

gist there, and from Dr. Dench, that the presence in the discharge of the *Streptococcus mucosus capsulatus* is considered sufficient to justify early operation. The patient may have little or no pain, little fever, no increased polymorphonuclear count and very little, if any, leukocytosis, and yet if this germ is present there is likely to be early involvement of the sinus. After returning home I had my assistant examine the discharge more commonly than before and we discovered only one case. In that case the patient refused the operation suggested, but later I heard he had to have two operations performed. There were practically no other symptoms when I saw him, except the discharge.

DR. SHERMAN VOORHEES, Elmira, N. Y.: This was a primary infection of the bulb, undoubtedly, although I did not find any opening into the bulb. As the last speaker said, I am satisfied that the case came from infection of the bulb. There was absolutely no pus in the mastoid. Except for the cells being congested, there was no affection of the mastoid. I was, unfortunately, denied an autopsy. The diagnosis was made from the high temperature and the sudden drop. When we get a temperature of 105 to 106 F. I think we are justified in exploring to see if the sinus is not thrombosed. The infection must have come from the middle ear.

A CASE OF MYOSITIS OSSIFICANS PROGRESSIVA

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CHICAGO

The opportunity of recording the history of this patient I owe to the courtesy of Dr. Lucian D. Clark of Toledo, Ohio, who brought her to me for examination December 7, 1907.

History.—The patient, F. B., was a girl of 17. There had been no other case of myositis ossificans in the family. Both parents were of American birth, living and in good health; no lues, no tuberculosis; two other children were living and in good health, neither of them presenting any developmental anomalies. Birth of patient was non-instrumental and labor was neither prolonged nor difficult. She was breast-fed and did not suffer from any infantile diseases nor exanthemata. At the age of 1 year it was first noticed that the thumbs and great toes were malformed. The mother stated that shortly after the patient entered her second year lumps (nodes) were observed to form on the head. They were never due to injury and appeared and disappeared without apparent cause. They were tender to pressure but never suppurated. At intervals during the succeeding three years similar nodosities developed on the back and shoulders, coming and going, but never entirely absent. At the age of five torticollis appeared and persisted about six months, the muscles of the neck being hard and tender. Subsequently swellings appeared on the arms and legs, interfering greatly with voluntary movements, so that the patient could neither feed herself nor walk. These swellings were painful and tender and more or less ephemeral, shifting from place to place on the extremities, lumps or nodes showing from time to time on the back. These were very sore but never suppurated. Since the age of 5 the patient had never been able to freely abduct the arms and had never in her life been able to comb her hair. When she was about 5 years old her medical attendant discovered the existence of a valvular heart lesion. There had been no previous definite rheumatic or other acute infection. The general health had never been robust, but aside from the special disabilities of her disease there was an entire absence in her history of morbid incident until January, 1907, when she had typhoid fever. In July, 1907, Dr. Clark was consulted for stiffness of the jaws. The jaws were locked so that she was unable to masticate solid food and was compelled to subsist entirely on a liquid diet. The teeth could be separated but very slightly, the submaxillary region being filled with a hard bony deposit. Shortly after this development swellings were observed along

both sides of the thorax. These were hard and circumscribed but were not tender to pressure or painful, and were apparently not connected with the ribs. These gradually disappeared. In October, 1907, the arms became stiff and the right elbow joint developed a partial fibrous ankylosis, preventing voluntary movements of the joint and but slight manipulative freedom of the articulation. The right elbow remained uninvolved and freely movable. Gradually the left shoulder became stiff, movements of the left arm on the body being seriously restricted.

There had been little pain throughout, the only subjective discomfort being a certain soreness and tenderness on pressure and manipulation of the indurated areas during the early stage of their formation. The skin over involved areas had at times been suffused and slightly edematous. As the indurations grew, harder the soreness would disappear and when fully developed no tenderness was present.

