PART SECOND.

REVIEWS.

Some Account of the Epidemic of Scarlatina which prevailed in Dublin from 1834 to 1842 inclusive; with Observations. By Henry Kennedy, A.B., M.B., &c. 12mo, pp. 213. Dublin, 1843.

As the author remarks in his preface, it would be almost more correct to designate the disease which he describes endemic, than epidemic, as it prevailed in Dublin during the long period of eight years. The account, though it certainly is not quite so complete and satisfactory as it might have been made with a little more care, is yet good and valuable, being evidently drawn from a careful observation and study of nature. It is an important addition to what Dr Graves has said in his Clinical Medicine on the same subject.

In the first chapter, the author speaks of the disease under the two divisions of simply malignant, and complicated malignant. The pathology of each of these forms is discussed.

"The epidemic," says the author, "which it is my object to bring under notice in the following pages, may be classed under the head of the 'Scarlatina Maligna' of authors; not that every case puts on the malignant form, but because in proportion to those attacked, the number of deaths has been very considerable. The late one, however, differed from all others in this respect, that at one period or other of its progress, it presented the features of all of those of which we have any account. Thus, for example, the form of scarlatina which has been so ably discussed by Armstrong, under the name of 'Congestive Scarlet Fever,' came often before me, but then it formed a part, and only a part of the whole epidemic; and so, I believe, the whole series might be gone through. Hence what follows will not be an account of a form of scarlatina never before met with, but rather a sketch of most of the epidemics hitherto put on record." Pp. 1, 2.

The second chapter is devoted to the symptoms of the disease, and a detail of illustrative cases. The third chapter speaks of the diagnosis and prognosis; the fourth of the treatment; and the fifth of anaasarca, and other sequelae of the disease. There is subjoined in an appendix, a report by Dr Sym, of an epidemic of scarlatina which prevailed extensively in the county of Armagh during last year. It was of a milder nature than that which raged at the same time.
in Dublin; and it is Dr Kennedy's impression, "that should two epidemics exist at the same time, one in a large city, and the other in the country parts, and if equal numbers are attacked, the former one will turn out to be the severer of the two. The denser population of a city, the greater misery and want, and the well-known difference of the air between town and country, are probably sufficient reasons to account for this." P. 212. We believe that this remark may be correctly applied to all epidemics.

The following extract from the second chapter is a description of the

"Symptoms of the Epidemic.

"The invasion struck me as being remarkably sudden; a boy would feel well up to a certain period, not having made any complaint whatever, and then some feeling came on in an instant, and from this forward the disease progressed. When the attack commenced in this sudden way, the symptoms were commonly, though not always, referred to the stomach; while at a meal, nausea would be felt, or vomiting, so unexpected, that I have known it to take place at the very table. At other times, it was a feeling of sinking or a sense of faintness, the distress still being referred to the stomach, and the countenance showing it by becoming pale. Again, the head was the first part complained of, and then the patient described a feeling of reeling or dizziness. As showing, too, the suddenness of the attack, it may be mentioned that the patient would feel well enough to go to school in the morning, and yet in two or three hours would return with the disease on him. I have known, too, a lady and her daughter go to their place of worship—be there seized with nausea—leave it within a few minutes of each other, and come home, the girl passing through a mild attack of scarlatina, while the mother was affected with the sore throat of the disease. The attack in other instances came on under very different circumstances. I saw a young lady at a boarding-school, who had gone to bed making no complaint; in the morning, when sent for, I found her covered with the eruption of scarlatina, and also having well marked sore throat. One of the most remarkable cases, however, which came under my notice, was the following:—A large powerful man about thirty-five happened to fall into water; on being taken out he was seized with rigor and symptoms of collapse, and from that moment scarlatina declared itself. Again, the throat was the first part complained of, and here the attack was usually more gradual; even to this, however, there were exceptions, for I met cases where, though the first symptom was referred to the throat, others followed so rapidly on it, that it could scarcely be said to take the lead. In a few instances the sore throat was distinctly intermitting, that is, the patient complained for two or three nights of it, and then scarlatina appeared. Sometimes broken sleep was the precursor of the attack, and then the patient on awaking found his throat sore. In other instances the disease began by well marked mumps, the patient stating that he was unable to open the mouth. Four individuals of one family were thus attacked, one of whom only got scarlatina; it is right to state, however, that the other three had been removed from the house before they showed any sign of mumps. One point connected with the sore throat I would particularly mention, as it appears to me of importance; I have satisfied myself that a patient may have the ulcerated sore throat of the disease, and yet make no complaint of it; and indeed, from all I have observed, I am led to suppose that, though the earliest symptom may be referred to another place, as the stomach, still some affection of the throat has preceded it in the great majority of instances, and it may even be possible to announce some day or two beforehand, that a person is about to be attacked with scarlatina, from inspecting the state of the throat. On this last point, I would of course speak with reserve, for I have not yet had sufficient opportunities of confirming it. Such
then was the sudden way in which many of the cases of the late epidemic commenced, and I mention them the more particularly, because some of them were so slight as to be very capable indeed of throwing a person off his guard, Who, for instance, could suppose that a person would make some complaint of nausea while at a meal, and yet within eight hours the same person would be found labouring under a most serious attack of scarlatina? This was of common occurrence. Where indeed the attack was ushered in by sore throat or violent vomiting, the possibility of committing an oversight of this sort was of course taken away.

"Rapidly following the invasion of the attack, such as has been described, set in the stage of collapse. It was marked by the usual symptoms of this state—cold extremities, weak pulse, and sense of chill over the frame. This latter seldom amounted to the distinct rigor which so often precedes other diseases; it was more of a creeping or shuddering, and it often existed with a warm state of the surface. Its duration was very various. At times it could scarcely be said to exist, while again I have seen it continue through the whole disease; in this last class of cases it was sometimes broken, as it were, and it then showed itself by violent shudderings of not more than a moment's duration; and a most formidable symptom it then was. It sometimes happened that reaction never took place, and then of course collapse marked the attack from first to last. This occurred to the man I before alluded to, who fell into the water; he never rallied. It has been stated that distinct rigor at the very commencement of the disease was uncommon; as, however, it progressed, and in cases where there was about to be purulent effusion into the joints or elsewhere, there were but too many opportunities of seeing rigors marked to a degree which, I believe, no other disease presents. Sometimes but one was observed, while in other instances they were repeated, and ever of the most violent description; exceptions even to this rule have however come under my notice. The average duration of the stage of collapse, as far as came under my observation in the late epidemic, occupied a period of from two to five hours, after which, as reaction set in, all the more prominent symptoms of the disease made their appearance.

