DR. O. H. FOERSTER, Milwaukee: I recall the case of a man who for twenty-five years had been affected with a skin eruption which had been variously diagnosed by experienced men as erythrodermia, pityriasis en plaque disséminé and other allied affections. Then suddenly, within the course of a week, it took on the appearance of a mycosis fungoides and eventually ended fatally.

DR. FRANK E. SIMPSON, Chicago: I should like to mention one point of apparent connection between mycosis fungoides and leukemia. We had a fatal case of what had been diagnosed as mycosis fungoides clinically and the necropsy showed it to be a case of leukemia.

DR. H. H. HAZEN, Washington, D. C.: In a rather extensive study of mycosis fungoides which Dr. Strobel and I made three years ago, the investigations led us to believe that this disease is a leukemic lymphomatosis, and that it may become leukemic, as exemplified in the case recently reported by Pardee and Zeit. Necropsy reports show that the visceral lesions are mainly confined to the lymphatic system, and changes in the bone marrow have been reported.

AN ABSORBABLE PLATE FOR USE IN THE OPEN TREATMENT OF FRACTURES *

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The fixation apparatus I have to present consists of plates and pegs made from animal bone. This apparatus is sterilized by boiling and then applied directly on the bone in a manner

From above downward: (1) A plate showing thirty-one days' absorption; (2) a plate ready for fixation; (3) especially turned pegs beveled at one end; and two cribbage pegs, used because they may be purchased at little cost; (4) the intermedullary splint.

similar to that used with the non-absorbable plate. Holes are drilled through the plate and into the fragments after reduction, and the pegs are then driven in and sawed off a short distance from the plate. The length of the peg left varies with the depth of the wound. Two pegs are put into each fragment.

* Presented at the annual meeting of the Maryland State Medical Society (Medical and Surgical Faculty), and at the Clinic Day of Orthopedic Association, Baltimore, May 5, 1913.

I have also an intermedullary splint, turned from animal bone. This splint has a hole drilled at each end through which is threaded a catgut suture. In using this, one fragment of the fractured bone is dislocated out of the wound far enough to make the medullary canal accessible. A hole is drilled through the cortex about 1 inch above the break and a double strand of wire passed through this hole and out through the end of the canal. The catgut is threaded through this wire and with it drawn out of the cortical opening. The entire splint is now forced up into the canal and the fracture reduced. While the fracture is held in a clamp, traction is made on the catgut, drawing the splint into the medullary canal of the other fragment much as a bolt is driven into its keeper. The catgut is now threaded on a needle and sewed into an adjacent muscle or fascia.

I have had only one opportunity to use the absorbable plate and none to use the intermedullary splint. The plate was used in the case of an oblique fracture of the tibia occurring in a boy aged 10. Closed reduction failed to hold the fragments in good apposition. The plate was applied with four pegs. Convalescence was uneventful and at the first dressing on the twenty-first day, pegs and plate were felt *in situ*. At the next dressing, ten days later, the pegs had been absorbed and the plate was felt loose in the subcutaneous tissue. It was easily removed through a small opening and the erosion shows the extent of the absorption that had occurred.

Fixation of the tibia is a severe test for any form of plate. This case shows, I think, that, while my plate is needlessly thick for fixation, absorption will occur, and that, in a deeply placed bone such as the femur, complete absorption would take place in the time required for immobilization of a fracture, and that the plate would resist absorption sufficiently long to give the necessary fixation.

114 West Franklin Street.

A CASE OF LYMPHANGIOMA CIRCUM- SCRIPTUM

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The following case of lymphangioma circumscriptum, a comparatively rare dermatosis, occurred in the service of Dr. Jerome Kingsbury at the New York Skin and Cancer Hospital, and was presented by him at one of the recent meetings of the New York Dermatologic Society.

The patient, M. D., schoolgirl, aged 13, has never had any acute illness, other than an attack of rubeola when 9 months old. Her family history is negative; her father, mother, three sisters and three brothers are perfectly healthy, and entirely free from angiomatous, or other dermatologic lesions. The patient is in good health, but occasionally suffers from indigestion. The disease began when she was 3 years old, first as a reddish inflamed patch, on which, in a very short time, vesicles appeared. The lesion slowly increased in size until four or five years ago; since then it has remained stationary. There are no subjective sensations, but occasionally during an attack of indigestion she complains of a burning and itching sensation, which subsides at once with the relief of the gastric condition. The patch is now about 4 by 5 inches in diameter, of an irregular or ovalish contour, and consists of an aggregation of pearly vesicles, of a glimmering translucent aspect. In a number of the older lesions the translucency is lost, and a slight verrucous appearance assumed. Because of the rupture of minute capillaries, and the admixture of blood with the lymph contents of the vesicles, a number of the lesions are of a deep red, purplish or blackish color. The