rhage occurs, and blood is vomited. In a case which I saw some time ago with Dr. Wilson Fox, this symptom had suggested the presence of ulcer of the stomach, but the further events of the case clearly demonstrated the uterine origin of the malady.

Uterine sickness is not unfrequently very severe in cases of dysmenorrhœa, and is, indeed, a distinct part of the dysmenorrhœa present under these circumstances. When so associated with the menstrual period, its uterine origin is more obvious. But it would appear, from observation of cases under my notice, that uterine sickness occurring at non-menstrual periods is more common than it has been generally supposed to be, and that many cases of obstinate and severe sickness are consequently attributed to other causes when the uterus is really at fault.

Taking all cases of uterine disease, my case-books show that marked sickness occurs in 11 to 14 per cent. of all cases of uterine disease applying for relief. It must be pointed out that severe uterine sickness is a symptom which is not one of very common occurrence. In a minor degree, it is not unfrequent. Presence of this severe form of reflex irritation implies, in all probability, a diseased condition, not only of the uterus, but of the nerve-centres; and the reason why it is more intense in some cases than in others is doubtless dependent on the nerve-centres being excessively excitable in some instances, while they are less so in others. This supposition is confirmed by the clinical history of cases.

Secondary Starvation.—The continual presence of this reflex symptom, uterine vomiting, has one effect to which very prominent attention must be directed. I mean the starvation which it induces and brings about. When the food is constantly brought up and rejected, it is of but little advantage to the patient. The condition is practically the same as if no food at all were given. One of the patients had lost 5 stone in weight. Unless in the very severe cases, however, sometimes the food remains long enough in the stomach for something to be extracted for nutrition purposes, or the rejection is not complete, and the starvation is, therefore, in less degree. But in these cases, the actual amount retained is so far below the daily requirement, that a chronic starvation ensues, and a certain, but gradual, diminution in weight occurs from week to week. This feature of the case is often not at first recognised. Further, there is the influence of the repugnance to food, nausea at the idea of taking food, which is a symptom in many cases. This prevents the patient even trying to help herself, and the attempts to take nourishment are finally almost given up. This state of things grows on the patient, so to speak. At first the sickness is only occasional; the nausea and slight occasional sickness go on, perhaps, for six months or a year before the condition is considered grave. Then the symptoms become more intense, medical advice is sought, and the patient is discovered to be extremely emaciated, the natural result of the long-continued deficiency in regard to absorbed nutriment.

The chronic starvation, initiated by uterine vomiting and nausea, becomes a very serious affair when prolonged, ultimately so sapping the foundations of life that, even when the symptom itself has been to some extent relieved, the weakness remains. A weakness so produced and so protracted is, I believe, a not unfrequent cause of tuberculosis. I know, at all events, of two cases, included in the foregoing series, in which the patients finally succumbed to this disease, concerning whose previous history, as regards the presence of uterine vomiting, I was well acquainted.

The *diagnosis* of the presence of uterine vomiting is usually not difficult, though in some cases circumstances do not attract attention to the uterus as the actual cause. The stomach, the liver, the gall-bladder, and bile-ducts, the intestines, the nerve-centres, etc., may be at fault, and the possible causes of vomiting are almost too numerous to recapitulate in this place. The diagnosis of uterine-vomiting requires a careful exclusion, therefore, of many possible diseases, an exclusion not always very easy to substantiate. One of the most common cases met with in practice is the confounding of uterine sickness with "biliousness," as it is termed. I have frequently been informed by the patient that she suffers much from "bilious attacks," which have been traced on inquiry to the uterus. I am in fairness obliged to state that, in one long-standing troublesome case, where the patient had suffered from troublesome sickness, with no particular sign of liver or biliary disease, a large biliary calculus was subsequently evacuated from the bowel. What adds to the diagnostic difficulty of cases of uterine sickness is the fact that, in some cases, the uterus itself may be found devoid of unusual sensibility to the touch, and that the patient makes no complaint directing attention to this organ particularly. In many cases, there is a complaint of pain referred to the uterus, severe pain in the groin, or in the lower part of the back; but I have before my mind some very severe cases, where it was not imagined by those who had seen the cases before that the sickness was due to the uterus at all. It rarely happens, however, that the uterine functions are carried on in a normal manner; in these cases, menstruation is either irregular or very painful, or menstruation is accompanied by special exacerbation of the vomiting, and it is obvious enough that there is uterine disturbance of some kind present.