"Sore Throat.—This is a symptom which, in my experience, was never wanting; it varied of course in the degree of pain present, as well as in presenting a great variety of appearances to the eye, but I did not meet a single instance where the throat was entirely free from disease. It certainly is not conclusive evidence on this point, that the patient expresses himself as having no pain in his throat, because I have often found it sore when he made no complaint, even on being asked; this point should not be forgotten. The most common appearance of the throat was that with which all must be familiar—a very intense degree of redness of the internal fauces, accompanied by more or less swelling, including the tonsils, palate, uvula, and encroaching on the arches of the palate itself. On this latter part, the redness usually terminated by a well defined line, engaging probably about one inch forward from the uvula. One side of the throat was very constantly somewhat more implicated than the other, and the varieties to be observed were to be attributed rather to the different degrees of swelling, than to those of the redness. Thus, while the latter was constant, the swelling was sometimes so slight as to be scarcely appreciable; while in other instances, it was so great that the tonsils literally met, pushing the uvula as it were out of its place. I met these varieties in the mildest as well as the severest forms of the epidemic. The surface of the inflamed parts was either observed to be covered with a thick tenacious mucus, or else to be quite dry and glazed, the submucous glands on the roof of the mouth being then very prominent. In the cases where the inflammation was still more intense, lymph was effused either in patches, or else in one continuous sheet. In this state of the throat, many have observed that the appearances are extremely like those of ulceration, and that they have often been set down as such there can be no doubt. This sort of sore throat was quite distinct to the eye from that of diphtherite, which, while speaking of the pathology, I have stated I had met with during the late epidemic. This latter was of a much whiter colour, more continuous, and as far as I have seen, came much
farther forward into the mouth itself. It was rarely met with in comparison with the variety of sore throat just spoken of before it. In some instances, an aphthous sore throat came under my notice; and in one remarkable case, which there will be occasion to speak of again, the appearance was nearly entirely confined to the uvula. The rapidity with which some of these spots disappeared, and again made their appearance, was very remarkable. The uvula was either inflamed like the other parts, or else it was infiltrated with serum, under which circumstances it attained an unusual size, and was then often seen two or three times larger than natural, and commonly lying forward on the tongue; under these circumstances, it sometimes gave rise to a great deal of distress. Two instances came under notice, where blood was extravasated into its substance, like a spot of purpura. The free extremity of it was now, too, larger than the attached; and indeed, where fixed to the palate, it often gave the idea of being much constricted, an appearance which I have also seen mid-way between the two extremities. I am not aware of any transverse muscular fibres being described, which would account for this. In cases where lymph was effused, it was not unusual to see the uvula glued to one of the arches of the palate; and in one instance, it was so fixed as to be pointed directly forward, not however deriving any support from the tongue. This gave a very remarkable appearance to the parts. More or less ulceration accompanied these forms of sore throat, with the exception of those cases where diphtherite existed; here, when the false membrane was thrown off, there would most probably have been found nothing but abrasion. On this point I only speak from what I have seen in cases of simple diphtherite; for the scarlatina patients, with this complication, did not live long enough for this process to go on. The ulcers occupied the upper part of the tonsil, a point which has been before stated, and which I suppose may be attributed to the greater size of the gland in this part,—the half arches of the palate, implicating either the free edges and so reaching the uvula, or else being situated entirely on the anterior surface, being then, in fact, in the mouth itself,—the back of the pharynx,—the root of the tongue close to the epiglottis,—and lastly, the inner side of the cheek. They appeared always to be well defined, their surface being either covered with purulent matter, like any common ulcer, or in more severe cases by an ash-coloured slough; in some cases, which will be alluded to again, the sloughs were perfectly black; they varied from simple excoriations up to ulcers of probably four lines in depth, found in the tonsil. Their edges were usually raised, and of a darker colour than the inflamed parts around. It was not uncommon to see the sloughs thrown off and again renewed. In these cases, though this process was so far favourable, still it was observed that the parts around did not show a commensurate degree of improvement, but still kept up their angry and unhealthy appearance; hence, one could easily tell the cases where the sloughs would in all likelihood be renewed. Hämorrhage to a slight degree frequently occurred in these cases, both from the mouth and in the form of epistaxis. It sometimes appeared to result from the efforts made to clear the throat, while, again, it came on spontaneously. It appeared often to give relief. No case of this form of hemorrhage proved serious in my experience; one of great interest, and which was ultimately fatal, is, however, detailed by Dr Graves, and will be given farther on. One instance only came under my notice, where a sloughing sore formed on the inner side of the cheek. It was the size of a sixpence, covered with the usual sort of gray slough, and was exactly like the sores in the throat of the same patient. In the cases where little or no swelling existed, the appearances of inflammation were usually very slight; it was rather a state of congestion, and was accompanied more by excoriation than ulceration of the tonsil; in such, the whole throat was covered with a thin coating of dry and transparent mucus. Of all the cases of simple scarlatina which I saw during the late epidemic, these were probably the most fatal. This point appears to me worthy of notice, as showing what varieties may be met with in the progress of a disease so well characterized as scarlet fever, more particularly by the constant presence of sore throat; it also establishes the fact, that the disease may prove fatal, the throat at the same time being all but healthy,—a point to which Dr Graves has drawn particular
attention, while alluding to the epidemics described by Huxham and Fothergill, under the titles of ‘Ucerous’ and ‘Putrid Sore Throat.’ Where adults took sore throat from patients affected with scarlatina, little if any thing different from what has been stated already was observed. In two such cases, aphthae formed in considerable numbers. A child of eighteen months old affected three grown-up persons in the same house; one of these three presented the appearance of the aphthae, while the other two suffered from the common form of sore throat. In the second instance, a medical friend was inspecting the throat of a scarlatina patient, and was struck in a moment with the feeling of having caught sore throat himself; in four or five hours after, his throat became sore, and on inspection it was observed that the inflammation was confined nearly entirely to the uvula, on and in the neighbourhood of which a number of aphthae made their appearance in succession. With this exception, I never saw an adult affected with the sore throat alone of scarlatina, in which there was not much swelling and inflammation of the other parts. Through the kindness of my friend Surgeon Antisell, I saw two children, brother and sister, who were affected with the severest form of sore throat which came under my notice during the whole epidemic. It is right to premise that, except from the throat, there were no grounds for pronouncing these cases to have been connected with scarlatina; for we were unable to trace them to any infection, neither had any eruption been observed. Both cases were remarkable, too, for their duration, the longest and worst case occupying a period of eight weeks. When I first saw this case, it had already lasted five weeks, and this too under very judicious treatment. The throat was very much inflamed, and of a dark unhealthy colour; the anterior face of either arch of the palate was occupied by an irregularly shaped slough of a jet black colour; when these fell out, a probe could be passed through the openings into the pharynx; there was purulent discharge from one ear, excoriations about the angles of the mouth, and a very obstinate diarrhoea, all of which reduced the child to a living skeleton. This child ultimately did well. The sister of this patient was affected in a similar way, though not to such a degree: besides the discharge from the ear, an abscess formed under it, which was opened, and she also did well.

The pain which was felt in the throat varied as much as any thing else; sometimes it was very much complained of, the more so when there were appearances of acute inflammation present; at other times, the patient seemed to suffer but little; and it has been already stated, that some denied having sore throat at all, and this when, on inspection, ulceration was found. These differences must, in part, I think, be set down to the temperament of the individual, for they could not be accounted for by any varieties observed in the throat; in other instances, they were clearly traceable to another and much more serious cause. Little complaint was made, because by the severity of the attack the sensibility of the system was much deadened; in those cases where a state of congestion existed, little if any complaint was made—sometimes the sensibility of the throat subsided after the first or second day, the part however still remaining sore; while again, pain was complained of during the whole progress of the disease, and was not got rid of till all ulceration was healed. Great distress seemed often to arise from the accumulation of the secretions of the part, and the difficulty of getting these away; inability to swallow often arose from this very cause, for when they could be removed, the patient swallowed comparatively well. The cases of greatest suffering appeared to me to be those where, together with enlargement of the tonsils, the uvula was also much inflamed and enlarged, for it was often one without the other. It was in these instances more particularly, that the act of swallowing seemed to be next to impossible, and any fluid taken was forced through the nose with great force.

The duration of the sore throat is of considerable consequence, from inattention to which, I feel satisfied, a great deal of mischief has arisen. The truth is, in many cases of scarlatina it remains much longer ulcerated than what is commonly supposed, and hence infection is spread far and wide without the slightest suspicion. How long the throat is capable of conveying the disease, I do not of course take on me to determine; but I think it ex-
tremely likely, that as long as ulcers remain, a power of infecting remains also. It frequently happened during the late epidemic, that patients were brought to the Dispensary who had not fully recovered from the attack of scarlatina; they made no complaint of their throats, and yet on looking into them, I often found ulcers still remaining in the tonsils, at the end of three and four weeks; and in two cases, this was even found in the sixth week; one of these was labouring under anasarca. No doubt the ulcers were of small size, but the subject does not appear to me the less important on this account. Chronic enlargement of the tonsils and an unnatural redness of the throat I have found to remain an indefinite time in some cases.

"The Tongue."—This organ presented commonly the following state:—for the first two days of the attack it was covered with a whitish coat, varying somewhat in thickness; it was of the usual size and moist. On the third day, it was observed to have become red at the point and edges; and then it was, if at all, that the papille became prominent, so as to put on the characteristic appearance. I believe the impression is general, that the tongue of scarlatina is always well marked; as far as my experience went during the late epidemic, this was not the case. Repeated instances came under my notice, where from first to last there was nothing about it to lead to the idea that the disease existed. As has been already stated, this was particularly the case for the first two and sometimes even three days. Exceptions to this remark did come under my notice, but they were exceptions to a general rule. About the time the disease had reached its height, on the fourth or fifth day, it was not uncommon to find that the tongue suddenly threw off all its fur, and it then presented itself both morbidly red and clean, being what is called the beef-steak tongue; in this state I have seen its edges and tip covered with clear vesicles, precisely like sudamina on the skin; it now, too, gave the impression of being abraded; and in some instances, was still more decidedly so, as very painful fissures formed on it. In some cases, after this cleaning process had been gone through, the tongue suddenly became dry, glazed, and pointed, or else a fur formed on it for the second time; either of these states was a sure precursor of coming mischief. In others, again, it gradually became clean as in other diseases, or else it assumed the appearance of the tongue in typhus fever, being covered with a black crust, as were also the teeth and lips with sordes. In particular instances, I met with the tongue, as it were, divided into two parts, one half being dry and shrunk, while the other was moist and of the usual size. This is a point worthy of notice, because I observed that this dry state of one half of the organ preceded in some cases the swelling of the parotid region of the same side; in others, it went hand in hand with it. It is right to observe, however, that I have seen the same state of the tongue in typhus fever, where no parotid swelling followed.

