

TABLE V. — PERCENTAGES OF FAILURE TO FIND THE GROWTH.

	1889.	1891.	1899.	1905.	Total.
Removed	18	28	265	160	471
Not removed	5	10	115	59	189
Per cent failure	22	26	30	27	29

This table reckons only the cases where there was a definite failure to find the growth at the seat of operation. Many of the so-called palliative operations may fairly be regarded as failures in diagnosis, and the cases where it was impossible to remove the growth when found also point to the limitations of the operation. Including all these, failures to remove the percentages differ, but show the same general trend, that there has been little if any real gain in the percentage of tumors actually found and removed.

TABLE VI. — PERCENTAGES OF FAILURE TO REMOVE.

	1889.	1891.	1899.	1905.	Total.
Removed	18	28	265	160	471
Not removed	6	20	224	107	357
Per cent failure	25	41	46	40	43

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A REPORT OF TWO CASES OF ERYTHEMA MULTIFORME DESQUAMATIVUM, ONE OF THEM COMPLICATED BY A PURPURIC ERUPTION, WITH A DISCUSSION OF THE UNDERLYING CONSTITUTIONAL CONDITIONS.

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CONSIDERABLE interest has been given by the numerous papers of Osler on the subject, to the conditions which underlie many of the obscure forms of erythema. Not enough cases have been collected to enable one to get much of importance out of a study of these underlying conditions, or of the symptoms common to a majority of the cases. Indeed, in the comparatively large number reported by Osler in five different papers, a summary of the conditions in which some form of erythema was a complication gives one chiefly the idea of how widespread and obscure the etiological factors may be which cause this trouble.

A review of Osler's 29 cases gives some very important information as to the etiology, course

and severity of the trouble, its many-sided manifestations and complications. Eighteen of his cases were males. The youngest was three years of age, 17 were fifteen or under. The oldest was fifty-seven. Twenty-two had purpuric skin lesions; 17 urticaria; 5 circumscribed edema; 14 the usual form of erythema; 25 had colic; 17 arthritis or arthritic pains; 15 vomiting; 15 hemorrhages from the mucous membranes; 15 albumin; 14 nephritis as a cause for the albumin; 14 fever; 5 diarrhea; 7 enlarged spleen, 2 had endocarditis; 1 doubtful endocarditis; 5 died of uremia as a result of the nephritis. The other deaths were due in one case to pericarditis and one to pneumonia during the third attack.

The other unusual complications were otitis media in 3 cases; bronchitis in 2; spasmodic croup from edema in 1; aphasia and hemiplegia in 1, and pneumonia, not fatal, in 2. It was impossible to measure the duration of the trouble in many of the cases, but it had occurred an almost countless number of times over a period of twenty-seven years in one patient of fifty-seven who finally died from hemorrhages in an attack. The shortest duration, in a female child of four, was three weeks. This case had purpura, urticaria and edema, fever with gastro-intestinal crises, albumin without nephritis, and arthritic pains.

Osler himself does not attempt any classification of the conditions which may bring about erythematous manifestations, nor does he associate any particular form of erythema with certain types of the underlying trouble. The commonness with which purpura, including peliosis rheumatica, circumscribed edema and urticaria, occurred in his cases, led him to question whether there was not a close affinity among these skin manifestations. He calls special attention to the substitution of these affections for each other in the same patient at different times.

I quote a statement made in one of his papers, because it seems to me that simplicity in classification is demanded in these obscure conditions, and because it has been my experience that these varying manifestations occur interchangeably as the result of the same systemic conditions. The special statement of Osler reads as follows:

"Henoch's purpura, characterized especially by gastro-intestinal crises, and Schönlein's peliosis rheumatica may be regarded as hemorrhagic types of exudative erythema."

Bearing out this same point, Thibierge, in his *Traité de Médecine*, vol. iii, groups both purpuras and urticarias under erythemas. He describes three types of purpura, namely, rheumatic, infectious and the purpura hemorrhagica of Werlhof. Galloway described a case of profuse exudative erythema with purpuric lesions and enterocolitis, and refers to "the purpuric type of the exudative lesions of the skin." Fayrer reports a case of arthritis, edema and erythema exudativa purpurica with final sloughing of the affected areas.

