and indigestion, or a daily rise of temperature, with or without cough being present, especially if combined with any loss of flesh or strength, in the absence of any other manifest cause, even without tubercle bacilli being found in the sputum or physical signs as outlined above, tuberculosis should be suspected and its presence or absence verified by the use of tuberculin.

Third: The presence of moist rales, when localized, are sufficiently indicative of pulmonary tuberculosis to make careful watching and repeated examinations imperative, but are not by any means pathognomonic of pulmonary tuberculosis unless persistent and accompanied by evidences of a mild toxemia.

Fourth: A negative examination of the sputum for tubercle bacilli is of no value. In all suspicious cases many examinations should be made. Tubercle bacilli may be absent from the sputum of a tuberculous case because none of the tubercles are softening and communicating with a bronchial tube, or because there is such a profuse bronchial secretion that the bacilli are relatively too few to be demonstrated microscopically, though an inoculation of the same sputum into the abdominal cavity of a guinea pig might show their presence.

Clinical Department.

CLINICAL REPORT FROM THE WARD FOR SKIN DISEASES AT THE MASSACHUSETTS GENERAL HOSPITAL.

BY HARVEY P. TOWLE, M.D., BOSTON,
Assistant Physician for Diseases of the Skin.

A CASE OF MYCOSIS FUNGOIDES.

CASE I. Sister F., age sixty-two. Family history negative except that father died at about forty of some asthmatic trouble. Previous history negative.

Present illness began twenty-three and a half years ago when a palm-sized red spot appeared on the outer side of the right thigh. This spot persisted a long time, how long patient cannot say as there were no subjective symptoms to call her attention to it. After its disappearance there was an interval of freedom. Two and a half years after the appearance of the first spot, or twenty-one years ago, a second spot appeared on the left ankle which was red, itching, scaling and painful. For a few weeks at its beginning this patch bore small blisters which were painful. When the blisters had attained the size of a pea they burst and with the bursting the pain ceased. This was the only time in the course of the whole disease when there was any vesiculation. The evolution of this second patch was very slow but it finally did disappear. From this time on patches which were red, scaling and slightly indurated and which pursued this same sluggish course appeared on various parts of the body. Gradually the evolution of the patches became slower and slower until for the last eight or nine years none have disappeared. Gradually also the induration of the patches became more and more marked until the skin was much thickened and very scaly. Eight years ago a reddened patch appeared on the left knee. For five years it was merely red and scaly with an unbroken skin beneath the scales. Three years ago it was noticed for the first time that the skin was broken. Thenceforward the ulceration progressed steadily both in

extent and depth. Its edges became rolled up and much elevated above the surrounding skin. About a year ago tumors appeared for the first time, suddenly and chiefly over the extremities, sparsely on the body. The general health has been unimpaired throughout.

On examination the scalp was found to be completely covered with large, white, thick scales beneath which the skin was reddened. There was marked thinning of the hair everywhere. The skin over the ears was red, thickened, roughened and covered with fine scales. The skin of the face was everywhere involved except over a few small areas. The process was most marked, however, over the cheeks and right eyebrow. Here the skin was much reddened and thickened and covered with large white scales, adherent by one edge and easily detached. On the right eyebrow was a

Mycosis Fungoides.

patch about one and a half by two and a half inches, which was superficially excoriated in small spots from which oozed a clear serum. The patch was not elevated and bore many large papery scales. Over the rest of the face the skin was dry, red, scaly and somewhat thickened. The neck, front and back, was covered by a red, thickened, scaling and elevated patch which was so extensive that scarcely any normal skin remained. The skin of the back was covered with numerous patches of a similar character of all sizes and shapes. These patches coalesced on all sides with other patches and thus inclosed irregular areas in which the skin was either entirely normal or at most erythematous. The involved skin was red, elevated above the surface about one sixteenth of an inch, covered with large papery, easily detachable scales, adherent by one edge. On close examination it was seen that the patches were made up of large papules and were surrounded by a narrow zone of redness. The skin of the

