A third point, of which my case affords an example, has not been noticed, as far as I am aware, in the heretofore published records of the disease, *viz.*, that the eruption may even extend to the cutaneous branches of the third, or inferior maxillary division of the fifth, and show itself on the lower lip.

The history is epitomised from the hospital case book, in which it was very carefully kept, by my late excellent pupil, now sub-assistant surgeon, Jaswunt Roy. Narain aged 40, (Hospital Register VI., page 286), admitted May 6th, 1867. Twelve days previous to admission, he began to suffer from fever: this continued for six days, and was periodic, occurring at night only. It was followed by severe frontal headache, for which he used some native application with temporary relief; but it soon returned with severity, and small vesicles appeared in clusters, at first on the forehead only, but within two or three hours, on the side of the face also. When admitted he complained of pain in the forehead, especially on the sound (right) side, and in the eye of the affected (left) side.

The vesicles were collected in patches, scattered on the left side of the face, not extending beyond the median line. The parts, occupied by vesicles, were the left side of the forehead, the upper eyelid, side and tip of the nose, the edge of the left ala, and the interior of the nostril, the upper lip, the tuberosity of the malar bone. There were a few spots in front of the face, about an inch external to the ala of the nose, and two or three on the lower lip. The whole was accurately limited by the median line. The patient was very weak, so that examination, in the erect posture, made him feel faint.

7th.—Much the same. Ol. ricini ʒ vi. lotio. plumbi to the face and forehead. 8th.—Quinine mixture ʒi terdie.

9th.—Complains of only slight pain: a good deal of swelling of the left upper eyelid; and slight inflammation of the conjunctiva, with chemosis.

10th.—Swelling of the upper eyelid gone down. Iris unaffected: there is a small phlyctenula at the upper and outer margin of the cornea, and a little opacity near it. There is one single vesicle on the *right* ala of the nose, and another on the *right* side of the lower lip.

13th.—Many of the vesicles have dried. The pupil of the left eye has been dilated with atropine, and is regular. The inflammation has subsided, and the patient looks better.

14th.—Almost all the vesicles are dried up; complains of slight pain in the left temple only.

16th.—There is a slight general haziness of the cornea, which is most marked in the centre; pupil still regular.

20th.—Slight nebulosity still present; vesicles are all dried up; complains of pain in the parts where the vesicles were.

21st.—Severe burning pain on the left side of the face; cornea still nebulous.

22nd.—Complains of great pain in the left side of the forehead and face, although the vesicles are all healed up, and nothing but cicatrices remains. Tincture of aconite to be applied.

27th.—Cornea almost clear; vision perfectly good, no pain, slight vascularity of the conjunctiva. Discharged.

This disorder in the face, must be somewhat uncommon amongst the natives of India. I certainly never saw it before in this country. Its occasional occurrence, however, is sufficient to render it interesting. Possibly it may be more common than would appear from my experience of a single case, for it may have been occasionally mistaken for erysipelas, from which it is distinguished* by its limitation by the medial line; by the smallness of the vesicles; by the special affection of the eye, sometimes running on to destructive inflammation; by the absence of danger from metastasis; by the severe pain, often commencing before the eruption, and persisting long after it, in some cases, rendering the patients existence miserable, and making him glad to submit to any remedy for its relief. Mr. Bowman relates some cases, in which division of the frontal nerve was successfully performed for this lasting pain. In my patient the pain was comparatively trifling, and was soon relieved by the application of tincture of aconite.

Much of course might be written about this curious disorder; but, as its main characters have been pointed out by Bowman and Hutchinson, I will not recapitulate the descriptions of these very able writers. My object is, simply, to show that the disease occasionally occurs in this country, and that the eruption may extend to the inferior maxillary division of the fifth, in the lower lip.

## CASE OF CUTANEOUS ANÆSTHESIA.

By Assistant-Surgeon B. Evers,
18*th Regiment, Native Infantry.*

Instances of the above disease so very seldom come under observation, that I forward the particulars of a case in the hope of eliciting something regarding its true pathology from my professional brethren.

