of such observations coming from India, and would suggest that future papers on the subject should be accompanied by a careful description of the naked-eye appearances, as also of the tests upon which the chemical diagnosis rests. It might also be advisable that a definition of what is exactly meant by the term "saponification" in such cases should be given.

MISTAKEN DIAGNOSIS OF HUMAN REMAINS.
The following instance (Arch. f. Krim. Anthrop., Bd. xxiii. Heft 3 and 4) of mistaken identity is of interest, and is on a par with the well-known case recorded by Taylor, in which the fin of a turtle was mistaken for a human hand.

In one of the Prague daily papers a notice appeared stating that in Strzechovitz two human hands, together with the wrist-joints, had been found. The thumbs were absent, and it was suggested that they were preparations which had been thrown away by some one belonging to the medical profession. The remains were sent for examination to the University of Prague, where they were at once pronounced not to be human. This ended the matter so far as the judicial authorities were concerned; but a point of considerable interest is the fact that Professor Dexler of the Veterinary Institute, to whom the parts were afterwards handed over, found it to be by no means an easy matter to determine the species of animal to which they belonged. The skin had been completely removed, with the exception of a small piece attached to the distal extremity of the end phalanx of the right forefinger.

As a result of his examination, Professor Dexler came to the conclusion that the remains were the fore-paws of either a tiger or lion, probably the latter, since inquiries proved that the proprietor of a neighbouring menagerie had recently received two lions, about the disposal of which he gave contradictory accounts. A photograph given of one of the corpora delicta serves to explain the case with which, in the first instance, the mistake in identity occurred.

DERMATOLOGY.

UNDER THE CHARGE OF

W. ALLAN JAMIESON, M.D., F.R.C.P.Ed.,

LECTURER ON DISEASES OF THE SKIN, UNIVERSITY OF EDINBURGH; PHYSICIAN FOR DISEASES OF THE SKIN, EDINBURGH ROYAL INFIRMARY.

THE PATHOLOGY AND TREATMENT OF LEPROSY.

Unna (Monatsh. f. prakt. Dermat., Hamburg, 1906, June 15) remarks that the time must now be regarded as past when leprosy was looked on as an incurable disease. One should not confound the cure with the spontaneous ameliorations which occur in its course, as the result of change of residence or of mere hospital attention. Ehlers and Cahnheim
have met with instances of cured leprosy in Crete and Tonkin in the Soudan. Kaposi and Vidal were hopeful, the former observing, "leprosy is till now an almost incurable infectious disease"; the latter, "we have no specific for it, yet we ought not, I think, to despair of finding one." In lepra-free countries the leper is unreasonably considered a pariah, and therefore when under treatment carries out to the letter the injunctions of his doctor, or submits to, nay demands, the employment of any measures, however painful, which offer a chance of cure. Unna in twenty-two years has treated sixty cases, and watched their progress for periods varying from two months to twelve years. The severity varied from slight examples to universal ones, involving the cutis and subcutaneous tissues. As he has viewed the question largely from the cutaneous aspect, his treatment has been essentially dermatological. Though there may be no specially applicable specific as is mercury in syphilis, it must be borne in mind that there are numerous cases, particularly of tertiary syphilis, which do not react to treatment by mercury and iodide alone, yet get quite well when to these energetic external measures are superadded, as by sulphur or cauterisation. There seem to be individual or local hindrances to the action of the drugs alone removed by association, be this an encapsulation of the virus or a mixed infection, or something else. In leprosy something analogous occurs. There are remedies which, according to authors, now and again cure, according to others may induce marked improvement. It behoves us to discover how the good effects can be heightened and the impediments removed. The most important obstacle lies in the torpid and feeble reaction of the cutaneous tissues evoked by the bacillus itself, leading to its fibrous encapsulation. Another consists in the blocking of all lymph canals of the affected tissues by the bacilli, so that no active metabolism goes on, and our remedies reach them but slowly. This leads to the paradoxical statement that lepromata of the cutis are more difficult of cure than those of the subcutaneous tissue. The bacillus, again, develops a firm internal fat, rendering it amenable more readily to oily than watery solutions. If it shares this power with tubercle bacilli, it surpasses the latter in inaccessibility by the production of a sticky investment made of dead and swollen bacilli, gloea intervening between them and the tissues. By a particular method of double staining he has shown that most of the bacilli in the vital tissues, and also most of those excreted, are dead. Since rational treatment must be directed towards getting rid of the solid fat in the bacilli themselves and in the enveloping mucoid masses, heat constitutes one of our most valuable agents. This is best employed as warm baths, which may advantageously contain sulphur, or iron and tannin-ink baths. Another mode of utilising heat is by firm pressure with a hot flat iron. This is especially useful in cases of widely distributed nerve lepromata, as also for individual emboli, characterised by slight reddening and increased local resistance of the skin. Shaving off prominent nodules gets rid of much diseased tissue, and the raw surfaces heal readily. The blocking of lymph channels and vessels with the masses of bacilli largely inhibits the absorption of remedies, and though pressure and massage seem indicated to displace these, there is some danger, if these measures are employed, of scattering them further, and so occasioning embolic nodules out of which new
lepromata may develop later. This is all the more likely, since it has been shown that the bacilli are not necessarily enclosed within cells, but lie free in the lymph spaces. Thiosinamin has proved valuable in reducing keloidal growths. Both pyrogallol and pyraloxin are efficient in ointment form. Ichthyl and camphor are applicable as internal remedies, the latter best used subcutaneously in the form of camphorated oil. Oleum gynocardii has had some reputation, but only a few can take it continuously without digestive disturbances. This has been overcome by prescribing it as a gynocardia soap in keratinised pills. To introduce a sufficient dose, however, many pills daily have to be administered, hence enemata of the oil emulsionised with milk has proved an admirable method. The reproach of Lie that such measures do not touch the internal manifestations of leprosy, is combated by Unna, who cites in support of his view the rapid and remarkable improvement in the general condition in cases treated by him. A short account of four of his cases which had been followed up for a considerable time after treatment had been discontinued, a sketch of his mode of procedure, with a series of formulae, conclude an interesting article.