Carter reports a case of hemorrhagic exudative erythema in which he describes the purpuric

eruption as identical with Henoch's purpura. The French school generally regard purpura as an erythematous manifestation, and particularly Brocq and Besnier, who have added much to French literature on the varying manifestations of this disorder. Dermatologists take exception to this classification, but it seems reasonable, and purpura occurs so commonly with other erythematous manifestations in rheumatic and certain grave infections, that I think it important to maintain the connection.

The two cases of scarlatiform or desquamative erythema which are recorded here are interesting in connection with several points in Osler's reports:

1. One had gastro-intestinal crises, fever, joint, heart and kidney complications; the other had intestinal disturbance, fever, slight kidney disturbance, angio-neurotic edema, and purpura with hemorrhages from the mucous membranes.

2. None of Osler's cases had the scarlatiform variety of erythema which seems usually not to be associated with as severe conditions as in these two cases.

3. Digestive manifestations preceded all the attacks in one case and preceded the single attack in the other.

The histories of the two cases are as follows:

CASE I. W. P., male, age six and one-half years. History of repeated attacks of endocarditis for the past two years, associated with sore throat and tonsillar disturbance. In one such attack, lasting three or four days, had one or two convulsions with temperature of 104°. History of irregular heart action in the father with some rheumatism. Mother has had growing pains. Has early sclerotic changes in the arteries. Maternal grandmother died of cerebral hemorrhage at fifty-six.

For six weeks following an attack of tonsillitis, patient had a daily temperature ranging from 1° to 2.5° above normal. It is extremely irregular, being often up in the morning and normal at night. Complained of headache on exertion during this time, looked pale and had disturbed appetite.

Heart action during most of this four years has been irregular in rhythm, and a systolic murmur, loudest at apex, has been constantly present.

For months at a time there has been a temperature range of 1° to 2° daily, with nothing but the heart condition to account for it.

Jan. 4, 1905. Patient seen Dec. 31, 1904, having had ten days of epigastric pain, cramp-like in character. A temperature this morning aroused the family. At 10 A.M., I found a diffuse, tiny, regular eruption all over the trunk, shoulders and thighs, which had not appeared on the face, neck, arms or legs. It was perfectly discrete. It had no crescentic appearance and consisted of tiny reddened areas, slightly raised in the center, each one about the size of a pin head. There was no pain anywhere. There had been slight throat symptoms forty-eight hours before, but there was no eruption on the cheeks or throat. No coryza nor eye symptoms. The glands were slightly large everywhere. There was no evidence of any skin infection. The heart was more irregular than usual and the murmur louder.

Temperature was 99.5° the following day, and the eruption had covered the entire body and the face except about the mouth. Where the itching had

caused him to scratch it a good deal, it was diffusely red between the patches, looking more like scarlet fever. There was a shotty feel to the eruption on the trunk and extremities. The palms and soles were also affected.

Temperature that afternoon rose to 102°, but on the two or three days following, it was not higher than 101°, and at 3.30 Jan. 6, was only 1° up.

Jan. 6. Patient's temperature last evening was still up to 100°. Examination of the urine shows a little albumin and a few casts, possibly more than could be expected from the febrile condition. Examination this morning shows the rash still lingering all over the body, although the face is quite clear, except on the neck. There are marks of his having scratched it very thoroughly in various places. The glands are easily felt all over the body, particularly the epitrochlear and postcervical glands.

Jan. 10. Patient has had rheumatic pains and swelling in the ankle joints of both feet for three days. The right ankle is still puffy this morning. Temperature ranges about 100°. He is peeling very markedly all over the scalp, and less markedly over the entire body, the peeling being scarcely perceptible as yet on the legs and the palmar surfaces of hands and feet. The peeling began Jan. 8, very lightly.

May 6. Boy's desquamation was complete six weeks after the attack was over. His nails desquamated but did not come off entirely.