Areas of involvement had been observed to disappear and there had been periods of arrest or quiescence during the progress of the disease. Soon or late, however, fresh areas of induration would make their appearance and run through a subacute progress to firm bony consistency causing much

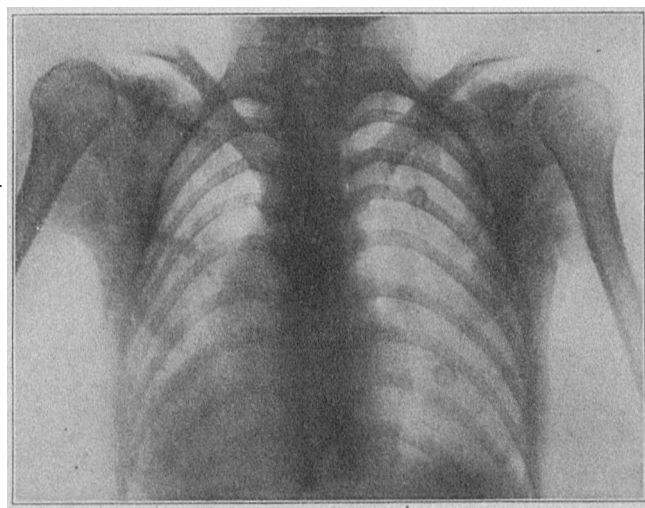


Fig. 1.—Bony induration of the submaxillary tissues; the lower jaw was displaced to one side and the incisor teeth did not articulate. The anterior and posterior muscles of the neck presented more or less induration; the mastoid end of the sterno-mastoid muscle was bony; a hard, insensitive node is shown on the superior border of the left scapular spine and small bony exostoses on the eighth, ninth and eleventh ribs near their posterior angles. A rod-shaped bony mass can be seen lying diagonally in the left pectoral region.

interference with muscular function. Repeated involvement of the same muscular area had taken place with final persistent hardness. There had been slight pyrexia at times. The patient's general health had always been unsatisfactory and her activities seriously compromised. Menses were regular since the twelfth year and somewhat profuse. There had been frequent epistaxis.

General Physical Examination.—The patient's stature was small, her face pale and round, her hair fine in texture and moderately abundant. The first point of interest to be remarked was the posture. The shoulders were rounded, the normal dorsal curve of the spine being increased. The head was bent forward, the chin flexed on the chest and there was but slight passive or voluntary mobility, either lateral or vertical, of the head. There was no hardness or induration of the masseters or other of the facial muscles. There were no cranial nodes. The teeth were well formed, even, with good enamel. The gums were soft and spongy at the teeth borders, bleeding easily, so that a tooth-brush could not be used. Maxillary movement was much restricted, so that it was possible to separate the teeth about an inch only, and the lower jaw was displaced from left to right so that the incisors did not approximate accurately. This restriction of movement and deformity was due to the presence of bony indura-

tion of the submaxillary tissues (Fig. 1). This mass was smoothly continuous with the jaw, reaching around to either angle. The overlying skin was soft and normal in appearance. Swallowing was not interfered with. The thyroid could not be palpated. The muscles of the neck, both anterior and posterior, present more or less firm induration, the mastoid end of the sternocleidomastoid being of bony consistency, while the clavicular insertions of the muscles stood out prominently and were firm but not bony. No glandular enlargements were present. A hard non-sensitive node was felt on the superior border of the left scapular spine. There were small bony exostoses on the eighth and eleventh right ribs and ninth left rib near their posterior angles and also on the crest of the ilium at the left sacral angle. The last was slightly tender to pressure. The body was bowed somewhat forward and rotation of the trunk or head was impossible. The patient could not pick objects off the floor. There was no

