stretched, a great deal of it disappears and the muscular fibres that surround the urethra are paralysed for a time; but in a very little while after the catheter is withdrawn the contraction begins again. The tenderness and irritability are still there; the tone of the muscular fibre returns and as soon as the stream of urine begins to unfold and open out the walls of the canal the stimulus sets up a slight but sufficient degree of contraction. So long as the stricture is wide the obstruction this causes is scarcely perceptible: the hyperæmia passes off almost at once, and there is so little exudation that the occasional passage of a catheter is sufficient to keep the channel dilated; but if the case is neglected, little by little the lymph collects until at length, when the contraction has passed a certain point, further progress is by leaps and bounds. For a long time I have practised internal urethrotomy after thorough dilatation, with the view of preventing muscular spasm and giving a long period of perfect rest for the removal of the last of the exudation; and although it is difficult to prove, I feel convinced that this method has met with a higher degree of success than either dilatation or internal urethrotomy by itself. Internal urethrotomy without previous dilatation succeeds sometimes, just as simple dilatation does in recent cases in which the stricture tissue is confined to the walls of the urethra, but not in those in which the exudation is old and hard, or very widely spread; absorption is too slow. The muscular fibres are divided so that there is no spasmodic contraction; but division, however thorough it is, does not restore the parts to their natural state. The expansion of the urethra when the urine passes down it is not smooth or even until the whole of the exudation has been absorbed; and this takes too long. Before the old and hardened lymph has had time to disappear completely the obstruction and irritation that it causes have led to a fresh deposit and the narrowing has commenced again. Unless the stricture is a recent one, and the exudation comparatively soft, dilatation is always necessary after internal urethrotomy—at any rate, for a time. Occasionally, if it is kept up diligently for some months and gradually left off, no recontraction takes place. External urethrotomy, on the other hand, practically fulfils all the required conditions, and to this it owes its success in some of the very worst cases. The whole of the urine escapes without tension or straining; muscular spasm is out of the question; however hard or widely spread the exudation, the whole of it must soften and melt away before the wound will close, and meanwhile the channel regains its natural size and the walls their flexibility. The rest that it gives is perfect, and certainly in some instances absorption is complete and the cure permanent, a fact that deserves more attention than it has hitherto received, for this method of treatment is rarely given an opportunity except in cases in which every other measure, including dilatation and internal urethrotomy, has been tried and has failed time after time.

Wimpole-street, W.

TWO CASES OF DERMATITIS GANGRENOSA INFANTUM.

By CAMPBELL WILLIAMS, F.R.C.S. ENG. &c.

DERMATITIS GANGRENOSA INFANTUM (Crocker) was first described by Mr. Hutchinson under the name of "varicella gangrenosa." As it is one of the rarer diseases of childhood I venture to record the two following cases. They are to an extent interesting in that in neither case could one obtain history or evidence of vaccinia or varicella as an etiological factor. Nor were they, as far as could be seen, the subjects of rickets or congenital syphilis. In the case that recovered the child was unvaccinated, and had not suffered from chicken-pox or other febrile disorder. It was badly nourished. Five preceding children had died in infancy from "consumption of the bowels." As is well known, this vague term often means diarrhoea from improper feeding. The second case had likewise escaped the usual preceding ailments, but was the subject of miliary tuberculosis. Dr. Thomas Barlow first pointed out the frequent presence of tubercle in this disorder. In 1888 I made a necropsy upon a child that had died from gangrenous dermatitis, when Dr. Barlow drew my attention to the combination, which was also present in that case. From a pathological standpoint these cases may

be regarded as due to microbic infection. In a way they are analogous to acute necrosis if skin is substituted for bone.

CASE 1.—C. W—, aged two years, male. This child was admitted into University College Hospital under the care of Mr. Christopher Heath on Sept. 9th. Being in charge of the skin department in the absence of Dr. Radcliffe Crocker, I was asked to see the case. The child was the younger of two. The elder had died from a tumour in the abdomen, the nature of which could not be elicited. The mother had also had two miscarriages. No signs, present or past, of infectious disorders were obtainable. The mother asserted that the child never had chicken-pox and that he was vaccinated in the early months of life. He did not snuffle, nor was there any discoverable evidence pointing to congenital syphilis or rickets. The eruption was first noticed on Sept. 7th—i. e., two days before admission. It was described as having begun as pimples about the size of pinheads. These became vesicles and later became covered by black scabs. The patient had diarrhoea for fourteen days prior to Sept. 9th, and had vomited slightly during that period. On admission the child seemed moribund. There were signs of broncho-pneumonia at the left apex. The pulse was small and rapid, 120, whilst the temperature was 99° F. During the night it rose to 102°. This fell next day to 101°, at which point it remained until just before the child's death. This occurred twenty-seven hours after admission. During this time he had twelve stools, which were very offensive, but brown in colour. There were altogether twelve ulcers upon the child's body. There was one upon the scalp in the region of the lambdoid suture. Here the scab had not separated and was suggestive of varicellous origin of the disease; but there were no other traces about the head or face to support that theory. In the remaining lesions the slough had separated, leaving typical ulcers. They were roundish, sharp-edged and conical. The sides and bases were covered with a thin adherent brownish-black slough. An inflammatory areola of about one-twelfth of an inch in width was visible around each lesion. The ulcers varied in depth from three-quarters to a quarter of an inch. There was one upon the left buttock, about the size of a shilling; it extended down to the deep fascia. A group of four occupied the posterior aspect of the right thigh, another group of four upon the right calf and two small ones upon the flexor surface of the left thigh. The left calf was clear. None of the ulcers in these groups had coalesced. The skin between them was apparently healthy. The child was fed on milk and brandy. The ulcers were dusted with iodoform crystals and dressed with iodo-vaseline.