The diagnosis of German measles was held for a day and scarlet fever was considered on account of the throat, but no report of the case was made to the health authorities. After the fourth day, desquamative erythema was diagnosed and some days later Dr. F. S. Burrows concurred in this. The throat condition was not more than a slight redness, with soreness on swallowing.

CASE II. M. C., male, age six and one-half years. Seen Jan. 8, 1904, 8 A.M., with Dr. K. Van Orden who gave the following history: Maternal grandmother had rheumatic joints. Paternal grandfather, now seventy-one, had rheumatic joints (ankles), one bad attack following overheating.

On the 7th of December, 1903, the patient was seen by Dr. Van Orden with a rheumatic attack. Temperature 101°. For several days had had pains in the back, arms and down the thighs. Felt cold and tired. On the 17th seen again with a temperature of 101° to 102°. Rash on the third day on the trunk; diagnosed German measles, mild attack. No cough, no sore throat. Seen only four days. On the 27th of December, day following a drive, had chilly sensation and temperature. Chilliness had been felt off and on for some weeks back. On the 28th a rash again appeared, brighter than before but of same character, spreading farther down the legs to toes. Very little on neck, none on face. Had been taking anisated ammonia, etc., little calomel, no quinine. The temperature reached 103° one day. Rash faded by the 30th. On the 31st rash gone and temperature normal. No desquamation. Not seen until Jan. 4. Had been up a day or two on limited diet. On evening of the 4th was downstairs. Felt badly all day. On the 5th complained of feeling cold, eyes heavy. On the 6th had fever of 104, flushed face, no vomiting, no sore throat. Was developing six-year old molars. On the 7th was more flushed on face, but not on body; hands and forearms to elbows and legs from toes to knees showed a papular vesicular eruption. Temperature 101-104.2°. Pulse 120 to 130. This eruption was noted in morning and didn't spread. On the 8th the face was edematous and there was a flush all over the body. Prepuce edematous. Complained of throat and eyes. Some ecchymoses on right shoulder. Tonsils said to be large. No

cough. Said to have passed some mucus with the stools yesterday. The urine was diminished this morning, but 26 oz. had been passed during the afternoon and early evening.

Examination: The child at 8 A.M., had a temperature of 101.5°. He was very bright. The face was considerably swollen and the eyes about half closed. There was no eruption on the face at all, but marked pallor. The papillae on the tongue were prominent and the tongue itself coated. The tonsils slightly large and red, with no membrane. There was no tenderness behind the ears, but the glands in the neck were slightly enlarged. The axillary and inguinal glands were tender and markedly enlarged, some of them being as large as very large beans. There was some swelling of the tissue under the angle of the right side of the jaw. There were some mottled red blotches, one nearly 1 cm. broad, on both ears. Over the chest and particularly over the back there was a slightly mottled but diffuse blush. It was particularly marked over the neck and buttocks, around the genital organs and slightly down the inner side of the thighs. Toward the extremities it became much more mottled, certain of the blotches being quite discrete. On the dependent parts the pressure of the clothes in folds had caused linear ecchymoses, looking very much like long scratches, particularly marked over the buttocks and shoulders. There was a marked absence of eruption or blush in the axillary spaces. The whole thing is said to have faded very much to-day. There is a slight puffiness over both ankles and the mother thinks over the instep. The conjunctivæ of both lids are slightly reddened. No discharge from the nose. Spleen slightly enlarged. No abdominal tenderness. The heart sounds are not quite clear, the first sound being replaced by what is apparently a functional murmur, transmitted well to the neck. The breathing is slightly harsh over most of the left lung, but this is not noted with expiration.

