doses of opium, antipyrin is most useful, a single 10 grain dose often mitigating or entirely removing the pain within a few minutes. The fulness of the head resulting from partaking of too much alcohol on the preceding night is not unfrequently dispersed by the remedy. The manner in which it sometimes relieves the headache due to exposure to the sun, justifies an opinion to the effect that it acts like a charm. That continued pain in the head which sometimes follows recovery from sunstroke is often lessened, but not cured by antipyrin. Ordinary migraine may be relieved by it, but its capriciousness in this respect is remarkable. The same patient may not experience relief on two successive occasions. Other patients may not be relieved at all. Although the drug does not exhibit any lethal manifestations in the doses recommended, one would throw out the caution that patients should not be advised sometimes to take 10-grain doses of it every hour as an ordinary measure for relief of the pain except under medical advice.

The analgesic effects of antipyrin are perhaps only second to its antipyretic properties. Its influence in removing or decreasing the pain in certain forms of neuralgia is sometimes very marked. The difficulty arises in differentiating the cases in which it is likely to prove suitable. It will be seen later on that though it is somewhat paradoxical to what has been said as to the effects of the drug in local complaints, it often removes the pain of peripheral neuritis in a few minutes.

Lastly, there is the localised pain of *trigeminal neuralgia,* which it sometimes appears to remove at once, to dissolve it away as it were, whilst the patient is still discussing the taste of the medicine. Here likewise it exhibits much feebleness, at one time relieving, at another mitigating and, it may be, have no effect at all the third time it is used for this purpose. There is no doubt it has done much good, by relieving thousands of victims to this malady. It would be a highly interesting investigation to inquire into the actual varieties of neuralgia it relieves. My experience leads me to think that those forms associated with a tenderness resulting from a local neuritis are more frequently affected for good by it than other forms.

Sciatica is sometimes relieved by this drug. It is said that the deep-seated or parenchymatous injections do more good here. The same has been said of its use in lumbago and muscular rheumatisms generally. In these latter, I have occasionally found it to give almost immediate relief. In the same category comes the relief afforded by this drug in the early "lightning pains" of "*loco-motor ataxy,* and the neuralgic pains sometimes especially in old people following attack of *herpes zoster.*

There are certain varieties of *insomnia* in which it is of service, especially those connected with an over-taxed brain, or exposure to the sun. Here the addition of 10 or 15 grains of bromide of potassium is a valuable accessary.

In a case of severe *spasmodic asthma* recently under my care, 10-grain doses, every hour for three doses, relieved the dyspnœa sufficiently to enable the patient to sleep in the horizontal posture which he had not done for a week.

Within the last four months I have tried it in diabetes mellitus. In one it decreased the urine from 12 to 7 pints within a month, lessening the sugar also, but not in the same ratio. In the second, it reduced the urine from 8 to 6 pints with practically no change in the quantity of sugar. The third, a patient of considerable bulk and suffering from a weak heart, was not affected by it after a week's trial, so the drug was given up.

It is reputed to relieve the pain of acute gout, of renal and hepatic colic, and of dysmenorrhœa; to allay the irritation of urticarial rash, and to affect the suppression of the flow of milk.

It has lately been advocated in the treatment of epilepsy, chorea, and in diabetes insipidus.* Of antipyrin in these affections I have no experience.

Antipyrin has been tried and successfully stood the test of that severe critical investigation to which all new and powerful remedies are rightly subjected. It has an established position in the treatment of diseases which I have attempted to set forth in these remarks. It would not be adding to its merits as a therapeutic agent, to endeavour to claim for it virtues and properties which it does not possess. Many of its earlier, and some of its later, congeners have already lapsed into the regions of forgetfulness.

It is now extensively employed, and cases of poisoning by it, over-dosing, occasionally arise. Except in the rarest possible cases, such calamities can only occur from the indiscriminate use of the drug. It is a poison; let it be dealt with as such, and used with as much care and judgment as we use other poisons of the pharmacopœia.

In conclusion, I would state that the views expressed in the foregoing references to the use of antipyrin, except when otherwise stated, have been abstracted from notes accumulated during the last four years, with regard to its effects in cases under actual observation.

A CASE OF ACUTE MALARIAL POISONING—ENTERIC FEVER ENSUING—COMPLICATED BY BRAIN AND LUNG SYMPTOMS, ALSO BY EXTENSIVE CANCRUM ORIS.

