

in the lumbar region, sensation of dragging in the rectum, and pain and straining at stool. The bowels never acted without purgatives. Examination of the rectum disclosed a firm thick band high up in the bowel. The patient gave a history of frequent attacks of diarrhoea with blood 10 years ago. There was no history of syphilis. More than six months ago she underwent an operation for external and internal hæmorrhoids without relief to the symptoms. Dilatation of the stricture had been done twice a week and this caused much pain but gave no relief. After treatment for four weeks by injections of fibrolysin every second day and occasional passage of a dilator the bowels have acted naturally without drugs, pain and discomfort have disappeared, and the instrument does not cause much inconvenience. The patient has gained weight and now describes living as a pleasure.

CASE 3. *Dupuytren's contraction*.—A man, aged 64 years, had had contraction of the palmar fascia in both hands for 20 years. The contraction was so marked in the right hand that the index and middle fingers were fixed closely to the palm and a pen handle could be with difficulty passed between the contracted fingers and the palmar surface. The bands of fascia stood up as hard, tight cords which were quite inelastic. Treatment three times a week resulted in softening of the hands and some elasticity being imparted to the cords. Passive movement and massage were also employed, and after 30 injections he can now extend and flex the fingers almost to the normal extent and the stiffness and swelling of the hands have disappeared, while the fascial bands have become soft and elastic.

CASE 3. *Chronic rheumatoid arthritis*.—A married woman, aged 47 years, for several years had suffered from this complaint. She was unable to stand on account of the pains in the knees, which could not be flexed without pain, and grating and swelling were marked. She had been practically bedridden for 12 months prior to the treatment. Various remedies and methods had been employed with slight temporary relief. After 12 injections the pain was much lessened and creaking and swelling disappeared, while the knees could be flexed voluntarily. After 30 injections had been given the pains also disappeared and she was able to walk about her room without artificial aid. She had previously used crutches for a fortnight. Her general condition was much improved. During the last five weeks treatment has been given once a week and she now can walk slowly with little discomfort, and she states that each day she feels herself becoming stronger in the knees.

CASE 4. *Stricture of the urethra*.—A man, aged 46 years, had suffered from double stricture for 20 years. Eight years ago urethrotomy had been performed without good result. False passages had been made by catheterisations and cicatrices could be easily felt. No. 5 (English) with difficulty was passed through the smaller stricture. Injections of fibrolysin were given twice a week and gradual dilatation was practised. The anterior stricture allowed passage of No. 12 at the end of three weeks, and two weeks later No. 12 was passed through both strictures. Frequency of micturition has been relieved and the patient has gained 12 pounds in weight. This patient had been treated energetically for syphilitic orchitis for some months ten years ago without avail, and one testicle had been removed. At the beginning of treatment by fibrolysin there was a nodular gummatous swelling in the remaining testicle. This became soft and has now almost disappeared.

CASE 5. *Gastric adhesion*.—A married woman, aged 29 years, suffered for five years from vomiting and pains in the left hypochondrium. She was anæmic and had vomited blood on several occasions. A large meal increased the pain and movements like stretching or reaching caused pain in the left side. Examination of the gastric contents gave slight hyperchlorhydria. Treatment by fibrolysin injections and massage of the stomach after a bulky meal for three weeks resulted in disappearance of the pains with increase in appetite and improvement in the anæmic condition.

CASE 6. *Fibrous adhesions of the knee-joint*.—A man, aged 29 years, had gonorrhoea nine months before, complicated by synovitis of the right knee, which remained stiff, painful, and swollen. Massage, hot air, and general treatment had no good effect. Fibrolysin was injected for two months and massage and passive movements were applied to the joint. The thickening round the joint became lessened and

movement has been restored, though the knee cannot yet be fully flexed. Pain disappeared after six injections.