Jan. 19, 9 A.M. Following the last note the eruption spread over the legs and became scarlatiform in character. There still continued some swelling in the neck and the enlargement of the axillary and inguinal glands continued about the same. On the 14th multiple subcutaneous hemorrhages appeared on the chest and tongue. These grew worse through Saturday the 16th. That night the temperature was 101° and the patient had a nose bleed from one nostril which lasted nearly all night. The subcutaneous hemorrhages were none of them large. Most of them pin head in size. The largest the size of a split pea. The skin had been dry and had cracked and itched extremely, and he had scratched it quite vigorously for some days before the hemorrhages appeared. The urine continued clear and the heart action favorable through Saturday night. With the rise in temperature there was an increase in the heart activity and the boy complained of feeling cold in his back. The face became more and more swollen and the hands also quite edematous. The skin cracked at the angle of the eyes and at the mouth. On the 17th, the temperature reached 103°. On the 18th a pericardial rub was heard toward the base of the heart which had not been there the evening before. The skin has been irregularly desquamating for five or six days over the entire body. There have been no throat, ear or gastro-intestinal symptoms. There may be a slight amount of constipation, but the patient is largely on a milk diet. The hemorrhage from the nose was so profuse that a large quantity of clots were expectorated and the patient became excessively anemic.

Examination: Very faint pericardial friction is heard and a blowing systolic murmur. The heart

action is 120. The murmur undoubtedly hemic. Heavy black scabs all over the angles of the eyes and the mouth. Skin peeling everywhere. Skin very dry and pretty well covered with very faint tiny purplish spots which are not nearly faded out. The largest one is on the lower lip. There are a few millet seed in size over the point and under surfaces of the tongue. The spleen is not enlarged nor tender. The glands are everywhere enlarged to about the same size as noted before. The hands and feet are pale and slightly edematous. The edema in the face and neck are said to have disappeared practically in the last twenty-four hours. The scrotum and foreskin are not edematous. There is no tenderness anywhere except over the enlarged glands. No pains in the bones. Child's temperature this morning is normal.

The blood cultures taken Jan. 19 were negative. The blood examination showed 28% hemoglobin, 1,700,000 red cells, 6,800 whites. Differential, 41.5% polynuclears, 17.5% large lymphocytes, 36% small lymphocytes, 4.5% eosinophiles, 5% myelocytes. The urine contained a faint trace of albumin with a few hyaline casts and a few leucocytes and red blood cells.

Jan. 20. The child has had an increased temperature of only about 1° by axilla for two days. The pulse runs 120 to 130. Skin is desquamating irregularly all over, more markedly on the backs of the hands. The fresh skin on the chest is slightly reddened and shiny, particularly on the lower border of the ribs. The papillæ of the tongue are much enlarged, pale, glistening and with a pedunculated beaded appearance. The ends of the fingers are pale and brawny. Large purplish area of subcutaneous hemorrhage in the palms of both hands, particularly the left, nearly the size of a dollar. The purpuric eruption has almost faded and there are no fresh hemorrhages anywhere. The back of the left hand is more edematous than yesterday. The edema elsewhere is about the same. There is still a slight pericardial friction sound, but the hemic murmur is less marked than yesterday. The child is markedly constipated. Has no pains anywhere. Appetite is normal. Child has had Crede ointment on lower limbs for the last twenty-four hours, and is getting calcium chloride in $\frac{1}{2}$ -dram doses by rectum every six hours. Iron and arsenic internally.

Temperature remained normal. There was some little trouble in having the bowels moved satisfactorily; except for this no complication whatever occurred during his rapid convalescence. At this time he has about finished desquamating and his general condition has improved very rapidly. The heart trouble subsided at once although the heart is above 100 most of the time and when it is a little more rapid there is $\frac{1}{2}$ ° of temperature.

Nov. 21, 1904. Father reports that the boy had a similar attack to the last one, only not nearly as severe, a few weeks ago. He was up in the country at the time. Had fever, a general eruption and later the skin peeled.

May 6, 1905. On examination yesterday, has three distinct ridges on the nails marked by a roughness and depression. He has had three attacks since the one that I saw him in. The first one last November a duplicate of the severe attack except for the hemorrhages and purpura. These attacks seem to have been preceded by an intestinal disturbance. For that reason he was kept six months on a diet of milk. In spite of the diet has had two more lighter attacks.

In August, 1905, he had a slight attack with temperature for two days preceded by a bad breath, but no distinct stomach attack. Eruption showed especially on hands and face both of which peeled.