"The Eye."—In the late epidemic, this organ assumed appearances which were most important to pay attention to. At one period or other, I was able to confirm all the remarks made on it by the older authors; thus, in almost all the cases where there was delirium, the sclerotic was more or less injected; this, when in a high degree, is totally different from the suffusion of the eye met with in typhus fever; the vessels are much more numerous, and run a straighter course. This appearance I was able to see at a very early period, by uncovering that part of the eyeball usually covered by the lid, a point long since observed by Fothergill; this state was remarkable too, for seldom, if ever, causing the patient any annoyance from the light; it was always a serious symptom, and in fatal cases went on increasing till the period of death. In these, the eye was literally glazed for some hours before death. With it was usually coupled a contracted pupil, and this to an extraordinary degree; most have probably met the same in some cases of fever. There was another state of the pupil which particularly caught my attention, and which has not been sufficiently noticed, if indeed at all. I mean where it was in constant motion; in the cases I allude to, it was incessantly flickering back and forwards, and this without any reference to the quantity of light falling on it; the iris, as it were, gave the impression that it was in a state of nervous tremor, sharing in this respect with the
nervous system in the same patients. I have not seen it when the eye was much injected. It was ever a serious symptom. In those instances where the disease either did not cause convulsions, or where they were about to occur, squinting often took place, and also a rapid oscillatory movement of the whole eyeball. It should be stated that in a few instances (four or five) which came under my notice, and where there were violent head symptoms, the eye was not injected at all. It is also worthy of remark, that in those cases where coma ensued, (and they were common enough,) the pupil was rather contracted than otherwise; it did not in fact give evidence of serous effusion taking place into the brain, as from the other symptoms might have been expected, and as occurs in the last stage of hydrocephalus. Connected with the eye, or, more correctly, with the face, I may state that swelling of the entire features was by no means uncommon: it was most evident at the onset of the attack, and in general showed a severe form of disease. The hands, too, were often swollen at this period.

"The Pulse.—As a general rule through the epidemic, the more rapid the pulse the more serious was the case, and the number of instances in which the pulse rose very high was, in proportion to those attacked, very great. To the first part of this remark, however, there were some very remarkable exceptions: thus, in some, who by the way were all females, the pulse kept up as high as 140 for three or four days, and yet they ultimately did well: while in others, it never ranged above 108 till the last day of life, and then only within three or four hours of death. Where there was nothing to complicate the case, I observed the pulse went through a series of phases, which it appears to me important to recognise, as they bore directly on the question of treatment; they are such indeed as one might be led to expect, though probably they have not been sufficiently noted. During the stage of collapse, the pulse was weak and indistinct; but in from eight to twelve hours it had again developed itself, and was then found ranging close to 120. Now, in the class of cases I allude to, while its beat was what has been just stated, or, at the very outside, 130, it was very remarkable how steadily it declined in strength from this period, till about the fourth day, when (supposing the patient did well) it again began to improve in tone and vigour, and then it was that its frequency lessened. Of course, in those cases where the pulse became more rapid, it also became weaker; but I am speaking of cases where its range did not vary six beats during the height of the attack, and yet its strength varied as I have stated. In those instances where the disease was more like a plague than scarlatina, that is, where there was little if any reaction, it at times happened that no pulse could be felt at the wrist for several hours before death; and even in a vessel like the carotid artery, it was more an undulation than a distinct pulse. Like what one meets with occasionally in other diseases, also came under my notice in some of the cases of scarlatina. I mean instances where from first to last the pulse did not exceed 80. As showing also the rapid progress of the disease, it may be mentioned that I have seen cases at the very onset, where the pulse was not above the natural standard, and yet at the end of six hours it had risen to 112.

"Eruption.—This prominent symptom of the disease received, of course, a good deal of attention, and presented many varieties. In its most intense form, it was in one continuous sheet of redness over the whole surface,—a point which has been particularly noticed by Dr. Graves. In other cases, it presented itself in great patches of a very bright colour, as large as one's hand would cover, but which were entirely separate one from the other. In both these forms, I met with instances where spots of purpura appeared subsequent to the general eruption: they were well defined—the size of the head of a large pin, and were most commonly seen in the inguinal regions: they were always on the red portion of the skin. The following way in which the eruption showed itself is well worthy of notice, because it ever went hand in hand with a very severe form of the disease. A case would occur in which the eruption of the common character had come fully out: it might or might not be favourable, but on the following day an additional crop would make its appearance: this was usually of a brighter colour, and much better defined than the first; and what was curious about it was, that this last eruption might disappear again,
leaving the skin only covered with the first. Something analogous to this came under my notice on the hands and feet: thus, at a time when the eruption was fully developed, it was not uncommon to see the extremities become perfectly livid, and again resume their natural appearance at the end of thirty-six or forty-eight hours. The appearance of a second crop of eruption came so often under my notice, that I was in the habit of looking expressly for it. I have seen precisely the same thing occur in some cases of petechial fever; and while alluding to this I may observe, that in very many cases the eruption of the epidemic could not by possibility be distinguished from the petechiae of typhus fever. Another form of eruption, which was often mixed up with the common one, was the miliary: it is alluded to by many of the older authors: in the cases I saw, it confined itself almost entirely to the lower part of the neck and front of the chest and hands; and, on close examination, was found to be owing to a vast number of minute vesicles filled with an opaque and milky fluid: it was met with three or four times in the groins. I do not recollect meeting this sort of eruption in any fatal cases. It prevailed more at one period of the epidemic than another, more particularly in the cases which I saw under the care of the late Dr John Crampton. Besides these miliary vesicles, which were of very small size, I saw one case where vesicles as large as a pea and surrounded by redness formed on the extremities: the common eruption of the disease was in this instance very partial. There was still another distinct form of eruption, which, however, I met with but rarely. It was precisely like the mark which the sting of a nettle produces, and was scattered here and there over the body.

"The extent of surface occupied by the eruption presented every variety, from the one continuous sheet of redness already spoken of, to the cases where there was literally none. Between these two extremes, the following came under my notice. Cases in which the eruption confined itself exclusively to the upper half of the body, including the face and scalp: others, again, where it was only to be seen about the flexures of the joints,—as the elbows and knees, or it might be, the wrists and upper surface of the feet. It has been already stated, that in many instances nothing but large dark petechiae were visible about the clavicles and inguinal regions, often running down the inner side of the lower limbs. Sometimes there was nothing in the shape of eruption but lividity of the hands, feet, and depending portions of the trunk. In many cases, where there was very little, the skin of the hands,—particularly where the nails join it,—assum ed a very peculiar red and shining aspect, and this without any swelling. These were all severe cases.

"The eruption often flitted about in a remarkable way. The following was not an uncommon sort of case to meet with:—A child, set. two years, was attacked with sore throat and very high fever: a warm bath was ordered, and half an hour after its use, patches of a bright red colour (three inches long by one and a half broad) appeared on the calf of each leg, and the corresponding portion of either arm. In the course of three hours these had all disappeared, but again became visible before the disease terminated in death, as it did too often in these cases.

"The period at which the eruption came out varied a good deal. In the great majority of cases, there was at least some appearance of it within the first twenty-four hours: sometimes it was to be found at the very onset of the attack, while at other times, two, three, and even four days elapsed before it became visible. This last case came under my notice only once.

"In the greater number of cases," the eruption occupied a period of from three to five days. No instance came under my notice of any eruption appearing subsequent to this period; cases of this sort have, however, been detailed by authors; among others, by Willan. The eruption I have seen at times remain as late as the seventh day. When it was on the decline, the whole surface assumed a very peculiar brown colour, much darker than the original eruption, and which, to a person seeing it for the first time, was very likely indeed to make the case be considered a serious one, when in reality it was not so. I was never able to trace any necessary connection between the extent or
intensity of the eruption and the subsequent desquamation. I can only say, that I met some cases where extensive desquamation was almost the first thing to point out the disease under which the patient had been labouring; while in others, who had barely escaped with their lives, nothing of the sort took place. The process in some instances occupied a month; that is, it was repeated so often as to fill up this period.