By Surgeon J. Fayrer, M.A., M.D., F.R.C.S.E., &c.

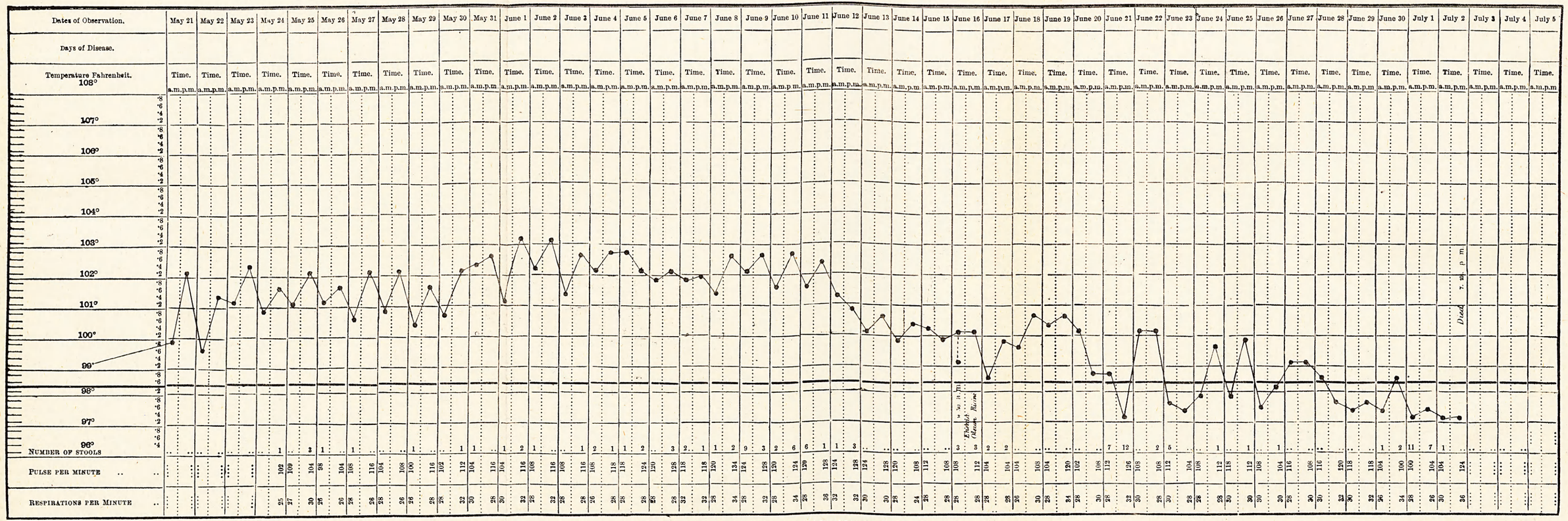
Private P. Bunting, 87th Royal Irish Fusiliers, a young soldier (*æt.* 23 years) and with

* *Lancet,* Vol. II, 1889, p. 431.

RECORD OF TEMPERATURE, PULSE AND RESPIRATION.

Corps—1st *R. I. Fusiliers.* *Regimental No.* 2842. *Rank and Name*—*Private P. Banting.* *Age*, 23. *Service*, 3 *years.* *Station*, *Landour.*

Disease—*Enteric Fever.* *Admitted*—21-5-1891. *Result*—*Died.* *Date of Result*—2-7-1891.



N.B.—Temperature, Pulse, Respiration, generally taken at 8 A.M. and 7 or 7-30 P.M.

J. FAYRER,
Surgeon, M.S.

two years' Indian service, was admitted into the Station Hospital, Landour, on May 21st, 1891.

Medical history prior to last illness.—General health, according to medical history sheet, on the whole good. He was sent up a convalescent to Landour, debilitated after fever contracted in Delhi; although looking very weak and anæmic, he managed his ten days' march from Meerut to Landour satisfactorily. He, however, obtained no benefit therefrom, and on arrival at Landour presented the same aspect as he had done on leaving Meerut: from the date of his arrival until his admission into hospital, he was a frequent attendant at the latter; his complaint being debility and general malaise; he also had occasional attacks of fever and ague.