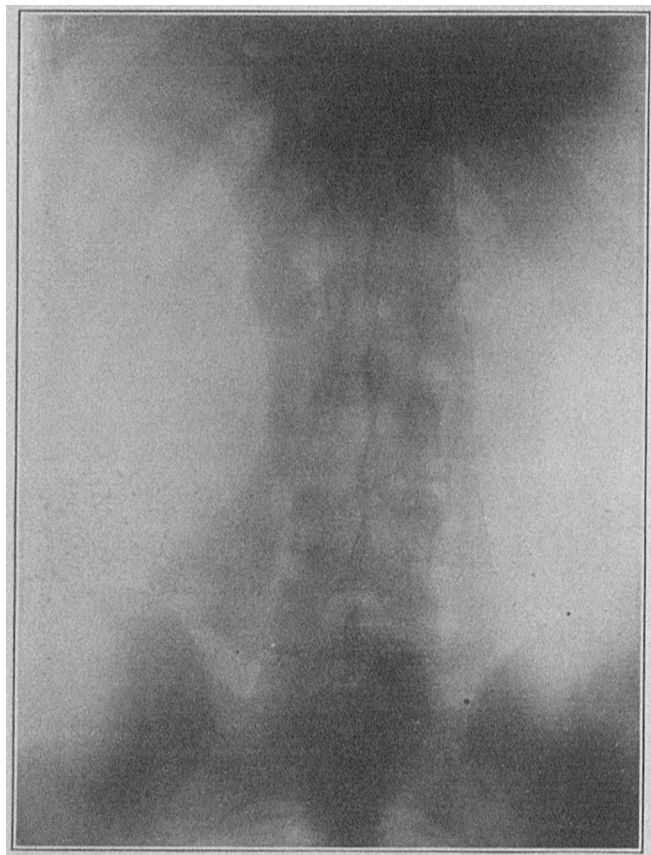


Fig. 2.—The spine was rigid. Broad bony masses are seen on either side of the lumbar and lower dorsal spine, as if the erector spinae muscles were turned to bone, forming two parallel planks with a combined transverse diameter of 10 cm. They were slightly movable.

sceliosis but the spine was rigid. When the patient was lying down, by placing a hand behind the head one could raise the trunk as if the whole spine were a rigid rod. A broad bony mass lying on either side of the lumbar and lower dorsal spine could be felt as if the erector spinae muscles were turned to bone. This induration formed two parallel planks with a combined transverse diameter of 10 cm. and reached from the sacro-iliac border up well into the dorsal region (Fig. 2). These bony plates were slightly movable and seesawed when pressed on at either end. A very interesting development was apparent in the abdominal muscles of the right inguinal region, where a mass of firm induration about the size of the palm of a hand could be felt. This was of recent origin and was tender to pressure, the overlying skin being suffused and somewhat hyperesthetic. The pectoral muscles were hard and contracted, the arms being locked to the sides so that abduction was impossible. A distinct hard mass could be made out in the body of the left pectoral group (Fig. 1).

This mass appears in the x-ray picture as a rod of bone, clubbed at both ends, lying in the long axis of the muscle and resembling in shape a child's femur. The biceps of both arms were indurated; no mobility of the shoulder-joints was possible. The deltoids and triceps appeared atrophied. The patient stated that but a few weeks before the arm muscles were much more swollen and hard than at the time of examination. The right elbow-joint was fixed in a position of slight flexion. This was apparently due more to muscular than to intra-articular changes (Fig. 3). A peculiar malformation of the right ulnar head existed. The ulna was about an inch shorter than the radius, to which it was attached by a bridge of bone (Fig. 4). A somewhat similar deformity was noted by Hutchinson¹ in one of his cases. Deformities of both thumbs existed. These consisted of complete bony ankylosis of the terminal phalangeal joints, the second joints being pliable but atrophied and dry (Fig. 5). There had never been any voluntary movement of the thumbs, which were held in a position of flexion on the palms. The thenar eminences were flat and atrophied. The muscles of the legs were much freer from involvement than the trunk and arm muscles, but the patient stated that they felt too short and often became sore and tender. There was some restriction of movement of the hips, knees and ankle-joints. Congenital deformity of both great toes existed. This consisted in the absence of one phalanx, the toes being short and directed outward, lying partly under the second toes, giving the appearance of hallux valgus.

Visceral Conditions.—The skin was dry but not harsh, nipples deeply pigmented, mammae undeveloped, no general panniculus. Lungs: Examination negative, respiration largely diaphragmatic owing to fixation of the thorax. Pulse 90,