"In alluding to cases of scarlatina, where there was no eruption whatever, I, of course, exclude adults, who were merely affected with the sore throat from children in the house. Instances, however, did, I know, occur in children and young persons, where there was every reason to have had eruption, and yet none made its appearance. One such came under my own notice. I was brought to a wretched room, where a mother and her daughter lay in the same bed, both seriously ill of scarlatina. A child, aged two years, was lying in a cradle: on looking more closely at it, I found it was in a state of profound coma, which was broken every now and then by convulsive fits of one side of the body. The father, who seemed an intelligent man, assured me the child had been quite well the previous day, and that there had been no appearance of any eruption; neither was there any when I saw it. I would most probably have set down this case to some other disease than scarlatina, had it not been that I found the parotid regions very much swelled, precisely the same as in other cases where there was no doubt of the nature of the disease. It may be mentioned, that cases of this sort were met with by others, where there was not the slightest suspicion of what the nature of the disease really was, and where one, and even two children, were so carried off: the obscurity, however, which hung over them was cleared up, when a third child in the same family was attacked with all the symptoms of scarlatina in a well marked form. The possibility of such cases as these being met with should be borne in mind, for otherwise very serious mistakes might occur. In all these instances, the fever was of the most formidable nature from the very onset of the attack, and the child was carried off in an incredibly short time.

"Age of Patient.—In my own experience, the disease was met with at every age between seventeen months and forty-one years. It has often been stated by others, and the fact is certainly a very curious one, that children under sixteen months are seldom if ever attacked with scarlatina, and I believe this is more certainly the case, if the children be suckled for a longer period than what is natural. In this city, the children of the poor are seldom weaned sooner than from fifteen to twenty months. It can scarcely be supposed that the period of infancy is insusceptible of the poison; and the only possible reason which strikes me, as being in part capable of explaining the fact, is that the child is kept so much at the breast, that it cannot inhale the poison of the disease, and that as it cannot yet run about and be in this way in contact with other children, it may so escape. One child only, while still at the breast, have I seen labouring under scarlatina: there was nothing remarkable about the case, except that three adults in the same house appeared to take sore throat from it, the mother being one. The disease repeatedly came under my notice in persons between thirty and forty years of age; and in two instances, the age was above forty. The effects of contagion were but too often seen, and very rarely indeed was but one member of the family alone attacked. In the instance, however, before alluded to, of the young lady at the boarding school, who was found with the disease fully out on her, without any premonitory symptoms, no other individual in the house was affected. The most remarkable case connected with contagion, which came under notice during the epidemic, was the following. I am indebted to the kindness of Dr John Ferguson for being able to give the details. One of the deputy nurses in Sir Patrick Dun's hospital was turning a patient affected with scarlatina in the bed, when she was suddenly seized with what she described as a bad smell and some sickness of stomach: from this moment she showed the symptoms of fever, which persisted for ten days, and then declined: the curious point about the case, however, was this,—that no symptom whatever of scarlatina appeared: I examined the throat several times, but it remained healthy. The patient had had scarlatina before. As far as one case goes, it
shows that the poison of scarlet fever may develop simple fever in a healthy individual who has gone through scarlatina before. It also shows strongly the protective power of the disease against a second attack; and I may mention here, that no instance of secondary scarlatina has come within my experience. It was from this same hospital-patient that a medical friend took sore throat, which has been before spoken of. The impression is strong in my mind, though there be no positive proof of it, that certain cases of scarlatina and other contagious diseases are much more capable of communicating contagion than others of the same class.

"Vomiting and Bowel Complaint."—These were among the most prominent symptoms of the whole epidemic. Very few indeed were the serious cases, in which one or other or both of these did not make their appearance at some period of the disease: at times, ushering in the attack; and again, appearing on the last day of life. The matter thrown up was most commonly bilious and of a light yellow colour, the quantity being very great: it was sometimes, however, of a greenish colour, even approaching black; and it was of importance to make this distinction, for in my experience these latter cases were always more severe than the former. A similar remark applied to the discharges from the bowels: the more they differed from what was natural, as a general rule, the more serious the case was. The discharges were often tinged with blood, while in some few, it was in such quantity as to constitute a haemorrhage. These last were all most serious cases.

"Neuralgic Pains."—These, including headach, were frequently prominent symptoms of the epidemic. They were chiefly referred to the small of the back and the lower limbs, were often of a rheumatic character, and were complained of more by adults than by children. The suffering from them was at times very great. They commonly ushered in the attack, while again they were only complained of, previous to some serious sequela making its appearance. On this latter account they required particular attention.

"Type of the Fever."—Taken as a whole, the fever divided itself into two great classes, one of which might be termed the irritative, and the other the typhoid. Any exceptions to this rule were cases in which the fever was of the inflammatory type; but even these were very rarely indeed of a true sthenic nature. In many cases, the fever was irritative all through the disease; in others, the commencement of the attack was of this kind of fever, subsequently however, becoming typhoid. By irritative fever, I mean where the pulse ranged from 120 to 140; where it was very easily excited, as by the movements of the patient; where its beat was quick under the finger; and where, though it appeared full, the mildest antiphlogistic treatment was at once capable of affecting it; where the tongue continued moist, and the gums and lips without sordes; where all medicines produced an undue effect, as for instance, an emollient enema causing a severe diarrhoea; and where the sensibility of the patient, both as to being touched and as to temperature, was exceedingly great. It was truly an irritable fever, as was indeed also proved by the effects of treatment, and was distinguished from the typhoid, by the different state of the mouth,—by the absence of marked prostration and nervous symptoms, as subsultus, and by there being nothing of stupor present." Pp. 31-61.

Lectures on the Theory and Practice of Midwifery. By Robert Lee, M.D., F.R.S., &c. 8vo. pp. 559. London, 1844.

This work contains forty-four lectures, delivered by Dr Lee, in St George's Hospital, London, during the session 1842–3. They were originally reported in the London Medical Gazette, and have now been revised and reprinted, as the author informs us, in accordance
with a strongly expressed desire on the part of many practitioners and students to possess them in a separate form. That he has cordially responded to this desire is to us no matter of regret, not that we consider a work of the kind imperatively wanted, but because we are glad to have collected together, in one entire work, the many valuable contributions to the science and practice of midwifery, which Dr Lee has made, in an extensive range of observation, during a practice of many years, and which have hitherto been scattered among the several medical periodicals.

The nature of these lectures, including, as they do, such a variety of topics, prevents us giving a lengthened analysis of the several subjects discussed; and, therefore, we will chiefly limit our observations to a brief exposition of the author's practice and opinions, instead of burthening our commentary by lengthened details of our own.

The first 150 pages are devoted to anatomy—230 to the subject of parturition—and 110 to puerperal diseases, of which no less than 100 are occupied with uterine inflammations alone.

Passing over the first three lectures, which are devoted to a description of the anatomy and pathology of the bones, the articulations of the pelvis, and the anatomy of the unimpregnated uterus and its appendages, we come to lecture fourth, which treats of menstruation. A considerable portion of this discourse is taken up with a review of the statements of those writers who maintain that females commence menstruating earlier in hot than in temperate and very cold countries. This view has been adopted by almost every physiologist who has written upon the subject, but Dr Lee is disposed to agree with Mr Roberton of Manchester, who has published several very elaborate papers, which contain numerous facts tending to prove that in this country, the natural period of puberty in women occurs in a much more extended range of ages, and is more equally distributed throughout that range than authors have alleged; and that in other countries, the parallel attempted to be established between the process of vegetation and the female constitution, does not hold good. Dr Lee, however, considers it right to state that "some gentlemen who have resided many years in the East Indies, the Brazils, and on the coast of Africa, with whom he has conversed on the subject, and who have had good opportunities for observation, are of a contrary opinion, and still firmly believe that the period of puberty is earlier between the tropics than in Europe, but as none of them investigated the subject with the requisite care, he thinks their evidence can have little weight when contrasted with the great mass of facts adduced to support the opposite view." (See page 38). In corroboration of the opinions entertained by Dr Lee, we may mention that we have for some years past instituted careful researches into the menstrual condition of girls occupied for twelve hours every day in the heated apartments