There can be no doubt in the second case that all of the attacks were due to the same condition and were more or less severe manifestations of the same trouble. An interesting factor in both cases was the involvement of the heart. In two of Osler's cases were there endocardial complications and a third one died of pericarditis. In one of my cases there was a history of recurrent endocarditis with an involvement of the endocardium in the present attack, and in the other there was a pericarditis. Both boys, who were nearly the same age, had pain in the abdominal region. Both had also vague rheumatic histories. One had a history of pain in the back, arms and down the thighs, with temperature, a month before the attack. The other had had several attacks of tonsillitis and pains described as growing pains for several years. There was also a distinct rheumatic history in both parents of this child.

Erythemata, as manifestations of serious constitutional conditions, have been reported sporadically for many years. In general the underlying conditions may be classed as (a) serious disturbance of nutrition, (b) certain contagious diseases, (c) protozoan infections, (d) evidences of visceral disorders producing toxins as a result either of improper food or imperfect digestion and metabolism, (e) Bright's disease, (f) rheumatism.

As types of the nutritional causes, Galloway reports erythema induratum with focal necrosis and acute gangrene of half the trunk preceding death. Patient had grown suddenly very stout in the midst of the disorder. Mackenzie, in a discussion of erythemata, recalls a case of a youth unusually fat, with congestion of the cutaneous circulation. After several years of suffering with simple erythema, he developed exfoliative dermatitis, became emaciated and died.

Under the bacterial and protozoan causes are most of the severe contagious and infectious diseases,—typhoid, cholera, cerebrospinal meningitis, diphtheria, etc. Vaccination itself has been followed by various manifestations of erythema. Malaria has occasionally been accompanied by herpes, urticaria, petechial eruptions and even multiple gangrene. No characteristic form of the erythema has been constantly associated with severe malarial infections. Mansen and Daniels report that trypanosoma infection causes erythema.

Most authors agree that erythematous manifestations occur most often in gastro-intestinal intoxications, from poisons introduced into the stomach, or from errors in metabolism. A great variety of types of erythema are reported under this heading, and the literature on the subject increases the list of substances classed under poisons all the time. Quite recently the various antitoxins have been added to the already long list. Diphtheria antitoxin was added to the list from the date of its first use.

The cases with eruptions and gastro-intestinal crises are, as a rule, the least serious form of the trouble, unless other complications supervene, as they are likely to in case the attacks recur.

Among the conditions underlying erythema and impossible of classification or belonging to the rheumatic class, Thornton has recently reported glandular fever associated with erythema nodosum.

McCulloch reports a case of erythema nodosum and erythema multiforme coexisting in a boy of fifteen, subject to frequent attacks of tonsilitis, and in whom both types of erythema appeared at the same time. The process lasted about three weeks, the acute stage eight days. The family history was distinctly interesting. The mother had had erythema nodosum before marriage. Maternal grandmother had had rheumatic fever; an elder sister died at sixteen with endocarditis and multiple joint affections. A younger sister had had rheumatic fever with endocarditis, another sister repeated attacks of tonsilitis, and a maternal uncle and three children had rheumatic fever.

Carter described purpuric exudative erythema in a woman of twenty-nine without rheumatic, digestive, or hemophilic disorders prior to the onset of the trouble. The history is briefly as follows:

Twenty-four hours after a late supper of sweet-breads and coffee she had sore throat and eruption of bright red spots on both elbows, which spread next day to other parts of the body. With this were severe pains in the upper abdomen, controlled only with morphine. The joints were generally tender, but none were swollen or red. Excessive indican in urine at beginning of attack only. Two recurrences within three weeks. No kidney involvement. No leucocytosis. No temperature. Always undigested food in stools after a recurrence. Abdominal pain limited to upper abdomen and tenderness especially to stomach.

Hohlfeld reports multiform exudative erythema, erythema nodosum, rheumatism, chorea, endo- and peri-carditis in a nine-year old boy, with no etiologic factors, no unusual family history. A dilated stomach and gastro-intestinal catarrh were found at autopsy and a definite statement was made that there were no gastro-intestinal symptoms with or preceding the attack.