The post-mortem examination disclosed the presence of miliary tuberculosis. Both lungs were studded with tubercles, whilst the apex of the left was quite pneumonic. The apical portion of the left parietal pleura was adherent to the visceral, and there was a patch of tubercle upon it. Two bronchial glands had caseated. The liver, spleen and kidneys, together with the mesenteric glands, were all affected. The brain was not examined.

CASE 2.—J. N—, aged seven months, a poorly nourished male infant. A brother, aged nine years, was alive and healthy. The next five children had all died in infancy, marasmic. This boy, the youngest born, was said to have been strong at birth. For the last few months the infant had been put out to nurse during the day whilst the mother was at work. On Aug. 30th I first saw the child. He did not seem seriously ill. The temperature was 99·8° F. The child had not been vaccinated and was said not to have had chicken-pox or other exanthem. There were certainly no recent signs of congenital syphilis. The disease was stated to have started a week previously as pimples. These the mother ascribed to bug bites. The papules were noticed to rapidly enlarge and become covered with black scabs. When seen by me the child had an ulcer on the right buttock from which the scab had separated, leaving a circular, depressed ulcer of half an inch in diameter and about as much in depth. The wall was covered by black-brown slough. There was a similar one on the right flank and a third one upon the abdomen. Here ulceration was going on beneath a black crust. Lastly, there was one upon the upper lip; it was quite superficial, but there was destruction of tissue such as one does not observe in impetigo contagiosa. A gland in the right inguinal region suppurated and was opened on Sept. 2nd, and did well. The child was properly fed and given small doses of cod-liver oil. As the bowels were irregular minute doses of mercury with chalk were given every other night. The ulcers were first dressed with dilute ammoniated mercurial ointment. As they did

not show signs of improvement iodoform crystals and iodo-vaseline were substituted. They at once commenced to heal by granulation, and by Sept. 27th they were all cicatrised. My friend, Dr. W. Carr, kindly saw the case with me and concurred in the diagnosis.

The above cases go to confirm the view held that the sphacelo-dermatous condition is not necessarily secondary to varicella or vaccinia. I believe Mr. Hutchinson acknowledges this. That tuberculosis takes a very prominent position amongst the predisposing causes, the frequent localisation of the disease to the buttocks and thighs, where the skin is inflamed or sore from wet diapers &c., suggests that the process is primarily one of inoculation. The rarity of the disease and the frequency of all the predisposing causes seem in favour of a specific micro-organism as the direct excitant.

Welbeck-street, W.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

METROPOLITAN HOSPITAL.

ULCERATIVE ENDOCARDITIS; CEREBRAL HÆMORRHAGE;
DEATH.

(Under the care of Dr. HOWARD H. TOOTH.)

THE difficulty which may be met with in making a correct diagnosis in some of the milder cases of ulcerative endocarditis is well illustrated by the account of this case. It is also interesting to the profession from the fact that the cause of death was cerebral hæmorrhage, this mode of termination being unusual. Our readers will recollect that Dr. Osler in his *Gulstonian Lectures*, which we published in *THE LANCET*,¹ divides the disease into three groups—the pyæmic, the cardiac and the cerebral; the third of these does not, however, refer to cases in which hæmorrhage into the brain is met with, but to those in which a meningitis has developed, often of a suppurative character. For the notes of this case we are indebted to Mr. C. P. Handson, house physician.

G. H.—, aged twenty-two, was admitted into the Metropolitan Hospital on Sept. 15th, 1892. He was a painter by trade. In September, 1891, the patient felt pain in the left side of the abdomen, which he was told by a doctor was due to lead poisoning. This lasted more or less till Christmas, 1891, when pain in the "stomach" came on suddenly and "rheumatism" in the muscles of the leg. The tips of his fingers at that time became swollen, turning blue and red. He had been attending as an out-patient at this hospital since Feb. 16th, 1892. He did not think there had been much improvement, and he had lost three stone in weight since Christmas, 1891. He had suffered from rheumatic fever three years ago, from "rheumatism" three times since, and from influenza three years ago. He had also one "fit" last year; another a few weeks ago. The nature of these was doubtful.