Condition on admission.—The patient had been "detained" in hospital for two or three days, and, on actual admission, the following was his condition:—On the evening of the 21st of May his temperature was 102·4F., he was very ill and almost unable to answer questions put to him, his only verbal complaint being of his throat; that it was sore and uncomfortable was manifest, as he was constantly (with a distressed look on his face) placing his hand over the lower part of his neck.

General condition.—Face muddy and expressive of fear and anxiety. *Body* much emaciated and having a very peculiar muddy look all over. *Tongue* very dry, furred and anæmic. *Throat*, no specific affection thereof, but its back part, as far as one could see, very dry and pale. *Abdomen* slightly distended; pain on pressure over splenic region. *Bowels* obstinately constipated. *Brain* undoubtedly involved as shewn by his inability to answer questions, his vacant stare and anxious look, and by the fact that he was constantly putting his hand to his head as though he was suffering pain from it.

Conclusions drawn therefrom.—That the patient was suffering from a continued fever; that those parts of his general organization whose functions were to secrete, excrete or eliminate, were absolutely at a standstill; that the cause or causes of the disease had been most insidious, in its, or their, onslaught; that the patient was very seriously ill, but that a satisfactory or certain diagnosis of his condition was impossible.

Short history of the case till June 16th.—For several days after his admission the patient continued in much the same state, his only complaint being the soreness of his throat; his temperature varied but little (*vide* chart), bowels remained obstinately constipated; unless roused he would always lie on his back in a semi-comatose condition and breathing heavily, but not stertorously, his abdomen still slightly distended, but no pain, gurgling or other looked-for symptoms could be elicited on pressure, and further (possibly owing to the peculiar discoloration of the skin, generally, and abdominally speaking, specially) no spots or characteristic rash were patent. At this period the patient's lungs became extensively involved, slight basic congestion being the first symptom noticed; this, however, soon ran into more acute mischief, and finally resulted in consolidation; both lungs were so extensively involved that his condition, especially as he otherwise was so seriously ill, was most imminent, and in this state he continued until June 11th, on which date he suddenly took a turn for the better, his face began to take on an intelligent look, he began to get some natural and refreshing sleep. Examination of his lungs shewed they were undergoing rapid recovery; the left, indeed, acting almost normally; he took all his nourishment well and under careful treatment, dieting and stimulation was rapidly gaining ground, (from the 4th June till the above date the constipation had given way to the most copious diarrhœa, all the motions in his then critical state being passed involuntarily in his bed clothes; the motions were light yellow in colour, sometimes quite liquid, at others semi solid).

The patient now promised to be really well; all the glandular structures of his organization (even to the liver) were commencing to perform their allotted duties as shown by the moistening of his parched tongue, mouth, throat, etc. However, on seeing him on the morning of the 18th instant, I noticed that the left side of his face was considerably swollen, (he looked exactly as though he had a "gum-boil") and apparently painful, judging from the fact that he was constantly putting his hand to it, believing, as did others, who saw it, this complication to be simply a "gum-boil," I, as his head symptoms, though considerably better, were still troublesome, desisted from operative interference, hoping that the pain and local discomfort might to some extent act as a counter-irritant to the brain. Whether the latter surmise was correct or not I cannot state; at any rate the head symptoms for a short time almost entirely disappeared, but the swelling on the face commenced to take on a very unhealthy aspect, all the tissues of the cheek becoming a sort of dirty purple in colour and brawny. In two days at the corner of his mouth, on the same side, a black spot made its appearance, which very rapidly increased in size until nearly the whole cheek became involved. Pure nitric acid, however, stopped the ravages of the disease and a line of demarcation was formed; the tissues included therein separating away most kindly.

Notwithstanding this new and most fatal complication, the patient after a few applications of the acid rallied; and this time became much better (lungs almost clear, no tenderness over abdomen, which region presented a normal aspect, no distension or tympanitis) quite cheery, too,

and he would attempt to carry on a conversation. This effort at recovery, however, was but short-lived, as he developed "Cancrum Oris" on the other side of the face. The cheek became involved exactly as did its fellow, but the disease, though spreading very rapidly, was stopped by the patient suddenly getting the most copious diarrhœa which carried him off on the evening of July 2nd, after an actual illness of 44 days.

Treatment of Case.