chest, abdomen and arms was almost universally covered by similar red, rough, scaling, elevated bands which ran in all directions and crossed and recrossed each other, inclosing islands of skin which were less involved but which were yet reddened and scaling. The skin of the hands was universally involved and much thickened, red, scaling and fissured. On the thighs were the same elevated and thickened patches and bands. But in addition there were numerous tumors which arose from the patches already described. These tumors were, in general, of an oval shape, with rounded tops, projecting from one fourth to one half inch above the surface of the patches and averaged two or three inches in length and one half to one inch in width. Some were comparatively solid, others were made up of long finger-like projections packed closely together so that the surface had a crackled appearance. The latter suggested somewhat in shape and appearance a macaroon. These tumors were discrete and as already stated usually arose from skin already thickened and elevated. Occasionally one arose from apparently healthy skin. There were many of these

Mycosis Fungoides.

tumors on the arms and, to a less degree, on the lower legs. The feet were dry and much fissured. Over the left patella and just above and to the outer side on the thigh were two ulcerated lesions. These were irregularly circular in shape. The lower had a diameter of three inches, the upper of five inches. Their edges were elevated about one eighth of an inch above the surrounding skin, were of a purple color, and sloping. The centers of the lesions were ulcerated. The bases of the ulcers were slightly irregular and papillomatous and secreted an abundant sero-pus. A blood count showed present polynuclears 63.5%, lymphocytes 32.5%, eosinophiles 4%. Two pieces taken from the

edges of the tumors were examined microscopically. The appearances were the same in both. There was tremendous hyperplasia of the rete. The inter-papillary prolongations were several times their normal length, and were thin and pointed. There was a corresponding increase in the length of the papillæ. There was nothing which could be called an infiltration of the corium.

Under the x-rays the ulcers of the leg healed promptly. Tumors in several regions were also exposed to the x-rays. All have improved greatly while many have disappeared wholly. An area on the forehead which grew red and threatened to break down was also exposed and healed rapidly. On other parts the tumors have shrunk very much under salicylic acid plaster but have not disappeared. The same treatment has also had a favorable effect upon the thickened skin. Before using the rays and the plaster the patient had been given various forms of internal treatment but without effect.

SCLERODERMA.

CASE II. Female, admitted to the Dermatological Ward, April 20, 1904; age nineteen. Family history negative. Previous history negative. Present illness began three years ago with the appearance of sores around the ends of the fingers and on the knuckles. At the same time the fingers felt cold and turned blue and were painful. The fingers remained sore for a year when they cleared up. Before the fingers were entirely well sores appeared on the large joints of the extremities, both upper and lower, and these joints have remained sore ever since. One year ago she noticed that her back and legs were becoming so stiff that she had difficulty in sitting down. Soon after this the fingers became stiff and finally contracted. A little later the forearms also became stiff. Two years ago her skin, which she states was formerly fair — she is of Indian blood — became universally pigmented. For nine months this pigmentation remained unchanged when small white spots began to appear. These white spots gradually increased in size and new ones were continually appearing. The general health was not much affected at first and, even at the time of admission, although she was much emaciated, she always said that she felt well. Examination showed a patient who was markedly emaciated. The arms and legs particularly were "skin and bones." Extension of the arms at the elbows was impossible beyond a right angle. The fingers were flexed at the second joint and motion in any direction was practically absent. Like the arms at the elbows, the legs were drawn up at the knees and extension beyond a right angle was impossible. The tendons of both arms and legs were tense and prominent. The motion of shoulders and hips was but slightly impaired. Over the dorsal and lumbar regions of the spine motion was much impaired. The heart, lungs and urine were negative. The skin of the whole body presented a speckled brown and white appearance, except the back which was uniformly brown. The face appeared to be white but close inspection showed many pea-sized patches of brown. The ears too appeared white. From the outer edge of the eyes to the ears and from the scalp to the edge of the jaws the color was chiefly brown. But scattered through the brown were many lighter spots which are either circular in shape or in the form of short bands, either discrete or coalescing, midway between a white and a brown in color. The skin over these areas was atrophied but was depressed, little if at all, below the surrounding skin. The upper half of the neck was quite brown but the lower half showed light areas similar to those on the neck. The skin of the chest

was thin and drawn tightly over the bones. There were more and larger white areas over the front than over the sides. The skin over the sternum was almost entirely white, having only a few small brown spots. Passing from the central line of the body outward the white spots grew smaller and fewer until far out on the

