injury, the triceps muscle was divided transversely an inch above the olecranon, and the humerus exposed. The triceps was dissected down, both internal and external lateral ligaments were divided, and the olecranon and head of the radius exposed. A half-inch chisel was driven in, first on one side and then on the other, between the olecranon and radius on the one hand and the humerus on the other, keeping as close to the line of ankylosis as possible. The radius was easily separated by this means, but the ulnar was fixed by the ankylosis of the coronoid process and humerus; this was readily broken through by flexing the forearm. The surfaces of the bones were now very like the surfaces of the normal bones in shape, but very rough. They were smoothed down as much as possible, and made to fit and move easily the one on the other. The ankylosis between radius and ulnar was only fibrous and was cut through. A flap of fat from the posterior surface of the triceps was then turned into the joint and sutured to the anterior capsule, a piece of Cargile membrane being placed on each side of the flap. The triceps was sutured together and the skin closed, the arm being put up at right angles. Gentle movement was started in ten days' time, but it was painful. Massage was commenced at the end of three weeks.

The patient was discharged in January, 1919, his movements being flexion 30° beyond a right angle and extension 45° from a right angle. Pronation and supination were disappointing, as it only amounted to about 30°. Flexion and extension were very powerful movements, as he had full use of his biceps and triceps, and there was no lateral movement at the joint owing to the preservation of the original contour of the bones. The amount of movement obtained might have been improved by the excision of more bone, but I think the joint would have been less secure and the power of movement lessened.

Conclusions.

The operations have little risk, and the benefit in each case was considerable. The joints were very strong and there was no tendency to dislocation or to abnormal movement, as the chief ligaments remained.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF PURPURA FACTITIA.

By KATHLEEN M. McKEOWN, M.B., B.S. LOND.,

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THE following case is a typical instance of hysterical deception, confirmed by the confession of the patient.

A girl of 13 was admitted to hospital on April 22nd, 1920, for "purpura," when she gave the following history. On April 17th she had not felt well, had vomited once, and had complained of pains in both arms not limited to the joints. She stated that large purple patches, not painful on pressure, had appeared all over her arms and legs on the same evening, and that her elder sister had had similar patches all over her body some years before. No history of rheumatism was obtained. The patient belonged to people in extremely poor circumstances and was rather hysterical in type. Since March 3rd she had attended the hospital as an out-patient as she had fallen down a flight of stairs, and she was about to be discharged on April 17th.

Condition on admission.—Temperature, pulse, and respiration normal. On examination there were seven large "purpuric" patches, varying in size but not in shape, on the flexor surfaces of both arms and forearms, with three similar patches on legs. The highest patch on the right side was on a level with the tip of the acromion process. The patches on the legs were on the inner and outer surfaces midway between the knee and ankle. The patches consisted of numerous minute hæmorrhagic spots and petechiæ set closely together and presenting a definite grouping. There was an outer band representing the outline of an oval and two straight lines somewhat broken running along the long axis. All the patches with the exception of two were oval, measured 2 in. by 1 in., and were very sharply defined. The two exceptions were on the arms and were linear, starting on the extensor surface and coming round to the flexor surface. The rest of the physical examination was negative.

At a first glance purpura was suggested, but a suspicion of self-infliction was aroused by the similarity in shape and size of the majority of the patches, the curious shape, the position and distribution, and lastly, the absence of any purpuric manifestation elsewhere.

During the first examination it was easily shown that all the marks occurred on places accessible to the patient's mouth, and later we were able to prove experimentally that similar patches could be produced by taking hold of a piece of skin with the teeth and then applying strong suction with the lips. The existing patches were ringed with silver nitrate, and the patient was given ample opportunities for producing fresh ones, but none appeared. After three days the patches became brown in colour and faded in a week.

A CASE OF BLACKWATER FEVER; RECOVERY.

By EDWARD F. GREENE, M.R.C.S., L.R.C.P. LOND.,

HONORARY CAPTAIN, R.A.M.C.

