

to form a pouch, and was associated with slight hydronephrosis. In the fourth dog a contraction was found, forming an almost complete obstruction at the lower anastomosis, with corresponding dilatation of the ureter and hydronephrosis. In every case the artificial portion of the ureter was transformed into a rigid, non-collapsible tube, which showed histologically in place of the peritoneum a typical transitional epithelium, such as is found in the normal ureter, surrounded by a thin layer of areolar tissue; outside of this, replacing the transversalis fascia, a definite layer of well organized bone had formed, with typical osteoblasts, and blood and lymph vessels. The transversalis muscle, forming the outermost coat, showed no change. Strauss thinks that the epithelium probably resulted from a proliferation of the epithelium of the ureter, the basement membrane of the peritoneum acting as a matrix for its implantation. The bone formation is to be explained, he thinks, by slight degenerative changes caused in the tissue by the irritating action of the urine, followed by partial calcification of this tissue from lime salts brought to it in the body fluids, together with the osteogenetic potentiality inherent in the particular group of muscles and fascia used for the flap. Strauss reports that he is continuing his experiments with free, non-pedunculated flaps, and has three dogs now alive three months after such operations.

**Tuberculous Origin of Ovarian Cysts.**—POLLOSSON and VIOLET (*Lyon Chirurgical*, 1913, x, 340) advances the theory that many of the so-called simple or serous cysts of the ovary are in reality of inflammatory origin, by far the most important type of inflammation in this connection being tuberculosis. They have observed that not infrequently ovarian cysts, showing themselves absolutely nothing characteristic of tuberculosis, occur in conjunction with tuberculous tubal or peritoneal lesions; they report, for instance, a case in which a cyst the size of an adult head, containing two liters of serosanguineous fluid, was attached to a tube showing distinct tuberculous changes, but without suppuration. Histologically, the cyst appeared to be of corpus luteum origin. In two other instances, tubal tuberculosis (producing no symptoms, but demonstrated histologically) was present, associated with bilateral ovarian cysts the size of oranges or larger. Pollosson and Violet believe that in such cases there is a distinct etiological relationship between the tubal lesion and the cyst formation, since the latter occurs only in conjunction with attenuated or slowly developing forms of tubal tuberculosis; in acute conditions the ovary apparently does not undergo the cystic change. In a second group of cases the cystic ovaries are associated with healed tubal or peritoneal tuberculosis. In the walls of the tubes of such patients there are often found small nodules containing caseous matter, occasionally the continuity of the tube may be completely interrupted, and all the pelvic organs buried in adhesions. In a case of this type operated on by Pollosson, the clinical history revealed the fact that at the age of four years the patient had had a severe attack of what had been diagnosed at that time as tuberculous peritonitis. At operation the characteristic conditions described above were found, and the ovaries were cystic. A third group comprises patients with cystic ovaries, without characteristic lesions of the surrounding organs,

but whose family history is such as to lead to a strong suspicion of a tuberculous condition. In many of these, although nothing typical is found at operation, this suspicion is subsequently confirmed by the development of tuberculosis somewhere else in the body. Polloson and Violet believe that the tuberculous inflammation acts by causing ovarian congestion, hyper-maturation of follicles, and excessive formation of atretic follicles, these conditions leading to the formation of sclerocystic ovaries, hematomas, and large simple cysts. They do not, however, believe that tuberculosis plays an etiological role in the production of true pseudoincucinous or papillary cystomas.

## DERMATOLOGY

UNDER THE CHARGE OF

MILTON B. HARTZELL, M.D.,

PROFESSOR OF DERMATOLOGY IN THE UNIVERSITY OF PENNSYLVANIA.

**The Treatment of Lupus Vulgaris with Hot Air.**—RAVAUT (*Bull. de la Société Française de Dermatologie et de Syphiligraphie*, 1913, No. 2), at a séance of the French Society of Dermatology and Syphilis, presented a case of nodular, non-ulcerating lupus of the jaw and ear which he had treated with great success with hot air combined with curettement. Under chloroform anesthesia the affected area was vigorously scraped with the curette and afterward cauterized with hot air at a temperature of 700° C. The eschar was detached at the end of ten days, and a month later cicatrization was complete, the scar being supple and non-retractile. About four months later a small suspicious point beneath the ear was cauterized with the hot air again. Two years later there had been no recurrence. Properly employed Ravaut thinks this the method of choice in the treatment of lupus; he knows of no other method which cures as quickly.

**The Course the Virus of Herpes Zoster Takes to Reach the Nerve Ganglion.**—MONTOMERY (*Jour. Cutaneous Diseases*, March, 1913) believes that herpes zoster is an infection, and that the virus enters the lymphatics of the nerve sheath and travels from the periphery to the nearest ganglion. He thinks this theory best explains the neuralgia which often precedes the eruption; the unilateral distribution of the disease, its most frequent occurrence on the head, neck, and upper part of the trunk, the much more frequent involvement of the sensory than the motor nerves, the limitation of the eruption to one or two nerves, the partial inflammation of the Gasserian ganglion, the frequent great severity of ophthalmic zoster, and the enlargement of the lymphatic nodules along with the eruption.

**Chronic Raynaud's Symptoms, Probably on a Syphilitic Basis, Associated with Livedo Reticulata.**—WEBER (*British Jour. Dermat.*, March, 1913) reports the case of a married woman, aged fifty-four years, who had suffered from the symptoms of Raynaud's disease for