The subject of the following remarks is the wife of a jemadar in the 18th Native Infantry. She is 22 years of age, and was married in her thirteenth year.

For the last two years she has been subjected to a variety of treatment, and even up to the day on which I saw her, fully believed herself to be a martyr to rheumatism.

Early in 1867, and about a year after child-birth, she began to experience short sharp pains in the right leg, but the limb did not swell, neither was there any pyrexial disturbance, no single *joint* has ever been attacked by this so-called rheumatism.

About six months after these symptoms first appeared, she gave birth to another child, that died shortly after from ulceration (probably syphilitic) of the mouth and arms.

It was about this time that she first noticed a whitish spot, in which sensation was completely lost, about an inch above the internal malleolus of right leg. This anæsthesia spread day by day, and now covers a space of very nearly five inches by three. For the last five months, however, the disease has been stationary. The affection is evidently confined to the parts supplied by lower portion of the internal saphenous nerve and its branches. In the earlier stages of the disease, the short sharp pains were almost constant, but at present she is quite free from them. She, however, complains of pain in the back, just above the posterior superior spine of the ilium. Motor power in the limb is perfect, and "one leg," she says, "is quite as strong as the other." The skin in the diseased part is somewhat thickened, and slightly roughened from frequent shedding of cuticular epithelium. The nails are not in any way affected.

Has otherwise always been in apparently good health. Urine normal in sp. gr., composition, &c., menstrual functions healthy. The temperature of the part affected is 92° f, in all other parts of the same limb 93° f. In the left leg the temperature is 94° f, and in the hands and trunk rather over 97° f.

The want of sensation in the diseased part is *so complete* that its boundaries could be determined with the point of a pen-knife. There is not the slightest history of anything like accident or injury, and nothing that could possibly be referred to pressure in the course of the nerve.

The question therefore comes to be.—Is the disease centric or peripheral? If centric, the loss of sensation should extend to the whole distribution of the nerve. If purely peripheral, how comes it that the portion of nerve below the affected part retains its function, for the internal saphenous nerve, as we all know, passes well on to the dorsum of the foot. Might not the retention of sensation in these parts be referred to the musculo-cutaneous nerve, some of the branches of which unite with those of the internal saphenous. Is the pain in the back in any way connected with the affection in the leg? How is the loss of temperature to be accounted for? Is it simply consequent upon impairment of nerve force; or is it due to circulatory obstruction, the result of chronic arteritis? The circulation in the large vessels of the leg and foot is not in any way affected.

Professor Maclean of Netley, in a case that came under his observation, drew attention to the symmetrical nature of the disease:—Within the last two months my patient has noticed a whitish spot, in which sensation is fast disappearing, on the left leg, just above the internal malleolus, and, she says, that it was exactly in the same way the disease commenced in the right leg. This seems confirmatory of the learned Professor's observation.

The disease is certainly not anæsthetic leprosy: it will give me great pleasure to receive any suggestions as to the treatment proper in this case.

## CASE OF CHIONYPHE CARTERII.

By Honorary Assistant-Surgeon Minas.
*Civil Surgeon, Mozufferghur.*

This case, inserted in the hospital returns by the Native Doctor as "caries of the foot," I found to be the same disease as prevails in the sandy parts of Bhuttiana and Hurrianah; accounts of which were given in the *Indian Medical Gazette*, during 1868.

Fuzzool, aged 60, Mussulman cultivator, admitted 6*th* December. About 30 years ago a small abscess formed under the arch of the left foot, it continued to discharge after being opened, and about a year after another abscess formed in the middle of the heel; gradually those abscesses extended to the malleoli and dorsum of the foot, discharging matter which the patient described as "something like the white of an egg mixed with a small blueish grain-like substance."

Up to within the last year he has been able to walk about with the aid of a stick; but latterly has been confined to his bed, and the pain in the affected part has been agonizing day and night.

The leg was amputated below the tuberosity of the tibia by a single flap, some secondary hœmorrhage occurred, and diarrhœa retarded his convalescence, but he was discharged with a good stump on the 6th January.

* See Mr. Bowman's and Mr. Hutchinson's papers.