Scleroderma.

sides the color was uniformly brown. On the abdomen also the white areas were larger and more numerous in the center than on the sides. There was also much speckling of the extensor surfaces of the arms and legs and the inner surface of the left thigh. These white areas occurred everywhere in round spots or in bands or sheets and varied in size from a pin's head in the smallest to areas four or five inches wide and six or seven inches long. In them the skin was atrophied, of a dead white or brown white color, not much if at all depressed. Here and there an area was bordered by a line of hyperpigmentation, which was quite marked. Over all the large joints, such as the wrists, elbows, knees, and many of the knuckles, on the outer sides, were wart-like crusted lesions which sometimes projected about a quarter of an inch above the surface and measured a half inch in diameter and which were situated on a reddened and indurated base. The skin over the outer two thirds of the fingers was white and atrophied. The only points of interest noted during the patient's hospital stay were that on May 18, the toes on the left foot became blue and painful. It was some days before this condition subsided. May 28, it was noted that a gangrenous spot had appeared on the ball of the left big toe. The general health had gradually grown worse until when she was taken home by her people she was quite weak.

FOUR CASES OF LAPAROTOMY DURING TYPHOID FEVER: WITH RECOVERY.

BY R. R. FITCH, M.D., BOSTON.

THE following cases are from the services of Dr. H. F. Vickery and Dr. J. J. Minot, at the Massachusetts General Hospital:

CASE I. Harry O., nine years old, born in Russia. Gave a history of two weeks' duration; headache, feverishness, loss of appetite and diarrhea, being the chief complaints.

At entrance his temperature was 102°, pulse 120, respiration 20. White count, 11,400. Widal reaction positive in dilution of 1 to 50. Urine not remarkable. Blood pressure 87 mm. by the Riva Rocci method.

The child was poorly developed and nourished. Nothing abnormal was found in the throat or chest. The abdomen was somewhat distended and tympanitic, with slight general tenderness. There were several rose spots but the spleen could not be demonstrated as enlarged or felt. Patient's mental condition was dull, but he was apparently comfortable.

The child took baths and nourishment only fairly well. On the second night after entrance he reacted even more poorly to bath than on previous occasions, and his pulse became small. However, he soon went to sleep and was quiet until 7.30 the next morning, when he complained of slight abdominal pain which was not sufficient to be reported by the nurse. The pain was unrelieved by a turpentine stupe. Two hours later the entire abdomen was acutely tender, somewhat rigid and not distended. The liver dullness was not diminished, the blood pressure was unchanged, and the white count had fallen to 4,200. His pulse became somewhat more rapid and of smaller volume. Temperature and respiration were practically unchanged.

Operation by Dr. S. J. Mixter, four hours after onset of abdominal pain, showed gas and intestinal contents in the peritoneal cavity. A perforation of the intestinal wall was found a short way above the ileo-cecal valve. This was closed and the peritoneal cavity washed out with normal saline solution and drained.

The temperature reached normal on the day after operation and the patient had an uninterrupted convalescence.

CASE II. Thomas W., twenty years old, born in Russia. Entered the hospital having been sick for five days. At entrance temperature, 104; pulse, 100; Widal reaction, positive. He ran a typical course of typhoid fever for the next two weeks, when his temperature began to come down, but he had a recrudescence with temperature going to 105°. The temperature remained high for five days and then rapidly fell, reaching normal on the twenty-first day after entrance. The temperature ranged from 98° to 100° for four days, when it began to go up again, reaching 102.4° in three days. At this time there was slight tenderness, dullness and resistance just inside the crest of the right ilium. These signs steadily increased until the next morning when there was a distinct mass palpable in this region. White count, 6,000.

Operation by Dr. G. W. W. Brewster. The mass proved to be an appendix abscess. The appendix was removed and the wound drained. The temperature remained normal after operation and the patient was discharged well after an uneventful convalescence.

These two cases, with one of perforation and another of ruptured pus tube, both operated upon by Dr. C. L. Scudder and ending in recovery (to be reported in detail by the operator) were the only cases of typhoid fever in this hospital during the past summer, which came to laparotomy, and are illustrative of the good results of early operation in such cases.