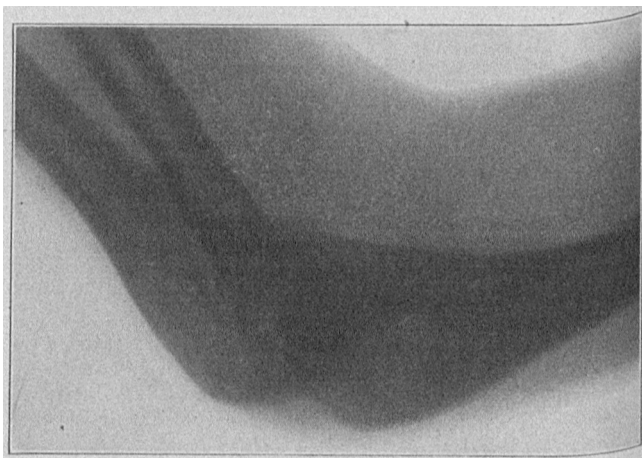


Fig. 3.—Showing the right elbow-joint fixed in a position of slight flexion and a peculiar malformation of the right ulnar head.

regular; temperature normal. Heart: Apex 12 cm. from midsternum; there was a well-marked systolic thrill and the double systolic murmur of aortic stenosis and mitral regurgitation.

Abdominal examination was negative; no splenic or hepatic enlargement. A good view of the throat was impossible, owing to jaw-lock; throat smear showed pneumococci and staphylococci.

Leukorrhea present; vaginal examination not permitted and no smear could be obtained.

Blood Examination.—Specific gravity 1.054, erythrocytes, 4,426,000; Hgb., 75 per cent.; leukocytes, 10,800. Differential count: lymphocytes, 23 per cent.; large mononuclears and transitionals, 5 per cent.; neutrophils, 70 per cent.; eosinophils, 2 per cent.

Blood-Cultures: Two flasks of bouillon, one containing 2 c.c. blood and one 4 c.c., placed in an incubator at 37 C. for seventy-two hours showed no growth of organisms.

1. Hutchinson: Arch. Surg., vii, 1896.

Urine.—Quantity in twenty-four hours, 900 c.c. Sp. gr., 1.020; albumin, minimal trace; sugar, absent; indican, pathologic excess; urea, 20 gm.; uric acid, 0.653 gm. *pro mille*; sediment, cells, cylindroids, oxalates and urates; no casts.

Course of Disease.—The patient was not again seen until February 19. Her condition at that date was as follows: The induration of the biceps and arm muscles had very considerably diminished. The hardness and tenderness in the abdominal muscles previously noted had almost entirely disappeared, leaving only a small, circumscribed, insensitive area of firmness in the right inguinal region. Since last consultation a large sensitive node had formed on the left scapular spine, but this was undergoing resolution. This appearance of sensitive indurated areas and their subsequent gradual disappearance characterized the progress of the case from the beginning. For a fortnight previous to the last consultation there was a slight daily rise of temperature of about 2 degrees Fahrenheit at its maximum. Recent advices from Dr. Clark convey the information that during the two years that have elapsed since my last examination of the patient her condition has undergone no particular change.

The foregoing clinical history is reported because of the great rarity of cases of myositis ossificans progressiva and the interest attaching to its etiology. Since Freke's² first clinical report of this disease in 1740, his description, corresponding very closely with that now given, only 107 cases, including the one herewith described, are recorded in medical annals. Doubtless many more examples of the disease have been observed, but have not been made matters of record. For a full consideration of the subject those who may be interested are referred to Münchmayer's³ classic description of the disease and to excellent monographs by Pincus,⁴ Roth,⁵ Helferich,⁶ and DeWitt.⁷ DeWitt's articles furnishes a review of the literature down to the year 1900, adding eleven collected cases to the sixty-seven already gathered by Pincus and Roth, making a total of seventy-eight cases to that date. Walker,⁸ in 1908, taking up the records where DeWitt left off, added fourteen reported cases, bringing the total to ninety-two. Since that date thirteen new examples,⁹ including the present report, have been placed on record and I have found in the literature four other case histories¹⁰ that have been overlooked in the reviews mentioned, making the grand total 107 cases to January, 1911. But nine of these have been reported from America.