1 Monthly Journal for 1842, pp. 712, and 767.
of mills and factories, which have satisfied us, that there is no foundation in fact for the assertion, that the period of the first menstruation in them is earlier than in others occupied in out-door employments. The important observations of Brièrre de Boismont and Raciborski on this and other points are not once alluded to by Dr. Lee. The author next goes on to combat some of the generally acknowledged theories of menstruation, and concludes by stating, that "the determination of blood to the uterine system, which takes place every month, and all the phenomena of menstruation, depend upon the ovaria; and that at each period a Graafian vesicle bursts, and its contents escape." (See page 40.) In support of this statement he refers to cases, in which, from the absence of the ovaria, whether congenital or otherwise, no attempt at the menstrual evacuation occurred, contrasting them with others wherein these organs existed, and the uterus was wanting, and yet in which violent pains, and all the other symptoms of menstruation, except the actual discharge, manifested themselves every month. The most convincing proofs adduced by Dr. Lee, of the phenomena of menstruation being dependant upon the causes specified, are to be found in the recital of six cases in which he was afforded an opportunity of seeing the parts of females who had died whilst menstruating. The first of these was seen so far back as 1831. We are thus particular in the date because certain Frenchmen are greedily contending for priority in a discovery which is more justly due to Drs. Power and Girdwood. In all the six cases enumerated by Dr. Lee, a ruptured opening in the peritoneal coat of one of the ovaria was observed, which led either to a Graafian vesicle on the point of bursting, or to a cavity which lately held the contents of one. Since the publication of these observations, Gendrin, Negrier, Jones, and others, have witnessed similar appearances. Indeed so far back as the year 1797, Dr. Cruikshanks observed the same phenomenon, but, as Dr. Lee remarks, there is no observation made in Dr. Cruikshanks' paper from which it can be inferred that he supposed all the circumstances of menstruation to depend upon the state of the ovaria, and therefore, although we must give Cruikshanks the merit of being the first who observed the fact, we cannot withhold from Drs. Girdwood and Power the credit of being the first who propounded the theory of menstruation being dependant upon the periodical development, maturation, and bursting of a vesicle in the ovary, whereby a sanguineous flux is determined to the genital organs. We are of opinion that the facts adduced by Dr. Lee in support of this theory, if sanctioned by the observations and concurring testimony of other equally respectable authorities, will not only render it the most plausible and satisfactory theory which has hitherto been brought forward on the subject, but will go far to render it incontrovertible.

1 Vide Lancet, vol. i. for 1842-3, p. 825.
Lecture 5th is occupied with an interesting description of the mode observed by nature in the formation of corpora lutea, which description differs from that given by Baer, Montgomery, Paterson, and Barry, the first of whom contends, that these bodies are formed from a thickening of the inner membrane of the Graafian vesicle; the two succeeding maintain, that they are new formations between its inner and outer membrane; and the latter, that they are produced by a development of the outer layer alone. Dr Lee, on the contrary, considers them to be formed from a deposition of yellow granular matter, in immediate contact with the stroma of the ovary, and, of course, outside both coats of the vesicle. To use his own language, "the corpus luteum is nothing but the empty Graafian vesicle, which contained the ovum, surrounded by a layer of yellow granular substance, which is formed subsequently to impregnation. The two coats of the Graafian vesicle are always enclosed within the yellow substance, and they can be separated from one another, and their existence as two distinct membranes as clearly demonstrated as the amnion and the chorion," (see page 48). This language is certainly strong, but we give the description without comment, as our own observations have not been sufficiently minute to enable us either to confirm or refute it.

The next lecture, or rather lectures, we would notice, contain an ample discussion on the mode of origin of the membrana decidua: in these, the author strongly condemns the opinion commonly entertained, that this membrane is formed in the uterine cavity prior to the ovum reaching it. This opinion rests mainly upon the statements of those who maintain, that the decidua is always found lining the uterus, even in cases of extra-uterine conception. Dr Lee, however, relates two cases, and refers to others, where no such structure was found. In one of the former he admits, that a layer of yellowish-white substance, resembling common adipose matter or lard, was observed, but which bore no resemblance whatever to deciduous membrane. From the facts Dr Lee has brought forward, we are inclined to conclude with him, "that the decidua is not invariably, if ever, formed within the uterus, in cases of extra-uterine gestation, and that if it were so, further evidence would still be required, to prove, that an organised membrane always lines the uterus, like a shut sao before the ovum enters its cavity after common impregnation," (see page 62.) Our readers will now be prepared for the only rational conclusion which Dr Lee deems deducible from these premises, viz., that the decidua reflexa cannot be formed, as is generally supposed, by a mechanical pushing forwards of the decidua vera, when the ovum reaches the uterine extremity of the Fallopian tube. After describing the decidua, Dr Lee proposes an entirely new doctrine, regarding the circulation in the appendages of the early ovum. It is evidently grounded on the curious fallacy, that he has mistaken for blood-vessels, the mucous ducts shown by Sharpey, Montgomery, and others, to exist in the interior of the
decidua vera. Had the author been aware of Dr Sharpey's beautiful investigations into the structure of the decidua, he could not have fallen into this strange error.

Lectures 13th and 14th are devoted to the consideration of the placentas, and contain a very precise and excellent account of its structure. In lecture 14th, Dr Lee candidly confesses that his paper in the Philosophical Transactions of 1832, gives an entirely erroneous account of the utero-placental circulation.

The eleventh lecture contains a description of the nerves of the uterus. This is a subject which, for some time past, has occupied a considerable portion of the author's attention, and has excited no little public discussion. Some of the most eminent physiologists of the day have examined Dr Lee's dissections, and have borne testimony to their accuracy. Few, therefore, we are inclined to think, can now hesitate in awarding to him the honour of having, (with Moreau, &c.,) displayed the nervous system of the uterus—in showing its continuity with the spermatic, hypogastric, and spinal nerves, and in demonstrating the important fact, "that there are many ganglia formed on the uterine nerves, and on those of the vagina and bladder, which enlarge with the coats, blood-vessels, nerves, and absorbents of the uterus, during pregnancy, and which return after parturition to their original condition before conception took place." (See page 107.)

Our limits oblige us thus briefly to pass over these and other subjects, treated in an equally graphic and scientific manner, until we come to lecture twenty-first, which we think contains matter of greater practical import. The author here adopts Denman's classification, which we agree with him in thinking the very best for all practical purposes which has yet been proposed. He then goes on to describe the symptoms and treatment of natural labour, and the practice that ought to be observed after delivery has taken place. These descriptions are so perspicuous and concise, and the practical rules so sensible and comprehensive, that we will merely commend them to our readers, as being among the best extant. In the succeeding lecture, the subject of difficult and protracted labours is treated with very considerable ability. The causes of protraction are reduced to seven. We are not of those who would multiply causes unnecessarily; but we cannot help thinking there are some omitted by the author, which occur with equal, if not greater frequency, than others which he has assigned; for example, under the head of feeble, irregular, or partial uterine action, no notice is taken of that condition which has been so ably described by Dr Wilson of Glasgow,¹ in the third volume of the Glasgow Medical Journal, and which Dr Rigby, in his admirable contribution to Tweedie's Library of Medicine, denominates "stricture of the uterus." This condition has also been recognised by Dr Burns, as a very frequent cause of protracted labour. The following case from Dr Wilson's paper demonstrates

¹ Referred to by Mr Stewart in his paper in this Number.
the existence, and establishes the importance of being acquainted with such a state of the uterus:—"Mrs T. had been in severe labour for two days, at length the head reached the perineum, where it remained for several hours; the pains were severe and irregular. The surgeon in attendance having left the house for a little, the woman was suddenly seized, during his absence, with a violent pain, and expired in a few minutes without any convulsion. On the return of the surgeon, the head was found to have descended a little during the last pain. No attempts were made to extract the child. The uterus was supposed, in this case, to have given way; but on inspecting the body, the uterus was found quite entire, and there were no appearances to account for the death, except a very firm contraction of the uterus, about its middle, which grasped the body of the child very powerfully. The head of the child had been expelled from the uterus, and the neck was firmly grasped by the os uteri, thus forming a double contraction, which had the woman survived, might have resisted for a long time the process of expulsion." The symptoms of this condition, as related by Rigby, are such as we have on several occasions recognised. He says,—"In cases of this kind we find, that although the uterus contracts, the child does not advance, but rather retracts, during a pain; the contractions are never general, but partial, and even where they are general, the fundus does not attain its due preponderance over the os uteri, so that the one contracts as much as the other does; in severe cases also, the uterus continues in a state of spasmodic action during the intervals of the pains: this is frequently accompanied with a painful and harassing sensation of tension and stretching, very different to that produced by the action of regular pains upon the os uteri; and, in the worst cases, we occasionally observe a peculiar state of the brain, which manifests itself by attacks of insensibility, faintings, or even convulsions." We repeat, that we have several times recognised the preceding symptoms depending evidently upon the cause specified, and have, moreover, derived advantage under such circumstances, from venesection, and from the administration of enemetic opiates, and such other remedial measures as are usually resorted to for the removal of spasm; consequently, we are disappointed in not finding any notice taken by the learned author, of such a serious, and by no means obscure cause of protracted labour.

