

case being 10–15 mg. A lower potency than this has been observed by us in a well-known brand of Norwegian medicinal cod-liver oil sold in this country. It is to be noted that these liver oils originate from fishes belonging to the genus *Gadus*, and we are now investigating whether oils of other genera also exhibit this exceptionally high vitamin-A potency. The relative potency of Lofoten and Finmarken medicinal oils and the influence of the mode of preparation of the liver oils on the vitamin content will form the subject of a separate communication.

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## Clinical Notes :

### MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

#### A CASE OF GANGRENE FOLLOWING MEASLES.

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THE following case appears worthy of record owing to the rarity of gangrene as a complication of measles and to the extreme youth of the patient. I have up to the present found no other case recorded.

M. M., aged 4½ years, was admitted to the borough infectious diseases hospital under my care on the fourth day of disease suffering from measles. She had had bronchitis at nine months and pneumonia when aged 2. On examination she presented a typical measles rash and signs and symptoms of broncho-pneumonia. She was obviously very ill, temperature 104° F., breathing difficult, and some cyanosis. Temperature remained high, in the region of 104° and 105°, and on the ninth day some meningeal symptoms intervened. These subsided on the eleventh day, and on this day a few dark purple spots were observed on the left leg and both limbs showed signs of circulatory troubles and became cold and pale. Active treatment was begun, a few septic spots were observed on the cheek and one on the abdomen. Within the next 24 hours gangrene made its appearance on the toes of the left leg and rapidly spread up that leg to the region of the knee-joint, a well-marked line of demarcation forming at the level of the junction of the upper and middle thirds of the tibia; at the latter part of this period of 24 hours a patch of dry gangrene was observed on the great toe of the right leg. The condition of the child was such that it was not thought advisable to operate and she died on the fifteenth day of the disease. A post-mortem was refused. Blood specimens were submitted to the bacteriologist and negative results obtained for the Widal test and for pathogenic organisms.

#### A CASE OF MULTIPLE SARCOMATA.

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THE following case presents some features of interest.

J. G., a woman of 46, was admitted to Duke-street Hospital in February complaining of tumours in both breasts and one on the back. She had had 11 children, the youngest being about a year old, but the right breast had never lactated. The tumour on the back had been present for about eight years, had steadily increased in size, and had always been painful. That in the right breast had been present for about six weeks prior to admission, while that in the left she had only noticed recently.

On examination the tumour in the lumbar region was seen to resemble a spina bifida in shape and general appearance, and was covered with glazed, dark-coloured skin. It was not movable, and while firm to the touch suggested fluctuation on deep palpation which, however, caused considerable pain. The tumour in the right breast presented as a hard irregular mass in the upper and outer quadrant, and was slightly tender to palpation. The breast as a whole was unduly firm, but moved freely on the underlying

structures. There was no puckering of the skin, retraction of the nipple, or enlargement of axillary glands. The left breast presented a small hard and tender swelling on the inner side. The tumour in the lumbar region was first operated on and removed without particular difficulty. It contained about 2 oz. of blood-stained fluid surrounded by quantities of necrotic tissue, and it grew apparently from the spines of one or two lumbar vertebrae, portions of which were removed along with the tumour.

Dr. R. M. Buchanan reported the fluid negative to tests for cerebro-spinal fluid. The tumour presented a highly vascular capsule encircling tumour tissue in great part necrosed. Another portion of tissue examined presented a dense fibro-vascular capsule of very varying thickness with small spicules of bone in places, and, centrally, tissue of the character of spindle-celled sarcoma. The right breast was also removed and Dr. Buchanan reported the tumour as a spindle-celled sarcoma.

Patient declined further operation and left the hospital, but in the interval the mass in the left breast had increased in size, the nipple was retracted, and the glands in the axilla were enlarged. We were informed that she became blind some time after leaving hospital.

Were the tumours in the breasts primary or were they secondary to the tumour in the lumbar region, and, if so, what was the channel of metastasis? Unfortunately, the pathological characters of the tumour in the left breast, clinically resembling a carcinoma, could not be ascertained.

#### A CASE OF INTRAPERITONEAL RUPTURE OF THE BLADDER

DUE TO RETROVERSION OF THE GRAVID UTERUS.

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THE following case is of sufficient interest to merit record.

Mrs. P., aged 25, was admitted to the Maternity Hospital, Birmingham, on June 10th, 1921, with acute abdominal symptoms complicating a four months pregnancy. Her general health had been good; she had had two previous labours, the first a breech presentation, the second normal. The history was that a fortnight before admission the patient had retention of urine for 48 hours followed by incontinence. No catheter was passed. On the afternoon of June 9th—i.e., 30 hours before admission—she became rapidly worse. She was seized with sudden acute abdominal pain and passed no urine after this.

On admission she was obviously very ill, pale, and collapsed, pulse 120 and feeble, temperature 99·2° F., respiration 40. She complained of severe abdominal pain. The abdomen was distended and tender all over. The uterus could be felt the size of a four months pregnancy. There was free fluid in the abdominal cavity. A catheter was passed and 20 oz. of urine withdrawn. This contained thick pus, blood, and shreds of bladder epithelium. The patient had a slight "show" shortly after admission. On vaginal examination the os was dilated and the foot presenting.

The case was seen by Mr. Lewis Graham and a diagnosis of intraperitoneal rupture of the bladder made. The abdomen was opened at once. The peritoneal cavity contained over a gallon of turbid foul urine. The bladder was contracted and a rupture about 2 inches long was present at the fundus. This was sutured with catgut. The abdomen was drained by one large drainage-tube. The patient's condition after operation was very grave and an intravenous saline was given. The foetus was expelled at 8 A.M. the following morning, the placenta, which was adherent, being removed manually.

The patient made a good recovery. She wore a self-retaining catheter for a fortnight and was catheterised at regular intervals till June 25th when she first passed urine normally. She left hospital on July 11th quite well.

*Note by* Mr. LEWIS GRAHAM.—The interesting features of this case are its great rarity and the fact that a patient was able to make an uninterrupted recovery after having a large amount of foul urine in the peritoneal cavity for 30 hours. The diagnosis was obvious and the treatment easy, although when first seen the patient appeared moribund and not worth operating on. However, an operation was her only chance, and she made the above remarkable recovery.