Bullous Affections and their Classification.

Bronson and Bowen contribute suggestive papers on this topic (Journ. Cutan. Dis., N.Y., 1906, March). Bronson observes that in every skin disease, whether idiopathic or symptomatic, whether a mere anomaly of growth or an inflammatory affection, there is a determining cause inherent in the local pathology. Erythema and inflammatory effusion ordinarily causing diffuse edematous swelling, do not produce a blister unless something particular transpires. Again, in coccogenic diseases usually resulting in pustules, when the sepsis is exceptionally pronounced or the epidermis easily disorganised, as in young children or infants, blebs in place of small collections of pus appear, and we have a bullous impetigo contagiosa. Similarly, with bullae as epiphenomena in special types, the effusion, instead of dispersing itself through the lymph spaces in the rete and in the tissues contiguous to the vessels, bursts asunder weakened cell connections and forms a lacuna in the epidermis. The change in the rete which permits this procedure is known as acantholysis. It varies in degree in different cases; less in the bullae of zoster, where the resisting trabeculae give rise to multilocular blebs, greater in impetigo bullosa and pemphigus, most marked in pemphigus foliaceus, where the least vis a tergo loosens the cohesion of the cells and thus produces flat, flabby, weak, ill-developed bullae of short duration. While acantholysis is a condition precedent to almost all bullous diseases, it rarely occurs in an entirely independent form unless in the congenital and usually inherited disorder known as epidermolysis bullosa. A fundamental distinction is to be made between bullae which have a dynamic or mechanical cause and those due to a preliminary deterioration of vitality in the prickle cell layer of the epidermis. The first constitute the obstructive, the latter the acanthyotic forms. In the former the cause is an obstruction either in the sweat follicles or lymphatic channels, causing, by simple mechanical force, an accumulation of fluid in the substance of the
epidermis. This gives rise to such affections as sudamina, dyshydrosis, and lymphangioma circumscriptum. To the latter, i.e., those in which there is preliminary acantholysis, belong by far the greater number of bullous affections. The source of the injury which gives rise to acantholysis may be—(1) *Extracutaneous.*—From traumatism, extreme change of temperature, or the action on the skin of acrid substances, as cantharides, *rhhus,* etc. (2) *Infracutaneous.*—As an incidental effect seen in erythema multiforme, erysipelas, urticaria, etc. Or from local infection by penetration of micrococci from without. (3) *Infracutaneous.*—From some disorder interior to the skin. This may be from toxic materials deposited in the tissues from the blood, but in most cases we must assume a neuropathic origin. Of these a good illustration is found in dermatitis herpetiformis. The term herpetiform here, however, rather refers to the general form of the lesions, their peculiar mode of occurrence, and their grouping and arrangement, than to the idea of vesiculation. When bullae appear in its course they may be attributed to any of the three sources of injurious influence tabulated above. Though the scope of pemphigus has been restricted, the chief distinction between it and dermatitis herpetiformis lies in the circumstance that in pemphigus the evidence points to a far more profound derangement of cutaneous vitality as well as to some graver internal disorder. It is not at all improbable that in many instances a slight external injury, chafing or scratching, is the exciting cause of the bulla in pemphigus, as it is in dermatitis herpetiformis bullosa. Indeed, a condition may be acquired analogous to what obtains in congenital epidermolysis bullosa. Still more does this surmise apply to the so-called pemphigus hystericus, where but a single bleb may appear. There is profound functional derangement of the nervous system capable of effecting trophic changes in the skin. The mystery of a single lesion can hardly be explained except by referring it to a local exciting cause, probably some slight traumatism. Bowen notes that the recurrence of the lesions in dermatitis herpetiformis in separate attacks is their most characteristic feature, and without this recurrence he does not believe a positive diagnosis possible. In children the element of multiformity in dermatitis herpetiformis is often wholly lacking, the disease tends to manifest itself in a purely bullous and vesicular form, while the subjective symptoms may be absent or insignificant. In their case, too, the parts about the nose, mouth, and eyes, the backs of the hands and wrists, the back of the ankles and the feet, and the genital organs, are those most prominently attacked.