Regarding the employment of secale cornutum, in cases of feeble uterine action, we are glad to find Dr Lee's opinions and experience in perfect unison with our own. He says,—

"As it is impossible to determine, in many cases, the precise cause of the difficulty in protracted labour—to be sure that the restrained uterine contractions do not depend on some unusual condition of the contents of the uterus, and that the life of the child may not be destroyed by its use, I have never ventured, either in public or private practice, except in cases of accidental uterine hemorrhage, and retained placenta, to administer the ergot of rye to a woman in labour; and I am satisfied, that no individual under my care has suffered from the want of it." P. 235.
Such are exactly our own sentiments. We are strongly persuaded, that ergot has been, and still is too indiscriminately used, and that the amount of mischief caused by it is quite incalculable. We have seen cases in which the strictured condition of the uterus just alluded to, could not consistently be attributed to any other cause than the injudicious administration of this drug. We have also seen cases, in which its exhibition lessened the frequency of the mother's pulse, and produced vertigo and delirium, in addition to its pernicious influence upon the foetus in utero; we say, pernicious influence, for we are by no means satisfied that the death of infants, so often noticed after the use of this drug, and causing it to be nick-named the *pulvis ad mortem*, is solely attributable to the continuous and spasmodic uterine contractions sometimes excited by it. In one of our own cases we had reason to think that the child had suffered from its poisonous influence, although the action of the uterus had not been perceptibly increased.

Regarding protraction of the first stage of labour, the author is of opinion, that the rule laid down by Hamilton and Burns, for having it completed in a given time from the commencement of regular pains, is not in accordance with the indications of nature; yet he does not go the length of others in condemning all interference with the os uteri, under almost any circumstances:

"If the first stage of labour, without rigidity of the os uteri, be greatly protracted, it is often of advantage to rupture the membranes, before it is fully dilated, to raise the head that the liquor amnii may entirely escape, and to make gentle pressure with the finger around the margin of the os uteri, during the pains, or to press up the anterior lip where it remains down between the head or symphisis pubis, and when the posterior lip has disappeared. Even in first labours where there has been danger of exhaustion, I have adopted this practice in some cases, with decided advantage." P. 235.

Our opinion of this practice is sufficiently expressed, by stating that we have frequently adopted it, and have never regretted so doing.

To return to the causes of protracted labour, from which we have just digressed, we would now notice that of malposition of the fetal head. The most simple form of this is where the forehead is inclined towards the pubis. The author quotes the opinions of Smelie, Denman, Clark, Merriman, and Ramsbotham, on the treatment of such cases, and ends with his own in the following words: "I am disposed to believe, that it is best to leave them to the natural efforts, and to avoid all interference,—all attempts to change the position, while the pains continue regular, and the labour advances, however slowly. If exhaustion should take place, it will then become necessary to deliver artificially, in the manner which will afterwards be described," (page 256,) that is, with the forceps or perforator. In connection with this point, it appears strange to us that the author should have occupied so much space rehearsing so many all but obsolete opinions and modes of practice, and should
at the same time have entirely omitted to mention the more modern and extremely valuable observations of Nægêlê, Stoltz, Dubois, Murphy, and others, upon the mechanism of this kind of presentation. The great advancement which midwifery has made within the last fifty years, is assuredly principally due to the greater knowledge which has been acquired during that time, of the proper mechanism of the different forms of natural and morbid parturition. In no part of these lectures does Dr Lee exhibit an acquaintance with the new and more correct views that are being adopted in all the principal obstetrical schools, both here and abroad, upon these matters. Believing, as we do, that the true doctrines of the mechanism of parturition are calculated to form in future the only sure basis for a scientific midwifery, we cannot but regard the want of them in Dr Lee’s work as a grievous desideratum.

Take, as an illustration, the case in question—the mechanism and treatment of head presentations with the forehead inclined towards the pubes. Such presentations were, not many years ago, described as exceedingly rare; they are now acknowledged by all careful and competent observers, to be exceedingly common, so common, say some, as once in every four or five labours. Dr Lee speaks of the “exigencies of the case,” and classes it amongst his protracted and difficult labours! Nægêlê has shown that it requires no unusual proportions on the part of the mother and child, and usually proceeds without greater difficulty than, and quite as successfully as, cases in which the occiput presents towards the pubis. Dr Lee states, that if the head and pelvis are of the usual dimensions, in most cases of this presentation, the forehead emerges under the pubis: Nægêlê and others, on the contrary, have fully demonstrated that in twenty-nine cases out of thirty, the head, in this form of labour, turns during its passage, so that the occiput emerges under the pubis. Dr Lee quotes the authorities of Smellie, Clarke, Burns, &c., for turning the head artificially in most cases of this kind; we now know that, in the majority of such cases, nature turns the head for us, and much more safely than the accoucheur. If forceps are required in this presentation, Dr Lee would seem to advise us to bring the forehead and face out under the symphysis pubis. We would certainly succeed often if we follow the more perfect midwifery of nature, and bring the occiput out under the symphysis pubis.

The next form of head malposition described, is that in which the face presents. Two varieties are specified, “the mouth may be either under the symphysis pubis, with the vertex occupying the hollow of the sacrum, or it may be situated close to the lower end of the sacrum and coccyx, with the vertex behind the symphysis pubis. The first of these positions is considered the most frequent and favourable, but the head, in a great proportion of cases, whether it be situated in this or in the second position, is expelled by the natural efforts, though a longer period than usual be required for the labour.” (See page 257.) If it is to be inferred from this
that the head of a child at the full time, of natural dimensions, can emerge from the outlet of a pelvis, with the forehead rising up behind the pubic symphysis, and the chin sweeping over the distended perineum, then we have no hesitation in stating that the thing is not only at variance with the observations of the most experienced accoucheurs, but that it is also physically impossible. No author, excepting Smellie, as far as we know, has ventured to assert that he had seen the face expelled from the pelvic outlet in any other way than with the chin under the pubis; and even in his case the child, as represented in his twenty-sixth plate, is evidently premature, and might consequently have been born in almost any position. If Dr Lee had reflected for a moment upon the measurements of the full grown fetal head, from the summit to the base, and of the thorax from the sternum to the spine, and had contrasted these with the sacro-pubic diameter of the pelvic brim, in which both the former must, according to Smellie's delineation, be at one period of the labour engaged, he would not, in our opinion, have fallen into the error which he appears to have committed.

The practice in face cases affords a curious chapter in the history of midwifery. As in other parts of his lectures, Dr Lee here confines himself principally to the literature of the subject, so far as it is given in the notes collected in Dr Merriman's Synopsis. Some have considered artificial interference, in one form or another, indispensable in these presentations. Portal long ago showed it to be unnecessary; and since his time, Zellar, Boer, La Chapelle, Chevreuil, Collins, Caseaux, Rigby, &c., have confirmed his views. Our author writes in similar terms; he says,—

"The head, in a great proportion of cases in which the face presents, passes through the pelvis without artificial assistance, and no unpleasant consequence is produced, except a swollen state of the child's face, from the long-continued pressure, but which soon disappears; and, again, my firm belief is, that the child would have a far better chance to be born alive, if the labour were left wholly to nature, and if the natural powers were inadequate, to extract it with the forceps;" (see page 257).

Another cause of protracted labour described, is an anchylosed condition of the coccyx. This has been often mentioned as a cause, but we confess that our experience has never yet furnished us with an example. Dr Lee, however, relates one "in which the forehead of the child rested on the point of the sacrum and coccyx for many hours, and the head was indented by the sharp point of the coccyx, and the skin abraded. The birth was ultimately accomplished by the forceps," (see page 275).

Lectures 27th and 28th are devoted to a consideration of the forceps. Dr Lee states, that in every case he considers it necessary to ascertain exactly the position of the head, before passing the first blade of the forceps. In doing this he states, "I would recommend you to pass all the fingers completely over the side of the head;" and again, "pass the four fingers of the right hand completely over the side of the head and ears." We are ready to
maintain, that no tyro, acquainted with the doctrines of the mechanism of parturition, and the modes of presentation of the head, should require to put the mother to such unnecessary agony and danger, as this strange recommendation implies. After this statement of Dr Lee, we cannot wonder, as we at first did, that he should use at the present day forceps "covered with leather," (p. 300), because, if all the fingers can be introduced, an instrument a quarter of an inch thick could be used. We think it superfluous to inquire whether such cases should be really forceps cases or not. Surely this is retrogression in practical midwifery! "The first principles," says Dr Lee, "of operative midwifery are not generally understood, and there is no other branch of surgery at the present time in such a rude condition," (p. 273). We cordially assent to the justice of Dr Lee's remark.

