FILARIASIS IN SAMOA.

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As a supplement to Surgeon V. Gunson Thorpe's interesting paper on filariasis in the South Sea Islands (British Medical Journal, October 3rd, 1896), I wish to record the result of the examination of certain blood films kindly sent to me from Samoa by Dr. Davies in 1884. The films were 56 in number and represented the evening blood of 56 adult Samoans, each of whom was affected by some form or other of elephantoid disease, either elephantiasis, or elephantoid erysipelas, or lymphangitis, or recurrent elephantoid fever. Of the 56 slides 27 contained filariæ, 29 had no filariæ. In some slides—each equivalent to about half a drop of blood—only from 1 to 10 parasites, in others from 30 to 100 were found. In not a few they were present in enormous numbers; 4 contained 161, 132, 165, and 232 filariæ respectively, and in one slide, by no means a large one, I counted no fewer than 566 filariæ.

It is evident, therefore, that filariasis is quite as common in Samoa as it is in Fiji and the Friendly Islands, if not more so. Unfortunately, Dr. Davies's slides were in a measure selected, coming entirely from that part of a filariated community least likely to show filariæ in the blood—namely, from the subjects of elephantiasis, that is of filaria-blocked lymphatics. Elsewhere I have endeavoured to show that such individuals are the least likely to have filariæ in the blood, seeing that the disease to which the parasite gives rise cuts its progeny off from the circulation. I have little doubt, therefore, in view of the enormous proportion of elephantiasis cases in Samoa, showing filariæ in the blood, that further investigation of the healthy adult population will bring out the startling fact that practically all adult Samoans harbour filaria nocturna, or are the subjects of filaria disease.

WARM BATHS IN THE TREATMENT OF MEASLES.

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Some eight or ten years ago, being called to a child supposed to be suffering from bronchitis, the breathing being greatly affected, I ordered the usual linseed-meal poultices back and front. The result was to bring out a rash upon the poulticed parts, unequivocally showing measles, none of the ordinary premonitory symptoms of that disease, except the pulmonary trouble, having previously appeared. Seeing this I had the patient placed up to the neck in a hot bath of 90° to 100° F., or as hot as could be borne without pain, in front of a good fire, screened from all draughts, and kept there for some 6, 8, or 10 minutes. Even whilst in the water, the rash could be seen extending over the rest of the body, after removal from the bath he was roughly dried, wrapped in a warmed blanket (without bedclothing), and put into bed. The breathing gradually became easier, and in a short time he was asleep. The bath was repeated twice daily for the first two or three days; in about ten days the case was well.

It has since been my invariable practice to order a hot bath immediately the diagnosis of measles has been made, and often before, if any suspicions of the disease were aroused, though not confirmed. After the bath the patient is dried roughly and wrapped in a warmed blanket. I repeat the baths every twelve hours, or oftener in obstinate cases (sometimes as many as five and six a day), until the rash is fully developed over the entire body, and continue them twice daily until a normal temperature is re-established, and then once daily, generally in the evening, during the whole of the attendance, which I find rarely if ever extends over ten days. The course of the disease is shortened, the tendency to respiratory and renal complications lessened, if not practically removed, at the same time it is very seldom that any of the usual sequelæ supervene, if they do it is only in the very slightest possible degree.

I have now adopted this treatment for the last eight years, in combination with isolation in a well ventilated room, having a sheet over the outside of the door sprinkled with a solution of carbolic acid in the usual way. I have generally succeeded in restricting the infection to the one case, even when the families numbered some five or six children. And of these first cases, I can unhesitatingly assert that 99 per cent. were well on the tenth or elventh day, and if the weather favourable, out on the twelfth day.

Some mothers, or grandmothers, make great difficulties, owing, I believe, to the old superstition "that measles must not be touched with water." But whenever I have been able to ensure that my directions were thoroughly carried out, there has always been a successful termination, and I have never found any real necessity to prescribe active medicines even for relieving the cough, which gradually subsides as the case recovers.

Having recently read of the application of the milkpack in the treatment of eruptive fevers, I have in several cases added from half to a full gallon of milk to the first bath (as a modification of the milkpack treatment in which the patient has also to submit to a warm bath after the packing). I have carefully noted the effects of the two methods; namely, of hot baths with, and hot baths without milk, in cases under treatment at the same time; the results were practically identical.

Having only this year had quite an epidemic of measles in these parts, I have been able to confirm the above remarks. In every case that has come under my care, and they have been numerous, the treatment has been successful where it has been used, and this fact it is which has emboldened me to make known my experience.

I would suggest a trial of this treatment in other diseases, as scarlet fever and small-pox, in which, on account of the prompt action of the sanitary authorities, I have had no opportunity of properly testing. But, as with measles, I have no doubt that this plan of assisting Nature in the elimination of the virus would give favourable results, and not only greatly tend to lessen the mortality, but also minimise the risk of the infection or contagion spreading.

I always add a disinfectant to the bath after use.

I never allow the head of the patient to be wetted when giving the baths: the hair takes long to dry thoroughly. The chance of a chill, which is to be carefully avoided, is thus diminished.

ON THE OCCURRENCE OF ZONA BELOW THE KNEE, WITH NOTES OF TWO CASES.

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The great rarity of recorded cases of herpes zoster occurring or extending below the knee is evident from the scant mention of the condition in the leading textbooks on diseases of the skin. Even in Kaposi's great work the subject is dismissed in a few lines. In Fox's *Atlas*, plate xxvii, the eruption does not extend below the junction of the upper with the middle third of the leg. According to Dr. Pye-Smith, Mr. Hutchinson says that it never extends below the knee, "and the only instance to the contrary is one figured by von Bärensprung in which there were a few small papules as low as the middle of the calf."[1]

In an able paper in the *Journal of Pathology and Bacteriology*, February, 1893, p. 343, Dr. James Mackenzie says, "accurate reports of cases of eruption below the knee are scarce." He quotes a case described by Blake in the *Birmingham Medical Review*, the eruption being over the inner side of the leg below the middle of the calf, the inner ankle and the dorsal and plantar surfaces of the foot representing probably the area of distribution of the fifth lumbar nerve. A case described by Taylor in the British Medical Journal, July 6th, 1889, in which the eruption extended "along the course of the internal saphenous nerve from below the knee to the inner ankle." A case is mentioned by Charcot,[2] the herpetic vesicles being seated on "the antero-external surface of the left leg," the subse-

[1] Fagge and Pye-Smith, *Principles and Practice of Medicine*, 3rd edition, p. 938.

[2] *Maladies du Système Nerveux.*