May 21st.—Poultices to neck four times a day; steam inhalations.
May 24th.—Same, also Ol. Ricini ʒvi.
„ 27th.—Same, also Expectorant Mixture three times a day; also turpentine to bases of lungs and spongiopiline jacket.
May 28th.—Same, also Quinine gr. iv.
June 2nd.—Same, jacket poultices four times.
„ 4th.—Omit Quinine Mixture and add Ammon. Carb. gr. v. to Expectorant Mixture; same as regards inhalations.
„ 5th.—Potassii Bromid. gr. xv.
Mist. Expect. Stim. ʒi. twice a day.
Potass. Bromide gr. xx. at bed-time.

Turpentine on Jacket Poultices.

„ 10th.—Enema Ol. Ricini ʒss., Aqua oi. Continue.
„ 18th.—Omit Potassium Bromide, Cough Mixture continued, also Quinine Mixture again.
„ 26th.—Continue. Foment face.
„ 27th „ Hypodermic injection of Morphia, zinc lotion to face.
„ 29th „ Nitric Acid to face.
„ 30th „
July 2nd „ Also Tinct. Opii m.v.
Mist. Cret. simplex ʒi, for diarrhœa.

Died 7 P. M.

The case was a very interesting one as its history shows, and was especially so in that it showed the extraordinary and extensive complications which may supervene on enteric fever; the prolonging of the patient's life also shows what can be attained by very careful nursing and constant attention.

The patient's life was prolonged, and his terrible condition rendered bearable, owing to the untiring care and attention tendered to him by Apothecary Galvin and Sub-Asst. Apothecary F. Farmer, the latter being in sub-charge of the case. As regards the diagnosis, although I have had considerable experience of enteric fever in this country, and well knowing the peculiarities presented by the disease out here, I did not believe, until the *post-mortem* undoubtedly demonstrated the fact, that the patient had suffered from the disease *de novo*. I was under the impression (from his appearance, peculiar colour, enlargement of spleen, etc.,) that he was a victim of malaria, acute malarial poisoning, complicated immediately by lung congestion (a most fatal complication in fevers of malarial origin), and that as a result he got into a pyæmic or "typhoid" state. Nothing, as before stated, during life could persuade me that the patient had enteric fever, although Deputy Surgeon-General Rudd and Surgeon-Major Powell both diagnosed the case as such. The former on seeing the patient at once declared his case to be a very peculiar one, but stated, without hesitation, that enteric fever was the disease. He explained how that certain looked-for symptoms were disguised by the peculiar colour of the patient's body, and said he had seen similar cases before. This shows how experience and observation, and these alone are absolutely essential adjuncts to book lore in dealing with diseases of a specific character, especially in a country like this, where this disease in particular never or very very rarely presents a normal aspect, and where the patient is exposed to so many and various vicissitudes of climate, etc. Below are given the notes taken at the *post-mortem* examination, the extraordinary condition of the small intestines being most interesting; the extent to which the patient had recovered as regard his lungs and healed ulcers in the intestines is also interesting, and is verified by the notes taken at the *post-mortem*.

Post-mortem appearances about fourteen hours after death.

Body.—Greatly emaciated.

Brain.—2lbs. 12 ozs. Vessels all injected, membranes much thickened.

Face, left cheek (involving its whole substance) presented a large, black, irregular and charred-looking exudation. The whole cheek was destroyed from the angle of the mouth to almost the articulation of the jaws. Gums commencing to be involved.

Right cheek not so extensively involved.

Lungs.—Right, 19ozs.; nearly healthy, slightly congested. Left, 7¾ ozs.; healthy.

Heart.—7¾ ozs.

Liver.—3lbs. 6 ozs., very dark colour. Gall-bladder distended.

Spleen.—13¾ ozs.; enlarged, soft.

Kidneys. *Right.*—4 ozs.; very hard.
Left.—6½ ozs. „ „

Intestines. *Small.*—About 8 feet, perfectly black and gangrenous looking; some ulcers healed and cicatrized, several partially healed. Ulcers here and there throughout whole tract. *Stomach* irritable looking.
Large.—Congested.

No Entozoa.

Since writing the above I have had pointed out to me a case (vide *Indian Medical Gazette*, page 14, of January 2nd, 1882) which, in some respects resembles the one under notice, the difference being that my case was partially the result of enteric fever, whilst the one referred to was undoubtedly the result of malarial poisoning. The author thereof, who must have had

extensive experience, points out that though cancrum oris is very common amongst natives whose constitutions have been debilitated by constant exposure to malarial influences, it is most rare among members of the army who spend a considerable portion of their lives out here.