On Sept. 16th the condition of the man was as follows: Extremely anæmic and emaciated; no blue line on the gums; tongue black (had been taking iron) and dry; fingers clubbed; pulse 68, soft; respiration not accelerated. Heart: Apex beat in the fifth space just inside the nipple line; dulness up to third rib. At the apex there was a loud systolic murmur heard also at the angle of the scapula. Over the pulmonary area there was an occasional systolic murmur; the second sound was accentuated there. Lungs: Great sinking in of supra-spinous fossæ behind; no dulness; no râles. Liver: Dulness up to sixth rib; not felt below the ribs. Spleen: Not felt; dulness not increased. Abdomen rather retracted and muscles held rigidly; nothing abnormal felt. Legs very wasted; wasting of thenar eminences; no wrist or foot drop;

knee-jerks present, though slight; no impairment of sensation. Urine acid, sp. gr. 1012; a cloud of albumen; no blood.

Sept. 23rd.—Heart: Apex felt best in the fourth space one inch outside nipple line; distinct heaving impulse seen; systolic apex murmur louder. Has been gradually growing very drowsy; his mental condition is peculiar; he is continually whining, "I want to go home"; refuses food and will not wash himself, and acts generally like a refractory child.

24th.—Has been taking food properly since an attempted nasal feed.

30th.—General condition unaltered. Urine acid; sp. gr. 1018; thick cloud of albumen.

Oct. 2nd.—During the night he got out of bed, was put back again, and shortly became comatose, with Cheyne-Stokes breathing and dilated pupils. Death followed soon after. During his stay in the hospital the temperature was of a hectic type, ranging from 96·8° to 101° F. Usually there was a difference of two degrees between the morning and evening temperatures. He complained of thirst; the bowels were obstinately constipated; the respiration and pulse were never accelerated.

Post-mortem examination.—Brain: Both lateral ventricles were filled with a recent clot, which formed a complete cast of the right and anterior part of the left ventricle. In the right lateral ventricle there was a separate clot pushed to one side by the larger one, which appeared older than the rest, and was beginning to break down. There was also a blood clot round the medulla in the fourth ventricle and at the anterior surface of the pons and a small hæmorrhage over the superior frontal convolution of the right hemisphere. Lungs: Both bases congested and œdematous. Heart: Right side much dilated and thinned. Left side: Large vegetations all over the posterior wall of the left auricle. Nearly all the mitral valve was absent; what was left was much thickened (evidently of old standing) and covered with recent vegetations. Aortic valves healthy. One or two ulcers were present on the endocardium of the left ventricle. Weight eleven ounces and a half. Stomach and intestines normal. Liver rather enlarged with venous engorgement. Spleen much enlarged, reaching just across the middle line. Weight twenty-two ounces and a half. There were two triangular ischæmic infarcts and one softer hæmorrhage. In the right kidney there were two infarcts; in the left three. The capsules peeled readily, and there were no signs of interstitial change.

Remarks by Dr. TOOTH.—The chief points of interest in the case are the following: 1. The difficulty of diagnosis. Chiefly owing to the history it was thought probable that he was suffering from acute anæmia after lead poisoning, although this did not explain the temperature. The question of ulcerative endocarditis was mooted, but no certain diagnosis was made. From the albuminous urine it was thought he had chronic nephritis. 2. There were no rigors or attacks of localised pain due to infarcts while in hospital. 3. His peculiar mental condition. In connexion with this it would be interesting to know the exact time the first hæmorrhage corresponding to the older clot took place. There was no paralysis or disturbance of sensation. 4. As regards the immediate cause of death by cerebral hæmorrhage, Dr. Bristowe² mentions one case under his care in which death resulted from effusion of blood into the substance of the brain, probably following an embolic aneurysm. 5. The clinical fact that, owing to various reasons—e.g., stomach resonance and rigid abdominal walls,—it is possible to fail to detect during life a spleen weighing twenty-two ounces and a half.

NORFOLK AND NORWICH HOSPITAL.

A CASE OF NEPHRECTOMY FOR CARCINOMA.¹

(Under the care of Mr. CHAS. WILLIAMS.)

THE following is a description of a case of primary carcinoma of the kidney, and bears out the statement that primary carcinomatous tumours of that organ are usually of the encephaloid variety. The presence of the purulent collection in the upper part of the organ probably accounted for the pyrexia, and rendered the diagnosis from calculous

² *Theory and Practice of Medicine*, sixth edition, p. 574.

¹ An account of this case was read at the meeting of the Norwich Medico-Chirurgical Society, May 3rd, 1892.

¹ *THE LANCET*, vol. i. 1885, p. 415 et seq.