We have been astonished at nowhere finding Dr Lee taking advantage of auscultation, in relation to the diagnosis and management of morbid labours. We are sorry to find such an important adjunct totally disregarded. Most practitioners now know its great value in making them aware of the degree of danger which the child incurs during a tedious labour. Dr Lee seems to be conversant with the important fact, that if the foetal pulsations become gradually more feeble, and, as he should have added, slower, the birth of the child ought to be hastened by the forceps, if there is no counter indication. Dr Lee seems occasionally to make himself assured of the strength and rate of the foetal pulsations, not by applying his (stethoscope, as most other people do,) to the external surface of the abdomen, but by actually thrusting his fingers into the uterine cavity itself. Thus, after some remarks upon the exploded doctrine of the shortness of the umbilical cord hindering the birth of the child's head, he advises "two fingers, or the whole hand," to be passed up, in order to feel the cord surrounding the neck. "In a case," he adds, "of tedious labour which I lately saw, with Mr Russel of Broad Street, I declined at first employing the forceps, because the cord was around the neck, and was pulsating vigorously, and the mother was not exhausted; but after some hours, the pulsations in the cord had become extremely weak, and the child would probably have been destroyed in a short time had we not interfered. The blades of the forceps were easily applied, and the child was soon extracted alive and uninjured," (p. 247.)

We have not space for further remarks upon the causes of protracted labour, and therefore pass on to the end of lecture 29th, where will be found a highly interesting tabular view of 127 cases, in which the author performed the operation of craniotomy. It shows at a glance the causes of the difficult labour, its duration, and the results to the mother. In addition to the great experi-

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1 Monthly Journal for 1843, p. 55. Vide Review of Lee's Clinical Midwifery, where cases illustrating this and other subjects are quoted.
ence which this table shows Dr Lee to have had in perforating children's heads, (an operation which we do not wish to insinuate he has ever performed without just cause), it also shows the immense extent of his general obstetric experience; for in Britain, according to Dr Churchill, this operation is performed but once in every 219 cases; so that estimating our author's experience by such a standard, his cases should amount to the enormous number of 27,813. As these figures are startling in appearance, we are charitably inclined to conclude, that his metropolitan friends have such a high opinion of his perforating dexterity, that they call him in to all their craniotomy cases. We observe many other tables of a kind similar to the above scattered throughout the work; and these constitute not the least interesting and valuable portion of it. Their value would, however, have been much heightened, had Dr Lee given the sum total of his cases, so that his readers might have estimated the relative frequency with which he met with difficult and dangerous ones.

This article having extended beyond our original intention, we are obliged to pass over preternatural and complex labours, and to confine our few remaining observations to one of the diseases of puerperal women, termed phlegmasia dolens. Upon this disease, Dr Lee has written largely; and, having adopted the opinion of the late Dr Davis, has propounded views which have been followed by the majority of the profession. In accordance with these views, he has taken it upon him to alter the name by which the disease is generally recognised, and to term it crural phlebitis; for he considers that he has demonstrated not only,—

"That inflammation of the iliac and femoral veins gives rise to all the phenomena of phlegmasia dolens, but that in puerperal women it originates in the uterine branches of the hypogastric veins, and subsequently extends from them into the iliac and femoral trunks of the affected side." P. 526.

Now, though we are satisfied, from the cases and dissections brought forward by Dr Lee, that in the majority of instances, (and probably in all the fatal instances,) the veins are inflamed; yet, we think, that he should not have overlooked the fact, that there are many eminent practitioners of the present day, who consider the disease to be an affection of the lymphatic vessels, accompanied or not, as may be, with crural phlebitis. Dr Rigby, who advocates this theory, relates what he considers an undoubted case of the disease, wherein the veins were not inflamed; and he gives it as his decided opinion, "that in phlegmasia dolens the lymphatic circulation of the swollen limb has been obstructed by inflammation, or obliteration of the main lymphatic trunks leading from it. To call this disease crural phlebitis, because in a case where the crural vein has been inflamed, the inflammation has spread to the surrounding fascia, or cellular tissue, is manifestly incorrect, and tends to confound two diseases together which are of a very different character. From the situation of the crural vein, as it
emerges upon the anterior and upper part of the thigh, and the cribriform appearance of the inner side of the femoral sheath and of the cellular tissue, which fills up the opening in the fascia lata at this part, owing to the numerous lymphatic trunks by which it is perforated, it would be nearly impossible that these structures should escape being inflamed whenever the attack of crural phlebitis is at all severe; and shows, that although, as we have stated, phlegmasia dolens may occur without crural phlebitis, it is very questionable whether crural phlebitis can exist to any extent without phlegmasia dolens.” Seeing that such opinions as the preceding are entertained by several high authorities, and that they are to a certain extent supported by the fact, that phlebitis is a very fatal disease, while phlegmasia dolens is not; we are of opinion that the change in nomenclature which Dr. Lee wishes to introduce, is, to say the least of it, impolitic, if not premature.

We might point out some redundancies throughout this work, which could have been advantageously omitted, and object to the novel use of words to express ideas and conditions at variance with their recognised application in medical literature; but we do not wish to appear hypercritical in matters of so little practical moment; on the contrary, our object has been to give to our readers a fair report of, and commentary on, the views and experience of the author. These, generally speaking, are much in accordance with our own; and from the clinical character of the work, and its including a vast amount of illustrative cases, we think it fully as well adapted for a book of reference to the practitioner, as for an elementary work on midwifery for the student.

Manual of Diseases of the Skin. From the French of MM. Cazenave and Schedel, with Notes and Additions by Thomas H. Burgess, M.D., Surgeon to the Blenheim Street Dispensary for Diseases of the Skin, &c. 12mo, pp. 320. London, 1842.

We recommended this work to the favourable notice of our readers upon its first appearance in English, and we would now, in transferring to our pages some of the valuable information which it contains, heartily renew our praises. Taking the volume all in all, it is the best manual of skin diseases with which we are acquainted, not only in our own, but in any other language. Dr. Burgess has ably executed his part of the performance—the version being always smooth and accurate, and his additions to the text, short and judicious. The whole of the article on “Glanders and Farcy” is well supplied by the editor. With this exception, the supplementary portions are very brief, and do not call for special notice.

The method of classification adopted by Cazenave and Schedel is that of Willan, as modified and improved by Biett, the celebrated
physician of St Louis, of whose doctrines and practice it may be remarked, that the work before us is the only record. The natural history arrangement of skin diseases has, we admit, its importance in systematic Pathology, but for an initiatory text-book, or as a guide in practice, that subjoined is by far the most suitable. The diseases are arranged according to their elementary characters; some which could not be comprised within the eight principal orders, being arranged under distinct heads.

**"Cutaneous Diseases."**

**Order I. Exanthemata.**—Erythema; erysipelas; roseola; rubeola; scarlatina; urticaria.

**Order II. Vesiculae.**—Miliaria; varicella; eczema; herpes; scabies.

**Order III. Bulle.**—Pemphigus; rupia.

**Order IV. Pustulae.**—Variola; vaccinia; ectyma; impetigo; acne; mentagra; porrigio; equina or glanders.

**Order V. Papulae.**—Lichen; prurigo.

**Order VI. Squamae.**—Lepra; psoriasis; pytiriasis; icthyosis.

**Order VII. Tubercula.**—Elephantiasis Grecorum; molluscum; frambesia.

**Order VIII. Maculae.**—Colorationes. Fuscedo cutis; ephelides; navi.—Decolorationes. Albinismus; vitiligo.

**Order IX. Lupus.**

**Order X. Pellagra.**

**Order XI. Malum Alepporum.**

**Order XII. Syphilida.**

**Order XIII. Purpura.**

**Order XIV. Elephantiasis Arabica.**

**Order XV. Cheloidea.**

"From the preceding table it may be seen that cutaneous disorders are capable of being reduced to a certain number of elementary lesions; the latter exist constantly in all eruptions classed under each order, and may be discovered at all periods of the disease, if we search for them attentively. Each elementary lesion has its special character, each possesses, as a symptom, its peculiar value.

**Exanthemata.**—This term is applied to patches of a reddish colour, varying in intensity, size, and form, disappearing under pressure of the finger, and terminating in delitescence, resolution, or desquamation.