Progressive ossifying myositis is not to be confused with the less rare forms of local ossifying myositis following traumatism and inflammation. Many cases are on record of ossification of single muscles or groups of muscles, sometimes following a single severe trauma, in other cases resulting from repeated injury or prolonged irritation. Under this last head may be included the ossification of the deltoid and arm muscles of soldiers and the thigh muscles of riders. Mention should be made also of calcification occurring in the course of

chronic inflammatory processes which may be rheumatic, tuberculous or syphilitic, or due to foreign bodies lodged in the tissues. Myositis ossificans progressiva is distinguished from any of these localized forms by the fact that it commences spontaneously in early life and progressively advances until the muscular system is extensively involved. A further distinguishing feature, if one were needed, is the occurrence in the great majority of these cases of congenital malformation and defect which shall be presently described.

Most of the recorded cases of myositis ossificans progressiva can be traced back to early childhood, the majority beginning before the tenth year. Owing to the masked character of the symptoms during its early stage it is often impossible to fix the exact date of its origin. The earliest signs of ossification reported occurred at 4 days after birth, at 3 months, 8 months (Wilkinson), and 3 months (Horand). Cases have been noted as beginning at a later period of life. Thus Kroneker relates the case of a woman in whom the disease began at 54.

Although of slow development and prolonged course the disease advances along definite lines to a uniform

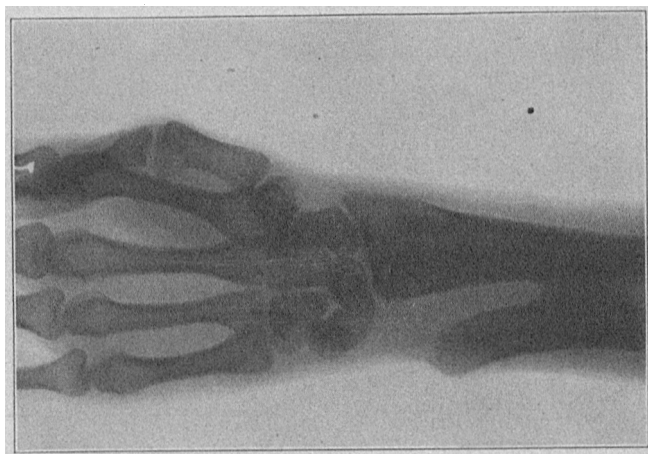


Fig. 4.—The right ulna presents a peculiar malformation, being about one inch short and being attached to the radius by a bridge of bone.

termination. This fact alone would suffice to establish the disease as a pathologic unit. The course of its development is about as follows:

A child otherwise in good health develops a local swelling of tender character in some part of the muscular system, usually the neck, producing a condition which may be mistaken for torticollis, or the back or shoulder, pectoral or abdominal groups of muscles may be first affected. The involved area is indurated and may be the seat of local and radiating pains, and the overlying skin is not infrequently suffused and sensitive. After a period of several weeks, during which the local symptoms slowly abate, the swelling may disappear, leaving the muscle more or less indurated, a condition which is sometimes temporary but may remain permanent. A series of recurring attacks of myositis may affect the same area, finally producing a bony hardness of the muscle. During the course of years successive localizations of this character occur until a condition of deplorable deformity and crippling results. The joints may become fixed and greatly restricted in pliability, not by true ankylosis, but by the rigid bars of bone formed in the substance of the muscles acting on them. In this manner deflections of the spinal column, flexions and rotations of limbs occur. From pressure and irritation

2. Philosoph. Trans.
3. Münchmayer: Ztschr. f. rat. med., 1869, xxiv, 9.
4. Pincus: Deutsch. Ztschr. f. Chir., 1897, xlv, 179.
5. Roth: München. med. Wchnschr., 1898, xlv, 1238, 1279.
6. Helferich: Aertzt. Int.-Bl. München., 1879, xxvi, 485.
7. DeWitt: Am. Jour. Med. Sc., 1900, cxx, 295.
8. Walker: Tr. Coll. Phys., Phila., Series 3, xxx, 121.
9. Nitch: Proc. Royal Soc. Med., 1907-8, Dighton: Edin. Med. Jour., April, 1908, p. 344. Garrod: St. Barth. Hosp. Rep., 1908, xliii, 43. Maxwell: Brit. Med. Jour., 1907, ii, 1647. Palmer and Clark: Am. Jour. Orthop. Surg., Phila., 1908-9, vi, 626. Meltzer: München. med. Wchnschr., 1909, vi, Thompson: Proc. Royal Soc. Med., 1909-10, iii, No. 6, Chir. Sec. 151. Hart: Med. Cor.-Bl. Württemb. ärztl. Landesver., Stuttg., 1909, lxxix, 908. Elliott, Geo. R.: Am. Jour. Orthop. Surg., 1910, vii, 332. Person: Khirurg. Arkh. Velyaminova, St. Petersb., 1910, xxvi, No. 60, p. 168. Mitchell: Jour. Nerv. and Ment. Dis., Lancaster, Pa., 1910, xxxvii, 547. Peteri and Singer: Fortschr. a. d. Geb. d. Röntgenstrahlen, xv, part 6.
10. Burton Fanning: Lancet, London, 1901, ii, 849. Gillette: St. Paul Med. Jour., 1906, viii, 165. Krause and Trappe: Verhandl. d. deutsch. Röntgen Gesellsch., Hamburg, 1907, iii, 162. De Reinzl and Pittipaldi: Gaz. d. osp., 1903, xxiv, 118.

