

examined in some cases of epistaxis, a clue would be often found to the cause of the latter.

Epistaxis is one of the toxic effects of salicylates given internally. Dr. L. Shaw<sup>2</sup> found that it occurred in 11 patients of 174 under the treatment of rheumatism by salicylates. None of my patients, however, had taken salicylates before the epistaxis occurred, and all but one, who did not respond to it, took the salicylate with good result. It is possible that in some cases of rheumatism treated by salicylates where epistaxis occurs it is due to the disease and not to the drug.

In all the literature on rheumatism I have not found any suggestion that rheumatism may cause epistaxis except indirectly, through setting up endocardial changes. In a very excellent article on epistaxis by Dr. F. de Havilland Hall,<sup>3</sup> various alterations in the blood are mentioned which are attended with epistaxis as a prominent symptom—viz., hæmophilia, purpura, scurvy, chlorosis, anæmia, pernicious anæmia, and malarial poisoning, but not the rheumatic diathesis. The only suggestion I can find that rheumatism has any influence whatever in the causation of epistaxis is in a paper by Dr. Rendu<sup>4</sup> of Paris, quoted by Dr. Hall, in which it is said that epistaxis may occur in young persons who become later the subjects of piles or rheumatism. I think it may be said that epistaxis occurs in the young who are already the subjects of rheumatism.

There is nothing inherently improbable in the supposition to which many cases point, that rheumatism may give rise to epistaxis, for many other blood states are acknowledged to do so, and rheumatism is a known cause of one variety of purpura in which hæmorrhages occur from cutaneous and mucous surfaces.

## Clinical Notes:

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

#### A CASE OF CHELOID.

BY H. TAYLOR, M.A. CANTAB., M.A., M.D. DUB.

A MAN, aged 21 years, healthy and dark-complexioned, with some tendency to acne as evidenced by the comedones scattered over his face, neck, and shoulders, sustained some two years ago—owing to the application by mistake of a poultice in an almost scalding condition—a large blister involving the skin over the lower ribs and the epigastric and hypogastric regions. This blister on healing left two elongated pigmented patches, unaccompanied, however, by any loss of the natural suppleness of the integuments until after the lapse of some five or six weeks, when the patient noticed that some “lumps” were forming in the outer patch; these gradually developed into a tumour which was tender and painful and which itched at times. It was, the patient states, however, completely removed by operation in October, 1900, but all the phenomena very shortly reappeared and in 10 or 12 weeks the recurrent growth was as large as ever. It now presents as two hard, fibrous, whitish-grey, spindle-shaped masses, with no evidence of any increase in vascularity, joined together in an A-shaped form by a shorter band of similar structure, and though at present the mass of the tumour has not trespassed beyond the area previously occupied the numerous outlying foci it is now surrounded with would point to an early encroachment on adjacent tissue. Tenderness, pain on pressure, and itching are complained of as in the original growth, but there is none of the burning sensation usually noted as one of the symptoms.

Virchow attributes cheloid to an irritation caused by, and proportionate to, the extent of the exciting lesion, while Alibert, who first described the disease, attempted to divide it into “true,” or spontaneous, and “false,” or cicatricial, cheloid. Others, again, would differentiate between a spontaneous or idiopathic growth and one arising from “scar tissue,” but it is now considered very doubtful, in view of the many trifling injuries to the skin which may

occur unnoticed or forgotten, whether it ever arises without some such exciting cause. It is sometimes associated with acne; it has developed in the scars of leech-bites, in those of vaccination, of herpes, and of small-pox. Showing itself as it usually does between the ages of 15 and 50 years it is a disease of adult life and more common in the dark than in the fair races.

It is affirmed by Liveing, in combating the view that a cicatricial cheloid is nothing more than a hypertrophied scar, that while in the former the tissue consists of fibres closely packed together and arranged in the long axis of the tumour, with a tendency to assume a spindle shape, in the latter the fibres run in every direction, forming a confused irregular network. This microscopical test, however, is not often applicable, and the same authority gives the following points in favour of a diagnosis of cheloid in distinction to that of one of “hypertrophied scar”: (a) if the growth is on or near the sternum, especially if it be multiple; (b) if tenderness, pain on pressure, and subsequently itching be present in the tumour; he states further that (c) cheloid eventually extends, though perhaps very slowly, beyond the scar, and hypertrophy of scar tissue never does this. A spontaneous involution, more usually in young subjects (Hutchinson), sometimes take place, and Goodhart has recorded a case in which extensive cheloid tumours arising after small-pox had in a few months disappeared.

Removal by operation or caustics is never, as in this case, successful in preventing a return. Pressure applied by elastic bandages, mercurial plasters, or deep incisions into the growth have all been recommended, and Morris has seen moderately sized tumours completely disappear after electrolysis applied once a week accompanied by a daily massage. He also recommends, if the growth be painful, the injection in and around it of cocaine or the local application of belladonna or opium.

#### FREQUENT REPETITION OF TAPPING FOR ASCITES.

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THE patient was a strongly-built, healthy-looking man, 50 years of age, of the country yeoman type. He described himself as a moderate drinker of malt liquor only, though he went as far as to admit that he at times substituted it for a more solid meal. My first visit to him was on account of an epileptic fit, the only one he ever had. In September, 1896, he found some difficulty in getting up and down from the box of a cab which he drove, and he complained of a feeling of distension in his bowels, which he likened to water rolling and splashing from side to side. A month after being treated internally for ascites he was tapped, that was early in October, 1896, from which date up to October, 1900, he was tapped regularly, at first once in three weeks, then once a fortnight, and ultimately every nine days, making a total of 150 tapplings. At first from 12 to 14 quarts were withdrawn at each sitting by Southey's tubes; towards the finish less was withdrawn but the total quantity was over 250 gallons. In October, 1900, he died from cardiac failure. Some features in the course of the case were œdema of the right leg, which cleared up, and then the same happened to the left leg, and thrombosis of the veins of the right side of the abdominal wall.

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#### A CASE OF CANCRUM ORIS AFFECTING BOTH SIDES.

BY E. E. LASLETT, M.D. VICT., B.Sc. LOND.

THE patient, a boy, aged six and a half years, was suffering from advanced pneumonic phthisis and for some weeks there had been great emaciation and weakness. For some days he had been suffering from severe stomatitis which was little influenced by local antiseptic treatment. The teeth became loose and dropped out or were pulled out by the boy himself. The gums were swollen and softened, and the lower gum especially was much discoloured in places. On Feb. 2nd, 1902, a black patch appeared on the skin over the right side of the lower jaw below the angle of the mouth. When I saw the patient in the morning of that day the

<sup>2</sup> Guy's Hospital Reports, 1887.

<sup>3</sup> Westminster Hospital Reports, 1893.

<sup>4</sup> La Semaine Médicale, June, 1884.