**Fibroma Molluscum.**

The origin of this morbid condition has given rise to much discussion, and a case investigated by Vörnor (*Dermat. Ztschr.,* Berlin, 1905, October) is interesting in this direction. The patient was a woman aged 30, who had characteristic small tumours all over her body. When these were pressed back into the skin a ring formed by the normal cutis became perceptible. A brunette in type, she showed marked alterations in the distribution of pigment, since she was studded over with brown stains, some of which, as a large one encircling
the pelvis, were of large dimensions. But there were also spaces, more especially one between the scapulae and within a darkly pigmented area, quite white, corresponding to leucoderma. A number of small growths were excised, with enough of surrounding skin to permit of comparison. These consisted of roundish tumours which, starting from the upper part of the subcutaneous tissue, extended to the cutis immediately below the papillary layer. Their structure in the main was made up of areolar tissue rich in cells, the individual elements being round and spindle cells with large oval nuclei, concentrically arranged. Very fine and delicate elastic fibres were sparingly discoverable, showing no signs of degeneration and resembling those seen in early embryonic tissue. Nerve fibres entered the tumours and at once became larger in consequence of an increase in the number of the cell elements of the endoneurium. This gave rise to a separation of the bundles of the nerve fibres themselves within the tumour. At its exit, however, the nerve again assumed its normal size, nor did it manifest any alteration of a morbid character. He thinks that this goes to controvert v. Recklinghausen's idea that fibroma molluscum arises from proliferation of the neural areolar tissue (neurofibromatosis), although it realises his view of the proliferation of the endoneurium within the tumour.

DISEASES OF CHILDREN.

UNDER THE CHARGE OF

G. H. MELVILLE DUNLOP, M.D., F.R.C.P.Ed.,
PHYSICIAN, ROYAL HOSPITAL FOR SICK CHILDREN, EDINBURGH.

LUMBAR PUNCTURE.

Kopitzky, in an interesting paper on lumbar puncture (a method first introduced by Quincke), considers the subject from three distinct points of view—(1) As an aid to diagnosis; (2) as a therapeutic measure; (3) as a procedure to produce anaesthesia.

The following are the essential points in the technique of the examination of the cerebro-spinal fluid as an aid to diagnosis:—

(1) The pressure under which it is obtained.—According to Quincke, pressure rises in grave inflammatory conditions, in tuberculous meningitis, and in brain tumour. The highest pressures recorded are in cases of hydrocephalus and in tuberculous meningitis. (2) Coloration.—The colour varies from clear yellow, or slightly cloudy in cases of tuberculous and chronic meningitis, to well-defined purulent turbidity in cases of acute purulent meningitis. (3) Bacteriological findings.—Nearly all forms of micro-organisms have been found in the fluid, the commonest being diplococci, especially in affections of the spinal membranes, Weichselbaum's Diplococcus intercellularis in cerebro-spinal meningitis, and the tubercle bacillus in cases of tuberculous meningitis. The latter is not found in all cases, and when discovered the tubercle bacillus is