In connection with the question of the diagnosis of uterine vomiting, should be mentioned a curious case, related by Dr. Bristowe, of what he terms "hysterical vomiting in a girl, aged 14, in which it was found that the vomiting was due to regurgitation from the œsophagus, and was cured by passing a tube into the stomach. Dr. Bristowe considers there was a spasmodic condition of the œsophagus present in this case, the food never entering the stomach at all (*Lancet*, June 20th, 1885, page 1115).

In one of the cases I have related, the patient eventually died of tubercular meningitis. It is possible that the sickness in this particular case was in part, at all events, due to the commencing tuberculosis. But, in this case, the sickness had been present for a long time, and it is probable that the cerebral complication was of comparatively short duration.

With reference to the precise pathology of uterine sickness, a good deal has been incidentally stated. I purpose to postpone any further remarks on the subject until we have considered the clinical features of another series of cases—the hysterical phenomena associated, more or less, with convulsive attacks. The pathology of the two classes of cases is, I believe, closely allied, and, indeed, we have frequent instances in which the two sets of reflex phenomena are observed together in the same individual.

ILLUSTRATIONS OF EXCEPTIONAL SYMPTOMS AND EXAMPLES OF RARE FORMS OF DISEASE.

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[*Continued from page 62.*]

XVII. Coffee-Stain Patches on one Shin, distinctly Lupoid in Character and probably Syphilitic: on the other Shin similar Patches, but not Yellow.

A gentleman, whom I had treated for syphilis many years ago, consulted me, in February, 1885, for an ulcer on his tongue, which he supposed to be a reminder of his disease. I found, far back, a small epitheliomatous ulcer, which had apparently not been preceded by syphilitic changes. I inquired as to any other symptoms, and he assured me that he had never suffered anything since my treatment; but, after a little thought, added "I have some yellow patches on my legs." I found, on the front of his left shin a group of yellow spots, covering a space half as large as the palm, and placed very near to each other. They were very conspicuous by their colour, but scarcely raised, and only scaly in the slightest possible degree. On careful inspection with a lens, it was quite certain that the disease spread serpiginously, and left thin scars where it receded. It was therefore clearly a lupous process, and probably it was consequent on his syphilis, though located by bruising of the part. On the opposite leg he had a similar group of scars, leaving patches; but, curiously enough, they were not in the least yellow, but rather livid and dusky. Those on the left shin were almost a bright yellow, brighter than the common coffee-stain.

I use the term coffee-stain as applicable to certain yellow patches which are often seen on the legs. All observers must be familiar with them, but I am not aware that they have ever been described. Patients who have had syphilis often show them, and seek advice in consequence, but they may be seen also in those who have never had that disease. They differ in some cases in tint from lemon-yellow to deep brown. In some instances, mostly syphilitic, they leave exceedingly thin scars.

XVIII.—Case of Eczema-Erysipelas: Recurrent Attacks on Face.

Certainly one of the most important cases, as illustrating the relationships of this affection, which I have ever seen, was that of a gentleman, who was brought to me in 1885 by Dr. Macpherson, of Mildmay Park. Mr. D. G. P., was a collector, aged 42, a nervous man, liable to dyspepsia; but, by dint of his out-of-door occupations, maintaining usually fair health. Ten years ago he had a sharp attack of erysipelas of the face and head, caused, as he thought, by going through the Thames Subway when in a perspiration. After