the overlying skin and cellular tissues may slough, forming ulcers and exposing the patients to septic accidents. In Linden's case the discharge contained gritty particles of bone and small sequestra. Sometimes large, deep abscesses are met with, doubtless due to irritation set up by sharp spiculae of bone (Rogers, Stoneham).

The distribution of the changes in the muscles is almost always the same, the trunk, upper extremities and neck being the seats of involvement. Rarely do bony plates appear in the legs, and the hands and feet are always exempt. The ossification of the muscles of the neck has caused the disease to be mistaken for torticollis and suboccipital Pott's disease. Of the facial muscles the masseters alone have been involved, this constituting a grave development by interfering with alimentation. A very frequent accompaniment or precursor of the myositis is the appearance of exostoses. These are most frequently seen where the long bones approach the surface; i. e., the anterior surface of the tibia, the ribs, the skull, etc.

One of the most striking and peculiar features of this interesting disease is its association with certain congenital deformities. This point was first noted by Gerber, but Helferich¹¹ emphasized the association as a



Fig. 5.—The thumbs were fixed in a position of flexion on the palms of the hands and could not be voluntarily moved. The terminal phalangeal articulation of right thumb has undergone bony ankylosis.

chief characteristic of the disease, and since then 75 per cent. of cases reported have shown the peculiar congenital malformations. These consist of microdactylia, a shortening of the great toes and thumbs, and, more rarely, the little fingers, due to a dwarfing of the metatarsal and metacarpal bones, with subsequent ankylosis of the interphalangeal joints. This gave the false impression before the x-ray was used that one phalanx was absent. The great toes are often directed outward and frequently lie under the second toes, giving rise to the deformity of hallux valgus. Other less frequent malformations are absence of certain muscles, absence of lobules of the ears, absence of superior incisor teeth, atrophy of testicles, and mammae, and sexual infantilism. It is interesting to note that deformities of the hands and feet were observed in the father of Simpson's¹¹ patient, although he did not develop the disease.

Myositis ossificans progressiva is essentially a chronic disease, subject, however, to exacerbations. An exception to this rule is noted by Ferraton,¹² who observed a patient who was able to eat in a perfectly normal manner on going to bed, but on rising in the morning found it impossible to open the mouth owing to involvement of the masseters, and at the same time noticed a hard tumor

in the right masseter. The usual history of the disease is a slow progression with longer or shorter pauses, the general health as a rule remaining good until increasing disabilities interfere with feeding and respiration, or on account of the latter disturbance some pulmonary infection develops. The average duration of the disease is from ten to fifteen years.

