Absorption of carbolic acid was suggested as the cause of the collapse, but I see no reason to regard that as probable, and the urine which was withdrawn was in no way abnormal. The disease had been slowly progressing for a fortnight before surgical interference. The patient suffered from pulmonary emphysema and was addicted to alcohol.

In a very large proportion of cases of cancrum oris pneumonia or noma, perhaps combined with gangrene of the anus, or pneumonia and noma together, appear as complications. Of 173 cases described in the *American Journal of the Medical Sciences* as occurring in a recent epidemic more than one-fifth had one or other complication or both combined. These complications may accentuate the constitutional effects or may introduce a further antagonist to the patient's power of resisting the disease, but from its position and its virulence and rapidity it must always prove exceedingly dangerous to the life of the individual attacked. The patient is always one with a constitution debilitated by disease or habit of life. With this weakened organism we have the disease in a position where, though the nutrient supply of the tissues is abundant, there is also an abundant absorption. Toxalbumins and bacilli will rapidly pass into the blood, and it is reasonable to suppose that in many cases septic emboli and thrombosis may extend through the veins to the cavernous and other sinuses. In nine bacteriological examinations carried out during the American epidemic a leptothrix was found constantly present, but it is impossible to fulfil all the laws which are required to prove this to be the distinctive organism of the disease. Probably it is a mixed infection, for there are always numerous other bacilli and cocci present, and in one of my cases the colour of the pus was distinctly bluish-green, as it would be under the influence of the bacillus pyocyaneus.

Cardiff.

A CASE ILLUSTRATING THE EFFECTS OF PRESSURE ON EARLY SYPHILITIC WARTY GROWTHS.

BY ARTHUR SHILLITOE, M.B. CANTAB., F.R.C.S. ENG.,
SURGEON TO OUT-PATIENTS TO THE LONDON LOCK HOSPITAL.

AT the October meeting of the Dermatological Society of Great Britain and Ireland I showed a young man with papillomata and condylomata present at the same time on the tongue. He gave the following history. Gonorrhœa was acquired about Christmas, 1900, followed by a chancre on the penis in January, 1901. He was treated privately from January to July and had had no eruption on the body to his knowledge. In June last he had warts on the penis which were destroyed by caustics.

According to Mr. J. Hutchinson, sen., if warts should be found on the penis of a syphilitic subject, the tongue should always be examined for a like condition; and, if present (which they often are), they will be seen to be situated on the posterior third of the dorsum between the arms of the V formed by the circumvallate papillæ—that is to say, on that part of the tongue which does not come in contact with the palate and therefore is not subjected to pressure. While agreeing with this—viz., the formation of papillomata on a part not subject to pressure—one cannot but remember how often in venereal patients (both gonorrhœal and syphilitic) are seen large masses of warts beneath a tight or phimosed prepuce where the pressure must be fairly constant and considerable. On examining my patient I found that he certainly had a few small warts about the corona and on looking at his tongue there were seen several papillomatous growths in the position above indicated. In addition, scattered over the anterior two-thirds of the dorsum and the margins of the organ were eight or 10 large, flat-topped, white condylomata, with sharply defined margins—that is to say, on that part of the tongue which is subject to the intermittent pressure of the palate and teeth. When we consider the positions of condylomata in other parts we find that they, too, occur in situations subject to intermittent pressure—e.g., the natal fold, the inner aspect of the thighs, and the sides of the scrotum.

It seems to me that (1) pressure, as seen in the case of a phimosed prepuce, and (2) no pressure at all, as in the posterior third of the dorsum of the tongue, exert an equal influence in determining the formation of ordinary-looking papillomata; whereas, if the pressure be intermittent, as seen in the anterior two-thirds of the tongue, the inner aspect of the thighs, and the sides of the scrotum, or in the natal fold, then these papillary hypertrophies assume a condylomatous form.

In conclusion, my patient told me that his tongue was in much the same condition last July and that it yielded so rapidly to treatment that he took no further medicine, until I saw him at the hospital early in October, when the lesions speedily disappeared under mercury.

For permission to publish the above case I am indebted to the Dermatological Society of Great Britain and Ireland.

Frederick-place, E.C.

NOTE ON A CASE OF CONGENITAL ATROPHY OF THE RIGHT KIDNEY.

BY R. NIVEN, M.B, CH.B. GLASG.,
ASSISTANT MEDICAL OFFICER, BETHNALL HOUSE ASYLUM, LONDON, N.E.