**Vesiculae.**—A vesicle is a slight elevation of the epidermis, containing a serous and transparent fluid, which, however, is occasionally opaque or seropurulent. The vesicle may terminate in absorption of the fluid, slight desquamation, excoriati{on, or the formation of small, thin incrustations.

**Bulles.**—Generally speaking, bullae differ from vesiculae merely in size; they are small superficial tumours, caused by effusion of serum underneath the epidermis.

**Pustule.**—This term should be strictly confined to circumscribed collections of pus on the surface of an inflamed mucous membrane. The contents of the pustules, in drying, produce scabs, and they may be followed by chronic induration, inflammation of the mucous surfaces, or excoriatio{on.

**Papulae.**—These are small elevations, which are solid, resisting, and never contain any trace of fluid; they may, likewise, give rise to ulceration, but generally terminate in resolution or furfuraceous desquamation.

**Squamae.**—The term squama is applied to the scales of hardened, dry, friable, and degenerated epidermis, which cover minute papular elevations of the skin; they are easily detached, and may be reproduced for an infinite length of time by successive desquamations.

**Tubercula.**—These are small hard tumours, more or less prominent, cir-

1 This arrangement is adopted by Mr Erasmus Wilson, in his recently published and excellent treatise on diseases of the skin.
cumscribed in form, and persistent; they may become ulcerated at the summit, or suppurate partially. In this definition we consider tubercles as elementary lesions, and not those which appear after abscesses.

"Macule are permanent changes of colour in certain points of the skin, or in the whole of the cutaneous envelope, but unattended with any general derangement of the health.

"Under these eight orders we have arranged the great majority of cutaneous diseases; we have, however, made a few changes in the classification of the species. Thus, in our opinion, pemphigus and pempholix constitute one and the same disease; acne is clearly not a tubercular affection, so we have placed it under the pustule, to which it really belongs. Erysipelas is an exanthematos disease, and scabies is a vesicular one; we have, therefore, transposed them to their respective orders; the diseases arranged under the seven last orders do not admit of being classed with any of the rest, and hence, we have thought it right to consider them apart."

Our space will not permit us to give a critical analysis of the work; but we hope that a selection from the Formulary of Biett, unaccompanied by remarks, will be acceptable to many of our readers.

"Internal Remedies."

"Subcarbonate of Soda, half, to one drachm; barley-water, one pint. Dose.—Four glasses daily. Use.—Lichen; prurigo; chronic diseases with itching.

"Decoction of dulcamara.—Dulcamara, half an ounce; water, a pint and a half. Boil down to two-thirds. The quantity of the remedy may be increased to one ounce, or an ounce and a half. Dose.—Half a glass at first; then a glass, morning and evening. Use.—Lepra vulgaris; chronic diseases.

"Decoction of orma.—Orma pyramidalis, four ounces; water, four pints; boil down to a half. Dose.—Two to four glasses a-day. Use.—Scaly diseases.

"Syrup of fumaria, twelve ounces; syrup of viola tricolor, four ounces; bisulphate of soda, two drachms. Mix. [M. Biett often employed this mixture in cases of eczema, lichen, and several chronic diseases of the skin.] Dose.—Two spoonfuls a-day.

"Syrup of fumaria, a pint; bicarbonate of soda, three drachms. Dose.—Two teaspoonfuls: one before breakfast; the other at bed-time. Use.—Eczema; lichen; prurigo.

"Pearson's solution.—Arsenite of soda, four grains; water, four ounces. Dose.—From twelve drops to a drachm or more. Use.—Most chronic diseases of the skin; eczema, impetigo, lichen; but chiefly in squamous diseases, lepra, psoriasis, &c.

"Fowler's solution.—Arsenious acid, and carbonate of potass, of each seventy-eight grains; distilled water, a pint; alcohol, half an ounce. Use.—The same as Pearson's solution. Dose.—Three or four drops, gradually increased to twelve or fifteen.

"M. Biett's solution.—Arsenite of ammonia, four grains; water, four ounces. Use.—Same as above. Dose.—Same as Pearson's solution.

"Larrey's syrup.—Sudorific syrup, one pint; bichloride of mercury, hydrochlorate of ammonia, and extract of opium, of each five grains; Hoffmann's liquor, half a drachm. Dose.—Half an ounce to two ounces. Use.—Syphilitic eruptions. Syrup of mezereon, two ounces; balsam of tolu, four ounces; subcarbonate of ammonia, half an ounce. Dose.—A spoonful morning and evening. Use.—Constitutional syphilis.

"Van Swieten's liquor.—Bichloride of mercury, eighteen grains; water, twenty-nine ounces; alcohol, three ounces. Dose.—A tea-spoonful daily in a glass of decoction of sarsaparilla. Each ounce contains a little more than half a grain. Use.—Secondary syphilis.

"Powders. Pills."

"Sublimed sulphur, magnesia, of each half an ounce. Make eighteen packets. Dose.—One daily. Use.—Chronic eczema; scaly diseases.

"Proto-ioduret of mercury, twelve grains; extract of lettuce, two scruples. Make forty-eight pills. Dose.—One to four. Use.—Syphilis. Or, "Proto-ioduret of mercury, half a drachm; extract of guaiacum, one drachm; extract of lettuce, two scruples; syrup of sarsaparilla, q. s. Divide into seventy-two pills. Dose.—One, and then two daily. Use.—Syphilis.

"Bichloride of mercury.—Extract of aconite, six grains; bichloride of mercury, two
grains; marshmallows powder, eight grains. Make eight pills. Dose.—One to four. Use.—Syphils.

"Deuto-ioduret of mercury.—Deuto-ioduret of mercury, six grains; marshmallows powder, half a drachm. Make thirty-six pills. Use.—The same. Dose.—Two or three a-day.

"M. Sédillot's pills.—Strong mercurial ointment, one drachm; soap, two scruples; mallows powder, one scruple. Make thirty-six pills. Dose.—Two or three daily. Use.—The same.

"M. Biett's pills.—Mercurial ointment, powdered sarsaparilla, of each a drachm. Make forty-eight pills. Use.—The same. Dose.—One to four daily. Or,

"Phosphate of mercury, half a drachm; extract of fumaria, one drachm. Make forty-eight pills. Dose.—One or two a-day. Use.—As before.

"Aconite pills.—Extract of aconite, half a drachm; mallows powder, two scruples. Make forty-eight pills. Dose.—One or two morning and evening. Use.—Syphilitic eruptions; nocturnal pains.

"Asiatic pills.—Arsenious acid, one grain; black pepper, powdered, twelve grains; gum arabic, two grains; water, q. s. Make twelve pills. Dose.—One or two a-day.

"Arsenite of iron. M. Biett.—Arsenite of iron, three grains; extract of hop, one drachm; mallows powder, half a drachm; orange flower syrup, q. s. Make forty-eight pills; each contains the one-sixteenth of a grain. Dose.—One daily. Use.—The two preceding formulae are chiefly used in cases of chronic eczema and lichen; in the scaly diseases, lepra, lupus, and psoriasis.

"Arsenite of soda. M. Biett.—Extract of aconite, one scruple; arsenite of soda, two grains. Make twenty-four pills. Dose.—One or two daily. Use.—As above.

"Hydrochlorate of iron.—Hydrochlorate of iron, twelve grains; gentian, in powder, twenty-four grains. Make twelve pills. Dose.—One to four daily. Use.—Employed with success by M. Biett in scrofulous eruptions.

"Sulphate of iron. M. Biett.—Sulphate of iron, one scruple; powdered mallows, twelve grains; syrup, q. s. Make twelve pills. Use and dose the same." Pp. 308—311.

PART THIRD.

PERISCOPE.

PRACTICE OF PHYSIC AND PATHOLOGY.

ON CEREBRAL AUSCULTATION. By S. S. WHITNEY, M.D., of Newton, Mass.

It is true, "that there are no physical signs applicable to the brain," such as are dependent on a cause similar to that of the act of inspiration and expiration of the lungs, or perhaps of the systole and diastole of the heart, while in their healthy state; for the brain, in its normal condition, can of itself develop no physical phenomena. The thing is incompatible with a physiological state of the organ.

There are, however, certain conditions of the brain, in which a new order of things has been discovered to take place; and the very fact that it is known and can be shown to exist only in certain derangements of that organ, while in its physiological condition, signs which are purely negative in their character are developed, proves the former to be, not only a physical sign, but one which is most surely pathognomonic of some derangement of the organ itself.

Such then, being the case, can it be shown that the organs within the cavity of the cranium are "so disposed" as to render the art of auscultation or percussion in any way available, and that these physical signs are applicable to the

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