The clinical course of every case observed leaves no doubt that myositis ossificans progressiva is an inflammation—a progressive polymyositis—terminating eventually in certain of the involved areas in ossification. In the case just reported I had the good fortune to observe an acute involvement of a very definite character in the parietal abdominal muscles. There were present all the signs of an ordinary acute myositis. Three months afterward, all indications had disappeared, the former involved area appearing normal in all respects. It is a matter of record that indurated areas that have existed for some time have undergone resorption, to the surprise of the observers. Although there is little to distinguish the individual lesion in its earlier course from an ordinary myositis, the disease becomes stamped with a special character when its course is followed for any period of time. A striking feature is its association with exostoses of the skull, ribs, scapular spines and ilia, which furnish proof of a tendency to aberrant bone formation, this later being further exemplified by the depositions of bone in the affected muscles. The congenital developmental defects constitute a very interesting feature, as they would appear to indicate the operation of a predisposing factor of congenital origin. The sequence of histologic changes through which the soft tissues pass to bone have been repeatedly observed and are exactly similar to those described in myositis ossificans traumatica. From the periphery to the center of the implicated area a sequence of fibrotic changes are apparent, passing through fibrocartilaginous transformation to osteoid trabeculation and calcification. New connective tissue, cartilage, osteoid tissue and bone are found in the same section. The new formed osseous plates possess the same histologic and chemical characters as does true bone.

Many theories have been advanced to explain the etiology of this extraordinary disease, but with little success at solving the problem. The disease cannot be classed with other conditions in which bone formation is observed as a terminal development, such as calcification in degenerated arteries, about old foci of tuberculosis, around foreign bodies, etc. These are but instances of the metaplasia of connective tissue and as such have eventuated in new formation of bone in nearly every tissue and organ of the body. The lesions of myositis ossificans are confined to the skeletal layer of the mesoblast. The visceral layer is never affected. There is no direct heredity. The only instance on record of occurrence in two generations of the same family is a case reported by Burton Fanning.¹⁰ The father of Fanning's patient had suffered from myositis ossificans progressiva, dying at 33 from an accident.

No exciting cause but injury has been established as the starting point of the disease. In a few instances injury has certainly produced local ossification and proved the apparent inception of the disease. In four of thirty-eight cases collected by Pincus the onset is plausibly ascribed to injury. The site of the lesions in most cases is, however, opposed to this idea and in the overwhelming majority of cases no such explanation can be entertained. There is no doubt, however, that after the disease is well under way traumata that in normal indi-

11. Brit. Med. Jour., II, 1886, p. 1026.

12. Ferraton: Rev. d'Orthop., 1903, Series 2, IV, 302.

viduals would produce no such result are followed by myositis and ossification. It is interesting to note at this point that research into calcium metabolism undertaken by Austin¹² on one of Painter's patients showed a perfectly normal calcium metabolism.

Without entering into details regarding the many theories that have been advanced, it may be mentioned that it has been thought to be a form of rheumatism (Stonellam), a trophoneurosis (Nicholadoni, Eichorst, etc.), a new growth (Mays, Zeigler), a form of atavism (Biernschohn), while Hutchinson claims it to be a morbid tissue perversion analogous to retinitis pigmentosa and xeroderma pigmentosum. None of these theories meets with acceptance, the present trend of opinion being toward the view that owing to some disposing factor of congenital origin—indicated by so large a percentage of microdactylia and exostoses—the muscles seem to be endowed with very low resisting power and are consequently highly susceptible to inflammation from various exciting causes which ordinarily would not so operate, such as injury, chemical and bacterial irritants, etc. Combined with this low resisting power of the muscles there is a morbid disposition to aberrant bone growth which shows itself in the calcification and ossification of inflammatory products.

Herringham, in sympathy with Pincus, finds many points of resemblance to multiple fibromata, namely, multiplicity, limitation to certain mesoblastic areas, and benignity. They are both also congenital, increasing by gradually attacking fresh areas, but always growing from one tract of tissue, never involving any other by continuity or metastasis. The chief stumbling-block to acceptance of this idea is the existence of congenital deformities found in 75 per cent. of cases. These mark the disease as peculiar, and it is difficult to connect them with new growth. In this extraordinary disease we appear to be on the borderland between malformation and new growth.

I gratefully acknowledge my indebtedness to Dr. R. W. Webster for assistance in reviewing the literature.

31 North State Street.

FIBROMA OF NOSE

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History.—The patient, H. B., aged 72, American teamster, had no remarkable family history.