Studying then this case and the one I have recorded, the question arises was my original idea of my case (*i.e.*, that it was due to acute malarial poisoning) correct, or partially so; could, as I have suggested, the enteric and other lesions have been secondary to the original disease? From what I have said, and, after discussing the *post-mortem* examination notes, it would appear that it could not be so. The two cases together, however, are most interesting, and give endless food for thought. Some will say enteric fever is a specific disease, *i.e.*, it attacks *de novo* certain structures in a certain portion of the body only. With this, from my own experience, I agree and acknowledge that for this reason the case I have recorded must have been one of enteric fever. But I also maintain, more particularly after having perused the case referred to, that in all probability in my case malarial influences had a good deal to say to the patient's extraordinary condition. In fact, we have a case of acute malarial poisoning *followed* by enteric fever, and from the patient's previous history it would appear that the poison (malarial) had for some time lain dormant or accumulated in his system.

Speaking of this, I would put forward interrogatively, and with the hope of gaining knowledge, also hoping possibly to assist those who know infinitely better than I do and have had far greater experience and opportunities of observation than I have, a theory, which has occurred to me as a result of personal intimacy with, and careful practical observation of, a number of cases, *viz.*:—

To what extent is the poison, or originator thereof, of malaria, accumulated, or capable of being stored in the system, and, if so capable, how long may it lie dormant; indeed, is it capable of never developing disease at all? If such an accumulation or deposit is possible, does it take place in the same way as does the poison of tuberculosis or is it not accumulative, but only, after entering the system, circulates in the blood, its quantity at certain times in that fluid depending in the action of the skin, etc., and its quality depending on the surrounding circumstances to which the recipient is exposed.

For my part, at present at any rate, I am inclined to think that the poison, or its originator, is deposited in the system, and, when once so deposited, is accumulative; indeed I have seen several instances which have led me to believe that such is the case, and instances of such cases brought forward as the result of practical experience and observation are most interesting, and likely, eventually, to assist in gaining useful and beneficial knowledge concerning a subject, about which we are so ignorant.

It seems to me possible, nay probable, that the poison or its originator may enter the system and be deposited therein—probably in the glands or brain and spinal cord—and, if this does occur, the various types which the disease dependant on the poison assumes, may, as will be presently seen, be perhaps more easily explained.

If we take a person with a tuberculous diathesis (supposing we do not know that he is so infected,) apparently healthy, and who states that he never had a day's sickness; well, we know, at least I do, from personal experience and observation, that such a person may continue for years and years in good health, but if he is exposed to certain unknown influences, atmospheric, telluric or what not, he suddenly becomes the victim of acute, or otherwise, tuberculosis, and, from that time he is no longer a healthy vigorous man, nor will he ever be so again, the soil on which the fatal seed was sown has, owing to surrounding circumstances, become fit to allow of the seed taking root and developing.

Somewhat in the same way the poison or its originator, of malaria, may be deposited in the system, its development depending on surrounding circumstances: and as I have supposed, it may lie dormant and accumulate, and the more an individual is exposed to malarial influences directly, the greater may be the actual deposit of the poison or originator, or the more susceptible to the action of the poison may the subject become: by this I mean that either the originator of the poison may be a substance concerning which we are entirely ignorant, and which may be deposited in an infinitesimal quantity, but which, under certain circumstances, has the power of developing the poison, its activity depending upon the system on which it has to work; or it is a deposit in the system of organisms, the quantity depending upon the extent of exposure of the individual to these organisms, which are capable of being stored in the system in an inactive state, and, not only stored, but which also have the power of reproducing themselves, and which, during this process of reproduction, still remain inactive, their vital force being brought to notice only, when the system owing to surrounding influences is rendered fit soil for them to produce the peculiar phenomena we so well know in connection with fevers of malarious origin. To demonstrate that in all probability this accumulative theory is correct, and how great may be the shock sustained by an individual on whom the poison be so accumulated, I quote one case which came to my notice in the year 1885.