this, nothing occurred for six years, when he sprained an ankle, used arnica, and had an attack of erysipelas of his leg. A year later, he sprained the other ankle, avoided arnica, and yet had erysipelas. For this attack he was treated by steel, and "the steel caused eczema." He had a troublesome attack of eczema of the scrotum and thighs, which lasted for months, and which, indeed, had scarcely even yet quite left the groins and popliteal spaces. This persistence must, I think, be held to be conclusive as to the eczema kinship of this dermatitis, as the transitoriness of the others allied them with erysipelas. We now come to another phase of his ailments. He took to bicycling, and used to perspire profusely in his rides. In October, 1883, after a ride in a sharp wind, he had an attack of swelling of the face (erysipelas), which laid him up for a fortnight; and, ever since then, he had had attacks every six months or so. On one occasion, leaving a hot dinner-room, and going across the street in an east wind, brought it on. Several times, riding in a hansom cab had done it, and now and then, he thought, stomach disturbance from taking wine, etc., was the exciting cause. The attacks were ushered in by "a rushing to the head," and "feeling of fulness and flushing." "Then it seizes my eyes, and the lids are swollen up till I cannot see out." Dr. Macpherson, who had attended him through four or five attacks, told me there was not usually much redness, but chiefly great œdema.

The temperature was never materially increased. The eruption never showed any tendency to spread over the scalp, and usually began to subside after a few days, leaving the skin feeling stiff, and covered with branny desquamation. No vesicles had ever been observed. The attacks always laid the patient up for a fortnight or three weeks, and of late his susceptibility had been such that he had scarcely been to business for two months.

As regards treatment, the prophylactic power of arsenic seemed to have been fairly tried. He had taken it for eighteen months, and the attacks had of late increased, both in severity and frequency. Formerly, the attacks had occurred in spring and autumn, and this was the first time that one had happened during winter.

XIX.—Injury to Lower Epiphysis of Humerus: State of the Parts Twenty Months afterwards.

A little girl, aged 4, daughter of the Reverend G. P., of the Chinese Mission, was brought to me twenty months after her accident. It was not known precisely of what kind her violence had been, since it had occurred under the charge of a nurse-girl, who only admitted that she had fallen. The elbow was bruised and swollen for some time. She was treated by plaster-of-Paris case, and subsequently by a hinged splint. When brought to me, the elbow could not be bent quite to a right angle, nor could it be straightened. It admitted, however, of being flexed within a limited extent. Pronation and supination were quite free. The arm was strong, and the child could use it for almost anything, but could not get it to its mouth. It appeared probable that the injury had been complicated. The head of the radius projected strongly, as if almost, though not quite, free from the external condyle. The finger could be placed in the outer two-thirds of the cup of the radius; still it certainly had not wholly left the condyle. The distance between the ulna and radius was much increased, and, no doubt, the orbicular ligament was completely torn. The inner condyle was lost; the inner side of the ulna being on the same plane, or nearly so, as the inner edge of the humerus. Then there was some thickening on the front of the humerus in this position, making it seem possible that the epicondyle had been broken off and displaced forwards. The thickening in front of the lower part of the humerus was, however, not nearly so great as is usual in separation of the whole lower epiphysis. Under an anæsthetic, I bent the elbow up to an angle of 45°, and made it very nearly straight. I advised that we should trust to time and to systematic and vigorous movements of the joint, and have little doubt that, in the course of a few years, its use will be almost perfect.

In the case of a boy, aged 10, whom I saw at the College of Surgeons (1885), it was very remarkable how rapidly full freedom of all motion had been restored. It was, I think, only nine weeks since the accident, yet there was not the slightest swelling, and he could flex and extend almost perfectly, and pronation and supination were equally free. The external condyle, together with the trochlea for the radius, was visibly displaced, and was very conspicuous. Some who examined it thought that it was still movable. The internal condyle was almost, if not quite, in due relation with the olecranon, but there was some thickening of the humerus, and the olecranon did not seem to project so much as usual. My impression was that the end of the shaft was displaced a little backwards, but I had not an opportunity for forming a deliberate opinion. Everyone agreed that there had been fracture and displacement of the external condyle, but, as to other details, there was much difference of views. The wonder was that there could be such displacement, with yet perfect motions.