A MAN, aged 57 years, died at Bethnall House Asylum on Nov. 9th, 1901, from asthenia consequent on general paralysis of the insane, complicated by hypostatic engorgement of the lungs. At the necropsy no trace of the right kidney could at first be discovered. On removing the right suprarenal capsule, however, a small reddish mass of about the size of a scarlet-runner bean was discovered embedded in the surrounding areolar tissue and close to the lower margin of that organ. The connexions with vessels and ureter were thus unfortunately severed before a careful dissection was made. A small vessel, probably a vein, was found emerging from the inner border of the reddish body. A very small artery, probably the right renal, came off the abdominal aorta opposite to, and on a level with, the left renal artery. On dissection, a fine tube was found following the normal course of the ureter and was traced downwards to the bladder which it entered at a point on the right side of that organ corresponding to the point of entry of the left ureter on the other side. A stout hairpin was with difficulty passed through a small surface at the right posterior angle of the trigonum vesicæ, and it travelled along the tube for about two inches. On microscopical examination the reddish mass embedded in fat had the structure of very atrophied kidney substance. A few tubules were seen to be scattered through an abundance of dense fibrous tissue. They were lined with flattened epithelium and were filled with retained secretion. The vessels in the dense fibrous stroma were very thick-walled. The right kidney exhibited some degree of compensatory hypertrophy. Its position and relations were normal. The organ weighed seven ounces, it was of healthy colour and apparently normal on section, and the capsule stripped easily. Microscopical examination showed the kidney to be practically healthy. There were small patches of fibrous tissue here and there, but the glomeruli were not degenerated and the convoluted tubules were not dilated. The urine was neither measured nor examined during life, as the man was during the period of his residence here indifferent to the calls of nature and passed urine and fæces under him. Throughout life there were no symptoms indicating defect in the urinary organs.

For permission to publish this case I am indebted to the kindness of Dr. J. Kennedy Will, medical superintendent of the Bethnall House Asylum.

Cambridge-road, N.E.

A NOTE ON A CASE OF PURPURA.

BY T. EDWARD SANDALL, M.B., B.C. CANTAB.

A WELL-MARKED case of purpura is perhaps sufficiently rarely met with in general practice as to warrant a brief report. The following case is of interest on account of the peculiarity and duration of the premonitory symptoms which completely puzzled me at the time, and until I saw the characteristic eruption on the ninth day of the illness I had no idea that I was dealing with a simple case of purpura.

The patient was a girl, aged 15 years, who had always enjoyed good health but had not yet menstruated. I first saw her on Nov. 11th, 1901, when she complained of acute pain in the calf of the leg and in the popliteal space on both sides which, having begun the day before, became so acute that she was quite unable to walk and she had to crawl upstairs to bed on her hands and knees. There was no other symptom; the temperature was normal, the appetite was good,

the tongue was clean, and the bowels were regular. On examination there was no abnormal appearance of the skin and no swelling or œdema, but there was acute tenderness on pressure on the calf of the leg and in the popliteal space. Lying perfectly still the patient was free from pain, but any attempt to flex the leg was acutely painful. She was kept in bed, hot fomentations were applied to the parts affected, and a mild aperient was given, but no other medicinal treatment was employed as I saw no indication for it. Next day the patient was better, feeling quite well in herself and complaining much less of the pain and tenderness. On the 13th she declared herself well again and got up for a few hours in the afternoon, but this appeared to cause a return of the pain and on the 14th it was worse, especially in the right leg; the right arm and elbow were now affected and there was some headache. Although the temperature remained normal, the tongue clean, and the joints free from swelling, I thought that the symptoms pointed to subacute rheumatism. The patient was therefore kept in bed, the affected parts were wrapped in flannel, and a salicylate of soda mixture was given. During the night of the 14th the patient vomited several times and again on the morning of the 15th, when the tongue was slightly furred and the headache continued, but the pain in the limbs had practically subsided. On the 16th the patient declared herself to be quite well again, and on the 17th treatment was discontinued, and she returned to her duties as a domestic servant. About 10 P.M. on the 19th I was sent for and I found the patient in bed, complaining once more of acute pain in the arms and legs which had begun in the afternoon. The skin was covered with a purpuric eruption, the spots varying from the size of a pin's head to about one-eighth of an inch in diameter or larger. They were most abundant on the limbs and were absent from the face. I was informed that a slight rash had appeared the day before and had faded again. The temperature was 102° F. There were slight œdema of the legs and feet and some effusion into the ankle-joints, particularly the right. On the 20th a few fresh spots had developed, but the general rash was fading; the spots were dull and purple in colour. The pain was less severe and the œdema was less marked. On the 21st the patient felt quite well; there was no longer any œdema or effusion into the joints, there was no pain or discomfort, and the rash seemed to be fading slowly. Improvement continued for the next two days, when the patient left for her own home, and passed out of my observation.

