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PRACTICAL MEDICINE.

THE MUCOUS MEMBRANES IN SCARLET FEVER.

Dr. A. Monti says *(Jahrbuch fur Kinderheilkunde*, vi. 3, p. 227, 1873), that the intensity of the scarlatinal sore throat is not proportional to that of the rash, but differs according to the epidemic constitution.

1. *Simple Scarlatinal Sore Throat (angina scarlatinosa simplex).*—This is the most essential and characteristic, and also the earliest symptom of scarlet fever. It begins with more or less uniform redness of the middle of the soft palate, the uvula alone, or the uvula, anterior pillars of the fauces, and tonsils; never the hinder wall of the pharynx alone. [The part first affected in small-pox is the hinder wall of the pharynx; in measles the posterior pillars of the fauces and neighbouring parts of the pharynx are always redder than the anterior pillars and soft palate.] For the first twelve hours there is very little swelling of the affected parts; children seldom complain of pain in the neck, or in swallowing. This form of angina often renders it possible to suspect scarlet fever before the rash comes out. After twelve or twenty-four hours, the redness (which is at first circumscribed by a very well-marked outline) becomes more intense and extensive; the parts swell also; pain in swallowing and in the neck are felt. The redness becomes less uniform, and more punctiform. This punctiform angina commonly shows itself six or twelve hours before the rash on the skin. It is still more sharply contrasted with the natural mucous membrane around. Angina faucium following the course described is quite pathognomonic of scarlet fever. After twelve or twenty-four hours more the redness begins to lessen, and has quite disappeared by or before the disappearance of the cutaneous rash, except in cases which may be called anomalous.

In these anomalous cases the redness of the fauces is livid; and during the height or the fading of the skin rash, great swelling of the uvula and anterior arches of the palate occurs; swallowing becomes proportionately difficult. In cases which do well, this swelling begins to diminish in one, two, or three days.

In other cases there is a further development of the anginal lesion. Vesicles, miliary in size, beset the uvula, the anterior pillars of the fauces, and the tonsils. The contents of the vesicles soon become turbid, and then there is an appearance as of small false membranes; but in reality the condition differs greatly from the diphtheritic lesion shortly to be described. Small ulcers follow the rupture of these vesicles.

The follicles of the tonsils become filled with an excess of puriform secretion, which is subsequently discharged so as to form a kind of false membrane on the surface of the tonsils. This exudation disappears along with the other anginal lesions.

2. *Malignant Scarlatinal Sore Throat.*—This form of angina consists in parenchymatous inflammation of the tonsils and neighbouring connective tissue. The cases in which it occurs are for the most part those in which the nervous symptoms are well-marked. The angina assumes this form from the first, i.e., in the prodromal stage. Resolution may be the result, but usually small abscesses form in the tonsils. These abscesses either heal or are followed by sloughing.

3. *Diphtheritic Scarlatinal Angina.*—In some epidemics this is a very frequent complication. The author agrees with Trousseau, that the larynx usually escapes. Paralysis of the soft palate sometimes follows; but paralysis of the limbs never. The author minutely describes three forms of scarlatinal diphtheria; the circumscribed, the diffused, and the septic. In the epidemic which he studied, diphtheritic sore-throat occurred in nearly one-third of all the cases (31 out of 105; in three cases, at the beginning of the disease; and in twenty-eight, at the height of the disease or afterwards.

THE PREVENTION OF PAROXYSMAL COUGH.

Dr. John Stockton Howe, of Philadelphia *(American Journal of Medical Science)*, has an article on the prevention of paroxysmal cough. He tells us that at the age of twenty, while a medical student, he took the whooping-cough, and the abdominal tenderness occasioned by the almost incessant coughing was so severely painful that it was necessary, in addition to the usual remedies, to resort to some method to lessen the effect of the diaphragmatic succession, or prevent the paroxysm of cough. The former was in some degree alleviated by placing the arms across the abdomen, and bending the body as far forward as possible, thus making considerable compression of the abdominal walls. But this last procedure did not afford sufficient relief; and at the time of a paroxysm the fortunate discovery was made that, by coughing out with a strong expiration, and immediately following it by a long deep inspiration through the nostrils, succeeded by slightly hurried breathing through the nostrils alone (keeping the mouth tightly closed from the time of the first cough), the paroxysm was generally prevented—rarely coughing more than once, instead of six to twelve times, as was the case when this precaution was neglected.

This fact seems to favour the theory of reflex irritation of the fauces, from sudden access of cold air at the gasping inspiration usually succeeding the first cough, as the cause of the paroxysm; while breathing through the nostrils allows of the air being warmed and moistened by contact with a mucous canal five or six inches in length.

It is unfortunate for the application of this remedy, that the majority of those suffering from paroxysmal cough are too young to be taught how to cough; but Dr. Howe does not think they suffer a tenth part as much from abdominal tenderness as those who are old enough to apply it; which latter—if the author's case were not above the average degree of severity—will gladly avail themselves of a remedy, unique in its effect, and easily applied, to relieve them of their excruciating agony.

COLD BATHS IN THE FEBRILE DISEASES OF CHILDREN.

Dr. G. Mayer has treated *(Jahrb. fur Kinderheilkunde*, vi. 3, p, 271, 1873), typhus (enteric ?) fever, pneumonia, scarlet fever, and erysipelas, occurring in children, by cold baths.

Of enteric fever (?) he treated more than twenty cases; all with a good result. The youngest child so treated was seven months old. The temperature of the water employed was 90° Fahr. to begin with, gradually reduced to 80° or even 70°. The duration of the bath was ten to fourteen minutes. An axillary temperature of 103·5°, or a rectum temperature of 103°, was regarded as the indication for a bath.

In catarrhal pneumonia Mayer abstains from baths; the danger to life lying, as he truly says, not in the pyrexia, but in the suffocation. In lobar pneumonia (croupal pneumonia, peripneumonia), on the contrary, antipyretic treatment is very useful. An infant, seventeen months old, was treated in this manner; in eleven days sixty baths, reduced to a temperature of 80° and 75°, were given. Mayer especially recommends cold baths or ice to the head in cases of pneumonia complicated with a convulsive tendency; deeming the convulsions to depend upon the pyrexia.

The results of cold baths in scarlet fever are not so satisfactory; except in the ataxic (or 'malignant') form of the disease, which has been treated in this manner, as everybody knows, since the days of Currie (1805).

Quinine he has tried in enteric fever; for a child of six, from seven to twelve grains, in two doses, half an hour or an hour apart, in the evening. A notable fall of temperature follows. Occasionally vomiting, deafness, and slight increase of diarrhœa ensue.

RETROPHARYNGEAL ABSCESS IN THE FIRST TWO YEARS OF LIFE.

Dr. Schmitz *(Jahrbuch fur Kinderheilk.,)* says, in three years he has seen sixteen cases of retropharyngeal abscess. Not one of these cases was associated with caries of the vertebræ, and therefore the author calls them idiopathic. He believes that the disease is commonly due to a lymphadenitis of the postpharyngeal lymphatic glands, which are constantly present up to the third year of life. In seven of the sixteen cases, the abscess formed a soft swelling below the jaw,