produce yellow discolouration of the tissues, they do not give the ordinary tests for bile pigments in the urine—in other words, so-called "acholuric" jaundice. The following is an instance in point:—

A young woman, aged nineteen, came into hospital for jaundice and an eruption upon the skin. The latter was a syphilitic roseola, almost confluent in type, and it had been out for a fortnight, although, as is so often the case in women, the patient had had no knowledge of the primary chancre. There was general enlargement of the lymphatic glands, particularly in the inguinal and sub-maxillary regions; but there were no vulval lesions, no sore throat, no headache, and no fever. The jaundice had appeared a week previous to the roseola, beginning gradually, attaining its maximum in three or four days, and persisting from that time without variation. There had been no previous jaundice and no noteworthy gastro-intestinal trouble, nor was there any pain to suggest a gall-stone.

The urine was not very highly coloured, and did not give the Gmelin's reaction. The stools were not decolourised, and there was no constipation. The liver dulness was neither increased nor diminished, and the liver itself could not be felt, but the spleen was increased in size. The pulse-rate was eighty, and there were no cardiac or pulmonary abnormalities. There was no itching. Treatment by intra-muscular injections of the biniodide of mercury in a watery solution was adopted, and the jaundice steadily diminished. Numerous blood examinations were made; the most important point determined thereby was that the blood serum contained bile pigments, although the urine did not. There was only slight anæmia, whilst the leucocytes averaged from 10,000 to 30,000 per cubic millimetre.

The case was clearly one of syphilitic acholuric jaundice of the variety sometimes attributed to "roseola of the biliary passages." The diagnosis in the present instance was easy enough on account of the copious eruption upon the skin, but in other instances the secondary syphilitic nature of hepatic symptoms may not be equally clear, though it is important to bear their possibility in mind.

HÆMATURIA AND NEPHRITIS OF SUDDEN ONSET AS AN INITIAL SYMPTOM OF TYPHOID FEVER.

THE onset of typhoid fever is, as a rule, gradual and obscure, but in certain instances the malady begins acutely and presents symptoms which for the time being seem to indicate an entirely different disease. One is familiar, for instance, with cases in which the first symptoms seem to be in the lungs, and lobar-pneumonia is the first diagnosis made. In other instances the part of the bowel which first becomes inflamed is the vermiform appendix, and there may even be an appendicular abscess for which laparotomy is performed. Less common than either of these, and yet very misleading when met with, is acute nephritis as an early symptom in typhoid fever, such as has been recorded recently in more than one case in France.

In one instance a young man of eighteen years of age came to hospital suffering from hæmaturia, which had begun acutely eight days previously after exposure to severe cold. The urine was normal in amount, contained a large amount of albumin, and

s of a dark reddish-black colour; microscopically the sediment exhibited granular tube casts and many deformed red corpuscles. Bacteriological cultivations were made both from the patient's blood and from his urine, and these remained negative. The other symptoms in the case were intense headache, a dicrotic pulse beating at about 100 per minute, a temperature of 104° F., bronchitic râles scattered over both lungs, some hypertrophy of the spleen, a tendency to constipation, and finally a decided œdema of the subcutaneous tissue, particularly in the lower limbs.

Looking back at this case, the dicrotion of the pulse and its relative slowness in proportion to the temperature, together with the palpability of the spleen, seem clearly enough to indicate that typhoid fever should have been thought of on admission; but so definite were both the œdema and the hæmaturia that it was not until eight days later that enterica was recognised as the result of the development of rose-red spots upon the abdomen. Five days later this was confirmed by Widal's test. Till this time the urine continued to contain an abundance of blood, but after the first ten days of the patient's stay in hospital both the blood and the albumin began to diminish, and at the end of four weeks, when the temperature had finally dropped to normal by lysis, the urine was perfectly clear. Polyuria succeeded this for a time, and even on the patient's discharge the urine contained 0.25 part of albumin per 1000.

The course of the disease seemed to be what one might term "average," the prognosis being rendered in no way worse by the fact that acute nephritis constituted so early and prominent a complication.

DERMATOLOGY.

CUTANEOUS DIPHTHERIA.

EVEN so long ago as the eighteenth century it was recognised that diphtheria may attack an open wound; few observers realise, however, that it is distinctly rare for cutaneous diphtheria to present any definite membrane, and it is on this account that the diagnosis is often missed. Bacteriological examinations in skin cases becoming more and more general, diphtheria bacilli are being found where they would formerly have been absolutely unsuspected. Several cases in point were brought before the Dermatological section of the British Medical Association by Dr. G. W. Dawson. Other observers have also recorded cases recently. The importance of arriving at the correct diagnosis is clearly great, for not only may the patient continue to have the skin affection for months if anti-diphtheritic serum treatment is not adopted, but also he is all this time an unsuspected source of dangerous infection to his family and to the community.

The commonest and, therefore, the most typical form of cutaneous diphtheria occurs in children, and has the appearance of an impetiginous eczema, nearly always affecting the head and face; often, but not always, associated with severe conjunctivitis, otorrhœa, or rhinitis; once seen and recognised the condition will seldom be overlooked again.

Seeing that the diphtheria bacillus may be simulated by certain common, but harmless, diphtheroid organisms, it is important to omit no cultural test in verifying its nature, and animal inoculation may be resorted to if need be. The malady is apt to be very resistant to ordinary treatment, lasting sometimes for *years* when its real nature is not recognised and the proper treatment adopted. Doubtless, some of the cases have not been primary diphtheria of the skin; various other affections may become secondarily inoculated with Klebs-Lœffler bacilli; but whether primary or secondary, the lesion invariably responds to anti-toxin, and anti-diphtheritic serum is the correct treatment.

The following is a severe case recorded by Dr. Kenneth Wills in the Bristol *Medico-Chirurgical Journal*. The patient was a boy six years of age, who came under observation for enlarged glands in the neck on December 16. Six months previously he had had "an abscess which discharged through the right nostril." Since then glands had slowly increased in size on the left side of the neck without obviously affecting the general health. On December 16 a slight follicular inflammation of the left tonsil was noticed, but there was no pyrexia, and the patient was well enough to enjoy games and sing with the other children. The glands gradually increased during the next six weeks, and threatened to break down. The left tonsil, in spite of treatment by carbolic swabbing, potassium chlorate, and ferric chloride, slowly changed its appearance from a follicular tonsilitis to a punched-out ulcer. At the beginning of February the throat began to be painful, and tablets of menthaform were substituted for the carbolic swabbing. The skin over the shoulders became scaly in the middle of February, and this condition spread in a couple of weeks to the whole trunk and, to a lesser extent, to the thighs, arms, neck, and face, leaving the hands, feet, and scalp unaffected. By the end of the month, while the scaly condition was extending, the parts first involved were showing more inflammatory changes, and a small amount of serous discharge appeared, and the scales were shed, leaving a raw surface. At the end of the first week of March the whole of the trunk had become raw, the conjunctivæ were involved, the gums and lips were also ulcerated, and the whole condition of the child was pitiable. The discharge had rapidly become purulent and offensive, but no local treatment seemed in any way to allay the symptoms. The temperature did not run very high, but it was of the septic type.