On the pathology of purpura, which is a difficult subject, I do not propose to touch, but I desire to call attention to one or two points as to causation and diagnosis. In the first place, had the non-appearance of the menstrual function any effect in the causation of the attack? There was absolutely no cause, as generally given in our text-books, and I am unable to refer to literature on the subject. The patient was a strong, healthy girl, taking plenty of outdoor exercise, and she had never had any serious illness. The diagnosis of purpura is easy enough with the rash before one's eyes, but the symptoms preceding the eruption were very puzzling and, I think, unusual. What was the cause of the acute pain and tenderness in the limbs? If the term "rheumatism" will cover these symptoms and if the eruption may be termed "purpura rheumatica," I still would urge that there was not rheumatism in the ordinary acceptation of the term. And what were the structures affected? Was the pain neuralgic or muscular? Lastly, I would call attention to the temperature, which remained normal during the whole illness except for a few hours at the onset of the eruption, when it reached 102°.

Alford, Lincolnshire.

BRISTOL HOSPITAL SUNDAY FUND.—A meeting of the committee of the Bristol Hospital Sunday Fund was held on Dec. 12th. The Lord Mayor gave an account of the progress of the fund, showing that in 1898 there were 92 collections at places of worship which realised £1128, whereas in 1901 there were 251 collections and £1772 were raised. Grants of £1711 were made to the local medical charities, which included the Royal Infirmary, £704; the General Hospital, £591; the Children's Hospital, £218; and the Eye Hospital, £105. It was decided that the last Sunday in January next should be observed as Hospital Sunday.

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., Procœmium.

NOTTINGHAM GENERAL HOSPITAL.

A CASE OF TRAUMATIC ANEURYSM OF THE VERTEBRAL ARTERY; FAILURE OF LIGATURE ON THE PROXIMAL SIDE; DISTAL LIGATURE; EXCISION OF THE SAC; PLUGGING; RECOVERY.

(Under the care of Mr. A. R. ANDERSON.)

THE treatment that is theoretically correct for a traumatic aneurysm is identical with that for a recent wound of an artery, that is, ligature on both sides of the wound; and the only exceptions that are admissible are cases where it is impossible or unadvisable to apply these two ligatures. It is generally acknowledged that the internal carotid and its branches form the chief exception to the rule and that with these proximal ligature may prove sufficient, but the vertebral artery from its depth might fairly claim to be also considered unsuited for the usual treatment. The circle of Willis, however, supplies the distal portion of the vessel so freely with blood that it must be acknowledged that ligature on both sides of the wound, or on both sides of the traumatic aneurysm, is imperatively necessary. The following report describes the successful treatment of a most troublesome traumatic aneurysm of the vertebral artery immediately below the third cervical vertebra.

A young woman, aged 21 years, was taken to the Nottingham General Hospital on Sept. 4th, 1900, having been stabbed in the neck a short time previously. The injury was inflicted by the small blade of a penknife used for nails and having only a short portion of blade at the end. A small wound, one-third of an inch long, was found over the posterior border of the sterno-mastoid on the left side, about the level of the upper border of the thyroid cartilage; its direction was forwards and inwards. There had been profuse bleeding, arterial in character, and the patient was pale and faint from loss of blood on her arrival. It had then ceased. A pad was placed over the small wound which healed readily and gave no further trouble, and at the end of three weeks she went out apparently well.

On Jan. 2nd, 1901, the patient was readmitted to the hospital with a pulsating swelling in the neck, of about the size and shape of a duck's egg, having its centre opposite the wound. Its upper limit extended as high as the lobule of the ear and its lower limit to within two inches of the clavicle. The pulsation was markedly distensile and a loud bruit could be heard on auscultation. No information could be gained by digital compression of the common carotid artery, the bulk of the tumour interfering with this, and any deep pressure caused the patient much distress. From the situation of the aneurysm and the direction of the wound it was thought probable that the injured vessel was the carotid artery or one of its branches, and on Jan. 4th Mr. Anderson made an incision over the course of the common carotid artery and exposed this vessel, and was somewhat surprised to find that compression of it produced no effect whatever on the pulsation in the aneurysmal sac. It was then concluded that the vessel involved must be the vertebral artery, so the incision was prolonged downwards and this vessel was exposed in the interval between the longus colli and the scalenus anticus, just below its entry into the foramen in the transverse process of the sixth cervical vertebra. Compression of the vessel here immediately and completely arrested the pulsation in the sac. The vessel was then tied with a silk ligature and the wound was closed.

The operation was followed by contraction of the pupil of the corresponding side, due to disturbance of the sympathetic filaments in relation with the artery. In the absence of other evidence this affords proof that the operator had ligated the vertebral artery, and not the inferior thyroid