raw rectal wall was at once carefully examined, but no bowel opening could be detected, and after closing the opening in the cyst with forceps, the enucleation was completed. There was no hemorrhage from any single large vessel, although the oozing from torn surfaces was profuse. The tumor had been contained in a sort of globular cavity made up of pelvic wall, sigmoid and rectum, bladder and uterus, and there was not the least suggestion of pedicle. The adjacent bowels were then cleaned and examined for perforations, but, although the surfaces were unhealthy and denuded, they presented no macroscopic tubercular nodules and no perforation could be discovered. Three cigarette drains were introduced, two to the depths of the cavity and one to the most suspicious bowel surface, and the abdomen was closed after excising the hernial sac and renewing the normal relations of all the parietal structures to the median line. The operation was followed by great vascular shock and considerable vomiting and distention, but in five days improvement was coincident with the appearance of a fecal fistula, through which escaped, at first, all of the evacuations and large quantities of flatus. Presently, however, the rectum resumed its function, the temperature became continuously normal, the appetite and strength improved, the fecal discharge ceased, and at the present writing conditions point toward a speedy permanent wound healing under occasional treatment of the fistulous tract with Beck's paste. Weight, 124, and increasing.

Examination of Specimen.—Smaller cysts (2 or 3) not preserved, but filled with clear contents; walls unthickened. Contents of large cyst not preserved, but of fecal odor, gray-brown color, not bloody, and about the consistency of butter-milk. Size, prior to rupture, that of an ordinary coconut; after removal, that of a baseball. Outline, irregularly globular; no pedicle; surface rough and fibrous, with no peritoneal surface in evidence. Thickened areas in the wall were later recognized microscopically as tube and ovary. Sac wall, irregularly thickened, fibrous and varying from .5 to 5 cms. (1/5 to 2 in.) in thickness; some soft spots containing blood and pus; a fistulous tract 4 cm. (1½ in.) long, lined with grayish-green membrane and terminating abruptly on inner and outer faces of sac. The interior of the cyst is rough, irregular and gangrenous, and the wall in places peels rather readily into layers.

COMMENT

The original pathologic diagnosis made by the laboratory in this case was pyosalpinx and pelvic abscess. Later Dr. E. R. LeCount, without knowledge of the clinical history, became suspicious of the specimen and took up the microscopic examination himself. After repeated section cutting, he was able to demonstrate:

(a) Many microscopically typical foci of tuberculosis were present with no gross tuberculous degeneration.

(b) The cyst was neither covered nor lined with epithelium or endothelium, and that its wall was made up of layers of organized fibrin and inflammatory cells.

(c) The tube and ovary were incidentally included in the cyst wall, but that they did not form any integral part of the cyst.

(d) The tube and ovary were not themselves tuberculous.

The findings at the first operation were those of the ordinary form of tuberculous peritonitis, probably secondary to intestinal tuberculosis. At the second operation the gross tuberculosis had disappeared, leaving the usual scar-tissue adhesions. At the third operation the pathologic finding was an extremely rare one: a pseudocyst composed of tuberculous inflammatory tissue, probably originating from an encapsulated perforating ulcer of the sigmoid, and fed from time to time with septic material from the bowel.

Such pseudocysts are mere sacculated receptacles for morbid products, and are to be differentiated from true cysts of the genital tract by their lack of true lining and covering membranes, by the

thickness and inelasticity of their walls, and by the wall itself being composed entirely of inflammatory material. Their origin is usually tuberculous. Clinically, these deposits are commonly taken for ordinary pelvic cysts, or for tubo-ovarian abscesses, and there is no possible way to identify them prior to operation, except through inferences drawn from the history.²

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CRURAL AND AXILLARY RINGWORM IN THE CANAL ZONE

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Mention in *THE JOURNAL* of June 26, 1909, of the prevalence of tinea cruris in the temperate zone would seem to make some description of this annoying disease, as seen so commonly in the tropics, of interest. Tinea cruris et axillaris is seen with great frequency among the laborers and lower class of natives in the Canal Zone, and it is by no means uncommon among the natives of the North resident here. The disease flourishes best among those of uncleanly habits and improper and careless personal hygiene. The practice of this class of persons of washing their clothing in streams and pools and of spreading it on the usually moist ground and grass to dry seems to provide a ready means of infection. The infrequency of change of clothing and of bathing may also be mentioned as predisposing factors.

The disease usually appears first, as the name implies, on the inner side of the groin next the body and in the armpits, rapidly spreading, if neglected, over the scrotum, thighs and trunks. Patients frequently present themselves for treatment who have two-thirds of the body surface affected. There first appears a small reddish area of inflammation with slightly raised edges, these spots gradually spread peripherally till they reach the size of a silver dollar or of the palm of the hand. The inflammation in the center of the "circle" recedes as the periphery enlarges. In neglected cases new areas of infection soon appear in the near vicinity and as they enlarge the rings coalesce, forming one large infected area of joining rings. The intense itching, especially at night, makes this disease most annoying and often causes badly infected sores and ulcers as a result of lacerations by the finger nails in an effort to find relief. The tinea cruris et axillaris as seen here does not usually destroy the hair follicles.

The treatment is prophylactic and active. Bathing and changing the underclothing should be practiced at frequent intervals, and all clothing should be thoroughly boiled in the laundry and hung on lines to dry. Effective active treatment will be obtained by cleaning the parts thoroughly with the tincture of green soap and water and applying with some friction the ointments of sulphur or salicylic acid or iodine, this procedure to be repeated once or twice daily for several days, or when comparatively small areas are involved and the individual is of sufficient hardihood to stand the few moments of severe burning, a thorough painting with the tincture of iodine or a solution of salicylic acid in alcohol and ether will very promptly eradicate the fungus. The latter measures sometimes give rise to a troublesome irritative inflammation that will require for a few days the application of one of the mild ointments, as boric acid or 1 per cent. carbolic acid in petrolatum.

2. Koenig: *Spec. Chir.*, II, 155, 1889.