XX. Node on Tibia, without Syphilis, and without Pain.

Mr. Weller, of Wanstead, sent to me in October, 1883, a case of osseous node on the tibia, which appeared to be identical with the splint of horses. Nothing whatever as to specific antecedents could be made out, and the lump was absolutely painless. It had never given its possessor any annoyance; it had been present several years, but, unless he got it knocked, he should not, he said, have known it was there. The patient was a tall slender-boned man, and the node, which was as big as the vertical half of a small egg, was very hard. The patient, a Mr. S., aged 39, was engaged as a clerk in the docks, and was liable to have his shins knocked occasionally, but he did not remember any special accident. The node had been so conspicuous two years ago, that a surgeon, to whom he showed it, suggested that he must have had his leg broken; it was, however, still bigger now.

XXI. Morphœa, taking the Arrangement of Zoster on Chest and Arm: Twenty Years' Duration: Recent Single Patch on Back.

Miss C. A., aged 36, consulted me on March 19th, 1885, for an eruption which she had had for twenty years. She well remembered its beginning, she said, on the inner side of the right forearm, during her last year at school. It prevented her from going without sleeves, and it also, she thought, was attended by muscular weakness, and spoiled her piano-playing. After it had been some years on the forearm, other patches appeared on the side of the right half of the chest, between the spine and the mamma, and above the latter. I found in the regions mentioned large brown stains, and groups of stains, placed exactly like those of herpes, in a sloping line downwards and forwards on the chest, and another long group of stains down the inner side of the upper arm and forearm. The breast on that side was not so full as the other, and there was a little appearance of wasting in the ulnar muscles of the forearm. I could not, however, appreciate any definite wasting in the muscles of the hand supplied by the ulnar nerve. In the middle of some of the brown stains there was a white area. The affected skin was a little harsh and rough, but there was not now any material induration. None of these patches were, Miss A. believed, less than ten or fifteen years old. A new patch had, however, formed within the last eight months on her back. This was an oval patch, as big as a crown-piece, thick, white, and brawny in its middle, gradually fading off, and surrounded, at its extreme periphery, by a faint violet zone. This was most characteristic of the early stage of morphœa. It itched a little. Miss A. was in good health, but had a very feeble circulation. Her hands were a little puffy, and everywhere of a deep dull brick-red colour, or almost livid.

The case illustrates, almost better than any other that I ever saw, the affinity of morphœa with herpes zoster. Probably, several of the intercostal nerves were affected; and, not only the intercosto-humeral, but some twigs of the internal cutaneous, possibly some of the ulnar. Neither herpes zoster nor morphœa usually keeps with exactitude to the known distribution of named nerves. It is interesting to note that, after so long an interval as twenty years, a fresh patch had formed on the back. The same happened in the case of M. This new patch was not on the same side of the trunk, but it was over the middle line to so small an extent, that it must be allowed to be possible that an erratic twig from the right supplied it. The conditions presented by the patches on the chest and arm suggested that they had all come out together—all were in the same advanced stage of retrogression. Miss A. was, however, confident in her statement, that those on the breast came five years after those on the arm.

It is very exceptional for morphœa to occur in the same person more than once. When it does so, the interval is almost always a long one, that is, several years. The second outbreak is usually on a very limited scale. I never saw a severe or extensive second attack, but I have seen three or four in which small patches appeared, as just said, after long intervals. As a rule, we may assure our patients that the deformities produced by the original outbreak will be the sum and end of their troubles. and that no recurrence is likely to happen. In the above case, three outbreaks, with long intervals, would appear to have occurred. In this feature of very exceptional recurrence we have another point in which morphœa and herpes have points in common.

Mr. G. T. A. Staff, L.K.Q.C.P., M.R.C.S.E., has been placed on the Commission of the Peace for the Borough of St. Ives.