These cases represent the most usual conditions that occur in the severe forms of the disease and the commonest general manifestations of the trouble. The scarlatiniform variety may occur as a sequence of any of the conditions that bring about the other varieties, but idiopathic cases of the disease are noted.

Millard reports a case which he describes as erythema scarlatiniforme desquamativum in a man who had had yearly attacks since childhood and in whom he states there was distinctly no etiologic factors. The case is given briefly because of its similarity to one of my cases.

Man, thirty-six, afflicted with eruptions covering him from head to foot in two days "closely resembling a severe case of scarlet fever," but with slight pyrexia and spreading more rapidly than scarlet fever. Desquamation in sheets, soles and palms last, lasting three weeks.

Urine normal. No sore throat, no strawberry tongue. Patient had had similar attacks about once a year, irrespective of season, since a child. Once two attacks in three months. Nails shed once. No dietary errors. Eight brothers and sisters, all healthy, but two cousins had had similar but less severe attacks.

It is interesting in connection with one of my cases that all of the child's subsequent attacks, of which there have been eight or ten, were preceded by a slight temperature and bad breath, and the first movements after the attacks have been noted to contain undigested food. It will not do to place too much importance upon this observation, because an infection of any kind might interrupt digestion and cause gastrointestinal manifestations. It would be impossible to state in such a case what the primary trouble really was.

The particular type of the disease illustrated by Millard's case as well as my two cases has occasionally been considered an idiopathic condition. Its independent existence, however, may be set aside, since it has been shown repeatedly by French writers, in whose country the disorder seems commoner than anywhere else, to be a symptom of some general disorder. Furthermore, v. Duhring of Constantinople has recently reported an epidemic of this form of erythema. The French authors regard the desquamative form as a sub-acute condition, occasionally so obscure in its etiological relations as to make its cause impossible to ascertain. It has resulted from as slight a condition as drug poison and it has complicated a good many of the infectious diseases of childhood.

Its similarity to scarlet fever is beautifully illustrated by both of my cases but more particularly the milder one. The rash was practically indistinguishable from scarlet fever and desquamation took place from the hair to the soles of the feet. The tongue especially was quite typical. Cases are reported where the recurrences are more frequent than they were in my second case, complete desquamation taking place each time, the intervals between the attacks being so short that the skin in some parts of the body was constantly in a state of exfoliation. This condition resembles closely the exfoliative type of dermatitis, which is not infrequently the terminal condition in this peculiar disorder. What helps further to distinguish it from scarlet fever is its earlier period of desquamation, the rather striking absence of throat symptoms in a majority of cases, its recurrence, the absence of the peculiar pale ring about the mouth and a disproportion between the fever and the intensity of eruption.

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 APOLIS, IND., OCT. 10, 11 AND 12, 1905.

SURGICAL SECTION.

(Concluded from No. 4, p. 110.)

INTRAPERITONEAL TUBERCULOSIS.

DR. F. F. LAWRENCE, of Columbus, Ohio, read a paper on this subject in which he drew the following conclusions: "1. Intraperitoneal tuberculosis is frequently a local disease. 2. It probably occurs much more frequently in the female than in the male. 3. In a large majority of cases it is primarily visceral and the general peritoneum is secondarily involved. 4. The surgical treatment is rational, sometimes agreeably surprising in results, and again bitterly disappointing. 5. In this, as in many other surgical conditions, early diagnosis and early operation will bring more certain results. 6. In this condition the greatest obstacle to overcome is the idea that it is a secondary condition. 7. No case of intraperitoneal tuberculosis should be denied the benefits of operation, no matter how extensive, so long as there is no positive pulmonary or pleuritic involvement, for the reason that some apparently hopeless cases fully recover. 8. When there is a tubercular peritonitis, a sequel of tubercular tubes, ovaries or appendix, the primary focus should always be removed. 9. In these tubercular cases the mesenteric glands have not been found frequently involved, and when they are operation accomplishes very little good. 10. In tubercle of tubes and ovaries the adhesions are usually firm, sometimes, though not usually, very vascular and not infrequently involve loops of the small intestine; hence the greatest care is necessary to avoid serious injury to bowel and at the same time separate completely all adherent surfaces and provide complete drainage. 11. Drainage is the great factor in recovery, when properly carried out."