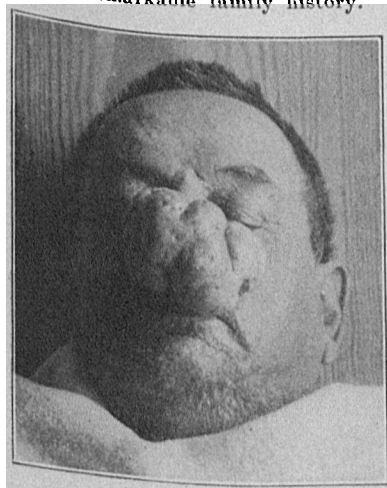


Fig. 1.—Front view of fibroma of nose.

He had grip and severe pneumonia sixteen years ago; otherwise his personal history was negative. He admitted very free use of gin for thirty-eight years, but since 1905 he had taken not more than two drinks each month (?). About fifteen years ago he noticed a small red spot under the skin on the right side of the nose. The redness increased gradually until it covered the whole nose; then he noticed it was beginning to enlarge. The growth was very slow and gave him no

inconvenience, except the appearance, until one month before he was seen. About this time he had dragging pain over the eyes, dizziness, frontal headache and when leaning over to lift boxes, etc., he would lose his balance and fall. These symptoms led him to seek relief. Previous to this time he had many strange ideas, that he ought not to part with the tumor, that he would bleed to death or die in some other way if it was operated on.

Physical Examination.—The patient proved to be a remarkably strong healthy man, although 72 years of age. A lobu-

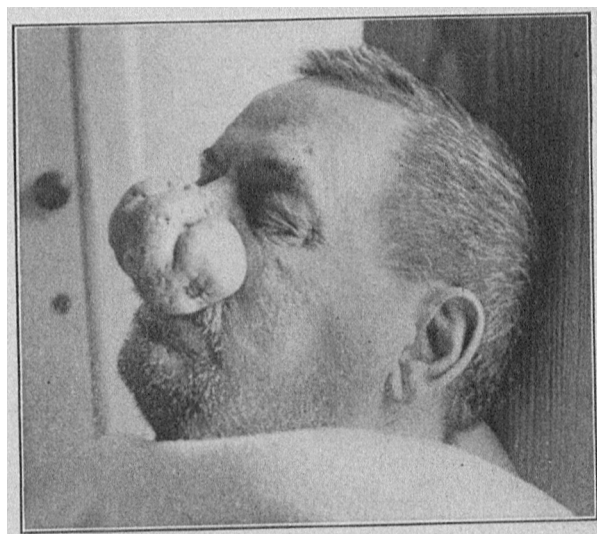


Fig. 2.—Side view of fibroma of nose.

lated mass 7.5 cm. lateral and 5 cm. vertical, was found firmly adherent to the lower three-fourths of the nose. It was somewhat larger and more dependent on the left and obstructed the field of vision, except upward and outward. It was firm to the touch and could be lifted away from the mouth, which it almost completely covered. Figures 1 and 2 make further description unnecessary.

Operation.—Under ether the growth was removed, an especially sharp scalpel being used. The rough and irregu-

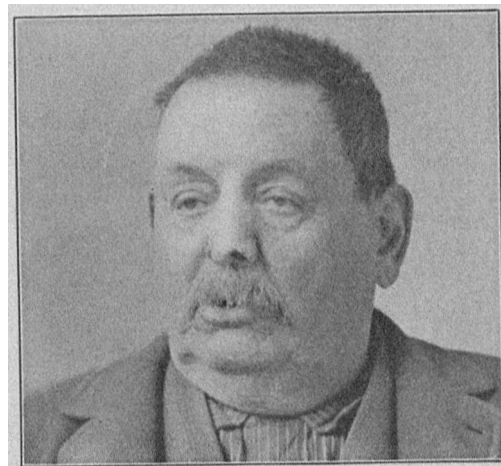


Fig. 3.—Same patient after removal of fibroma of nose.

lar tissue was shaved down to correspond to his normal nose, but in spite of much care, the right adherent ala was partly removed. The bleeding was very profuse but controlled by pressure and cautery. Four weeks were required for healing, and the patient would not allow skin-grafting to cover in the lower part of the left ala. Macroscopically, it was thought to be a fibroma—the end-result of an acne rosacea—and the microscope confirmed this diagnosis.

90 Main Street.

¹² Painter: Jour. Med. Research, n. s. xvi, 451.