A young exceptionally healthy and strong British Subaltern came out to India in 1881 with his regiment; he served four years in the plains at Jhansi, Fyzabad, &c.; during that time he

spent his leaves shooting, sometimes in the Terai, at others in malarious districts and Sarun. After four years, during which period he enjoyed excellent health, he was appointed Adjutant to a Goorkha Regiment stationed at Abbotabad, which I am informed is a very healthy station. When he had been there but a few days, he went out for a drive with a friend in the evening. When he started he was perfectly well, but the drive terminated most disastrously for him as he was brought back insensible. For two or three days he continued in this state, and his life was despaired of, there being nothing to account for his terrible condition. However, he recovered and was sent home on a year's sick leave. When at home he visited many eminent physicians, specialists on the liver, kidneys, &c. The one verdict returned always being that he was sound, and that his peculiar condition in India was inexplicable. For many years I have been possessed of my "accumulative" idea, and when asked my opinion on this officer's case, I suggested that it was one of acute malarial poisoning. The shock in his case was so great that he might just as well have been thrown out of his trap and have sustained concussion of the brain, instead of having become insensible when quietly sitting beside his friend. That my suggestion was correct, or, in all probability so, I soon became assured of, as shortly after coming home this officer (he was in London) developed regular tertian ague and fever. This very marked case, and others I could quote less marked, convince me that, supposing I am mistaken, the theory, at any rate, is worth considering. A theory such as I advance is the only one, as far as I can judge, that can account for all the extraordinary phenomena connected with the fevers of malarious origin. Unless the poison, or its originator, can be stored in the system, how can we account for individuals developing malarious fevers, intermittent, continued or otherwise, when perhaps they have been living in a non-malarious climate for years, and have not been exposed to malarious influences for a still greater number of years. Take for instance a man who was born in Devonshire, lived there till he was twenty-one years of age —at that age he goes out to India, and is stationed in a malarious district: he remains there three years, all the time enjoying good health, and, very probably during this time seeing his friends and neighbours victims to fever in its various forms—well, from this district he is transferred, say to some hill station where he remains four years; at the end of this time, he goes home again to Devonshire in perfect health apparently, when, in a few weeks, to his astonishment, he suddenly gets an attack of fever and ague—to counteract the effects of the poison he takes well quinine, and may or may not get rid of the fever. Quinine is an undoubted antidote, but the extent to which our patient is susceptible to its action depends entirely on the extent to which his system is saturated with the poison, plus those surrounding influences which existing everywhere, up to date, have not rendered him susceptible to its action.

The above fabricated case is not overdrawn as any one who has seen much of malarious fevers will corroborate; indeed, many and varied instances similar to the above are common. Again, this theory can account for the extraordinary conditions seen amongst native children, who, I may say, suffer from chronic malarial poisoning, and who possess these enormous "ague cakes" (spleen); in such cases the children born from parents whose systems are saturated with malaria come into the world hotbeds for the development of the poison, whose seed they at once assimilate: or, perhaps, and I don't see why it should not be so, the seed or seeds or organisms are deposited in utero. Well, with the hope of gaining knowledge and of perhaps assisting those Bacteriologists and Pathologists who are eminently more capable of dealing with the subject than I am, I would suggest that the *de novo* cases of fevers of malarious origin are due to a deposit in the system of, as I said before, a so far unknown substance whose properties I have dealt with, or to the actual deposit of bacilli in an inactive state—an inactive state not referring to their own powers of development whose activity, as regards the production of the phenomena connected with the fevers, is due to surrounding influences which render the system susceptible to their poisonous action. A suggestion then would be to those who are in a position to undertake the investigation to examine *especially* the brain and spinal cord, then the glandular structures of the body, in *all cases*, when possible, of individuals who have been exposed even to the slightest degree to malarious influences, or who have been born from parents who have been so exposed, to ascertain whether the bacillus malariæ in any of its stages may exist. It has been demonstrated that, during certain stages of the fever, bacilli innumerable exist; well from what I have said, either they, or they in some form, must have pre-existed.