PYLOROPLASTY WITH THE MCGRAW LIGATURE.

DR. J. HENRY CARSTENS, of Detroit, Mich., said that many cases with disturbances of indigestion could not be diagnosed or relieved by medication. These should be subjected to an exploratory celiotomy. Gastro-enterologists should not treat patients for months and years if they could not make a positive diagnosis or cure the patient. After reasonable efforts the patient should be sent to the surgeon for relief. The McGraw ligature was a valuable means of relieving stricture at the pylorus and the resulting dilatation of the stomach. This method of operating was easy and quick; the danger was very small, and the operation was preferable to those heretofore used in benign contractions at the pylorus. It was a great deal better than gastro-enterostomy, as one restored as nearly as possible the normal condition. Quite a number of gastro-enterostomies had been reported, with a most gratifying result in some of the cases, but the difficulties

encountered, the trouble with the vicious circle, frequently called for a double operation. The McGraw elastic ligature method should be the operation of choice.

Dr. Carstens concluded by saying that: (1) Many stomach troubles were due to mechanical means. (2) These cases could only be relieved by surgery. (3) Many cases could not be properly diagnosed in the present state of our knowledge. (4) Obscure cases that had been subjected to various modes of treatment without benefit should receive the benefit of an exploratory celiotomy.

OVARIAN CYSTOMA.

DR. L. P. LUCKETT, of Terre Haute, Ind., reported a case of ovarian cystoma upon which he had operated. The tumor originated from the left ovary, was attached by a broad pedicle which was tied off in sections. The uterus and right ovary were found to be normal. The fluid and tumor were estimated to have weighed between seventy and eighty pounds. The patient made an excellent recovery.

SURGICAL TREATMENT OF NEPHRITIS.

DR. ALEXANDER HUGH FERGUSON, of Chicago, presented a further report on the surgical treatment of this disease. He reported seven cases upon which he had operated, with two deaths.

CASE I. Capsulectomy and nephrotomy; return of symptoms; no second operation; still improved.

CASE II. Chronic nephritis and pregnancy; unilateral capsulectomy and nephrotomy, with recovery.

CASE III. Chronic painful left interstitial nephritis; capsulectomy and nephrotomy, followed by recovery.

CASE IV. Nephritis; unilateral capsulectomy and nephrotomy, with recovery.

CASE V. Nephritis; unilateral capsulectomy and nephrotomy; death.

CASE VI. Bilateral nephritis; bilateral capsulectomy; unilateral nephrotomy; multiple punctures on the other side; death.

CASE VII. Double recapsulectomy; multiple punctures; patient progressing toward recovery.

DR. MAURICE J. ROSENTHAL, of Fort Wayne, Ind., discussed the subject of

CLOSURE OF URETERO- AND VESICO-VAGINAL FISTULÆ, and reported a case. The author concluded by saying that a considerable area of scar tissue and vaginal mucosa might be inverted into the bladder without producing ill effects. Ureteral fistula embedded in scar tissue might be inverted into the bladder and continue to discharge its urine without becoming stenosed. Even large vaginal fistulæ, where part of the bladder walls were lost in scar tissue from a previous hysterectomy, might be successfully operated by the operation of denudation and suture through the vagina without disturbing the relations of the bladder or any adhesions of pelvic viscera which might have formed in the scar.

SPRAINED ANKLE.

DR. ROBERT CAROTHERS, of Cincinnati, Ohio, read a paper on this subject in which he drew the following conclusions: (1) No one is exempt from a sprained ankle although some are more prone to it than others. (2) That in severity, a sprained ankle will range from a trivial accident to one of extreme severity and everlasting. (3) That the outer side more often than the inner side of the ankle is the seat of trouble. (4) That the diagnosis which is ordinarily made with ease is at times made with difficulty, and occasionally an x-ray examination is required to make the diagnosis certain.