THE following details of treatment of a case of blackwater fever, which proved to be very satisfactory, appear interesting enough to warrant publication. The patient came on board the s.s. *Zaria*, West African mail boat, at Duala on July 14th, 1920, and was perfectly well up to 11 P.M. on July 22nd. On July 23rd at 1 A.M. he was taken ill, the symptoms beginning with epigastric pain, sickness, and the passing of coffee-coloured urine. The patient stated that two men employed at the same factory as himself had recently died of blackwater fever.

Course of the disease and treatment:—

July 23rd: 8 A.M., temp. 105.5° F. (phenacetin, gr. x.), water dark brown, one quarter albumin. Half a pint of hot water with one teaspoonful of salt given every half hour, 10 gr. of phenacetin every two hours. A hypodermic injection of hyd. perchlor., 1 in 1000 (10 minim dose), given at 9 A.M.; temp. 9 P.M., 102.5°.

July 24th: Water slightly lighter, but redder, albumin one quarter; 10 A.M., temp. 99.5°.

July 25th: 9 A.M., temp. 102.5°. Inject. hyd. perchlor., 1 in 1000 (10 x.), temp., 9 P.M., 99.8°.

July 26th: Temp. 102°. Repeat injection of hyd. perchlor. and saline solution being given continuously throughout. 9 P.M., temp. 102°; urine bright red.

July 27th: Temp. 98.4°. Saline solution still given. Albumin, trace only.

From this date the temperature continued normal, the urine became normal, and the patient made a rapid recovery. By August 3rd he was able to resume normal conditions.

I attribute the successful recovery to the continuous use of the saline solution and the injection of the 1 in 1000 perchloride of mercury solution.

A CASE OF PYORRHŒA ALVEOLARIS.

CAVERNOUS SINUS THROMBOSIS; HEMIPLEGIA.

By R. ECCLES SMITH, F.R.C.S. EDIN.

IN THE LANCET of August 2nd, 1919, I recorded under "Intracranial Lesions" a case of the above condition which is of rare occurrence. Yet within two years I have to note a further case, demonstrating the urgent need and great value of attention to the teeth both in the adult and the child.

The patient, a girl of 24 years, had a perfect cesspool in the upper jaw. She was treated for five days for an increasing swelling of the left side of the face and œdema of the left eyelid. Paralysis of the right side ensued, and she was sent to me moribund. Pronounced pyorrhœa, ulcerative gingivitis, ulceration of the cheek adjacent, with a spreading cellulitis of the face, led the way to the cavernous sinus via the pterygoid plexus of veins. Extreme proptosis of both eyes and chemosis, especially on the left side. Involvement of the left crus cerebri by its close relation to the cavernous sinus, with corresponding right-sided hemiplegia. Œdema over the left mastoid (via the petrosal sinus) completed the ghastly picture of cavernous sinus thrombosis. Death ensued in 12 hours from profound septicæmic coma, six days after the onset of symptoms.

Apart from all the minor miseries and ill-health caused by septic infection of the teeth, I think these two fatal cases should promote further interest in the question of even compulsory dental inspection and treatment.

Barry, Glain.

DEATH OF DR. A. W. D. HUNT.—Albert William Dunning Hunt died at his residence, Heylands, Chagford, Devon, on August 27th, in his forty-fifth year, after a long illness. Dr. Hunt was highly esteemed in and round Chagford; he was devoted to the people of Dartmoor, where his father and grandfather had been in practice before him. He qualified M.R.C.S., L.R.C.P. from the Middlesex Hospital Medical School in 1899, and held the appointments of house physician at the Hospital for Consumption, Brompton, and house physician and house surgeon at the Oxford County Hospital before settling in practice. He held several public appointments and was honorary surgeon to the Moretonhampstead Cottage Hospital. Dr. Hunt will be greatly missed in Chagford, and much sympathy is felt there for his widow and three young children.