It may be argued, oh! but in other stages of the disease these bacilli are invisible. All I can say is then, that either owing to the exhibition of an antidote or because the organisms have lived their life, they no longer exist, their memory being painfully impressed upon us by the fact that they have so altered the condition of the blood and so deranged the nervous system that fever is the result. However, as I think I have pointed out, either more bacilli exist in an inactive state, or they exist in embryo, their development, as I said before, depending upon certain unknown influences. To continue then, it would appear that the occurrence of fevers of

malarious origin is due to the deposit in the system of a poison or its originator, which under certain circumstances becomes active, producing the phenomena, we are so well acquainted with in connection with those fevers. It may be asked now, what are those circumstances or surrounding influences upon which so much depends? In reply, I say I do not know what they are—possibly, as suggested, atmospheric or telluric: however, be they what they may, it would appear certain that they exist not only in locô malariæ, but also everywhere else; how else could an individual become the victim of malarious poisoning, when he is in a non-malarious district and has been free, possibly, from malarious influences for years? Next, the question arises: but a person who has been exposed to malarious influences must to a certain extent have been exposed to these influences in question; else, how could the poison or its originator have come into existence prior to its assimilation by the system, and, if so exposed, why doesn't he at once, or even shortly, fall a victim to the effects of the assimilated poison? To this I answer, that either the poison or its originator exist in locô malariæ in embryo, *i. e.*, in the same inactive state in which it exists when assimilated; its development then into an acute form, depending partially on those surrounding influences which, as shewn, exist not only in locô malariæ but also in all parts of the world, plus either the state of the recipient's health, or more probably still the condition of the recipient's nervous system: or, as before suggested, the originator of the poison is a substance of which we are entirely ignorant, and which is assimilated and deposited in the system, its active development depending upon the same unknown influences; but depending on them when existing under different circumstances. The foregoing theory and arguments, I am well aware, cannot, at present, materially advance our knowledge of fevers of malarious origin, but at any rate they apologize to some extent for our ignorance in the matter; but, if it be proved, as I feel sure it will be, that as in tuberculosis a substance or organism or poison is deposited in the system in an inactive state, which substance can lie dormant for an indefinite period, coming into activity under certain conditions, then, at any rate, we shall be in a position to give a definite prognosis concerning the disease, and shall be able to show the world at large that we are not ignorant concerning the etiology of a disease whose symptoms, and indeed treatment, we are so well acquainted with. What is the use, some may say, of knowing that the disease is originally due to a certain deposit in the system, if we are ignorant of those other influences on which that deposit is dependant for its action? Just as much use, I say, as knowing that tuberculosis is originally due to a deposit which may lie in an inactive form in the system; indeed, I may say of more use, as it would appear certain (from the peculiar phenomena connected with the disease, *viz.*, rigors, periodicity of the attacks) that the nervous system is a factor indispensable to the development of the disease: indeed, as I before suggested, the brain and spinal cord may be the home of the deposited poison or its originator. To recapitulate then, I would suggest that for the production of fevers of malarious origin, and to account for all the peculiarities connected with those fevers, there must be a deposit in the system (the locality already discussed) of a poison, or its originator, which may lie dormant and accumulate in that system for an indefinite period—its active development depending probably on certain climatic surroundings, plus a certain constitution of the victim's health or nervous system.

To conclude, I would say that though the above paper may prove foolish and uninteresting, I consider it a duty when (from practical observation and careful examination) one becomes possessed of an idea which may prove useful, to inflict that idea with its consequent arguments on the medical world, full well knowing that, in that world, there are many who are capable of, with a grain of a new and common sense theory, converting that grain into bushels of useful and beneficial knowledge.

Finally, be it understood, I would bring forward many cases to support my depositing theory, and could, but it appears to me unnecessary to advance more arguments in favour thereof.

A Mirror of Hospital Practice.

TWO CASES BEARING ON THE TREATMENT, IN AN EARLY STAGE, OF FILARIAL DISEASE OF THE LYMPHATICS.

By Surgeon-Major J. MAITLAND, M.D.,
Ootacamund.

R. R., Hindoo, age 24 years, a student, was admitted into Hospital on the 19th February 1889, on account of two tumours in the right femoral region.

History.—The disease commenced eight years ago with rigors, fever, and the appearance of a small lump in the right groin. Since then he has been subject to periodical attacks of fever, accompanied by swelling in the same region. These attacks used to come on at one time as frequently as once in four days; but latterly, they have only come on once in three or four months. During the attacks there was always severe pain in the right groin, and at times there was swelling and pain in the scrotum. The lumps in the groin have grown gradually larger since the first attack. The patient consulted a medical man, who said, that the tumour was a hernia, recommended the application of a truss, and advised the patient to go to Madras to be operated upon.