From the foregoing it will be seen that fibrolysin is apparently indicated in any pathological state having fibrosis as its basis. The softening of the fibrous tissue allows of manipulation and stretching. The injection of the drug *of itself* will not result in local benefit in my opinion. It should be *supplemented* by massage and other physical measures. The remarkable general improvement in health in all cases is noteworthy, as well as the advantages which patients may derive in cases that have hitherto been regarded as hopeless. Absorption is fairly rapid after intramuscular injection in adults of middle age, and in one case, that of a man aged 77 years, the taste of the drug could be detected a quarter of an hour after injection. In this case, too, the skin became soft and pliable and the health much improved. Sufficient time has not elapsed to allow one to form an estimate of the permanency or otherwise of the good results obtained. In the case of urethral stricture so far there has been no tendency to recontraction. I purpose keeping cases under observation so that later a further communication may be made on the subject.

Melbourne.

AN UNUSUAL TYPE OF STOMATITIS IN AN INFANT.

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THE following case of stomatitis occurring in an infant of four months presents unusual features and may be worth recording. Hænoch in his lectures on Diseases of Children mentions two varieties of severe stomatitis—ulcerative and gangrenous. The former is nearly always associated with teething; the latter usually occurs as a sequel to one of the acute infectious diseases amidst unhygienic surroundings. In both cases the mucous membrane is first involved; sometimes the ulcerative type develops into the more severe, and usually fatal, gangrenous type.

In the present case the age of the patient—four months—is unusual; the severer types of stomatitis occur especially between the ages of two and 12 years.¹ Primary dentition had not as yet set in; there was no history of any acute infectious disease or of mercurialism; the surroundings were not such as to call for censure. The case occurred on a farm and there was no history of illness among the cattle.² The child was bottle-fed and had no evidence of rickets or scurvy; he was anæmic but was well grown and sturdy. The acute onset and the great local reaction showed the infection, whatever its nature, to have been local and not constitutional in origin. Unfortunately I was not so placed as to be able to take cultures of any micro-organisms which may have been present.

The patient, aged four months, was seen on April 30th, 1908. The history as obtained was that on the previous day (the 29th) he had been ill or very bad tempered all day; in the evening it was noticed that the cheek was a little swollen; by the next morning (the 30th) this swelling had undergone considerable increase in size. On examination the left cheek was seen to be very swollen and the skin was shiny; the swelling was not localised. The cheek was very hard and tense, no pitting could be obtained, it was extremely tender, and a slight touch produced a shriek. The inside of the cheek was dusky, and about half-way back on a level with the alveolar border of the lower jaw there was a small patch of about the size of a No. 4 shot, dusky grey in colour, which had the appearance of threatening gangrene. There was no specific odour attached to the breath, but it was foul. The glands in the neck on that side were enlarged and tender; any lateral movement of the head produced pain. The skin of the neck was oedematous as also was that of the scalp, especially over the occipital region. The temperature was 104·6° F. and the pulse was uncountable (probably 160). The diagnosis arrived at was that it was probably a case of early gangrenous stomatitis. Surgical interference was mooted but was refused. Accordingly

¹ Goodhart and Still: Diseases of Children.

² Erichsen's System of Surgery, tenth edition, vol. i.

I ordered a lotion³ for frequent application to the interior of the cheek, giving at the same time two grains of bromide of potassium every two hours for six hours, subsequently every four hours. On the next day the cheek was not so swollen or tense, but the eye was closed by the cedematous lids. The inside of the cheek had lost its dusky colour; the dusky grey spot had disappeared, its site being occupied by a small zone of hyperæmia. The breath was not so foul. The cheek could bear a moderate amount of manipulation; the glands in the neck were not so tender, and the cedema of the scalp was not so marked. A slight cough was present but there were no physical signs. The temperature was 103°. The child was taking a little milk. On May 2nd the temperature was normal, the cheek not so swollen, the cedema of the eyelids was disappearing, while that of the neck and scalp had gone. The child was taking his food well and was rapidly approaching convalescence. By May 4th the external appearance of the cheek was like a chronic superficial abscess pointing; there was a localised swelling of about the size of a hazel-nut, the skin over it being congested, but the swelling was solid in character. The child was taking its food well and sleeping well. The swelling gradually diminished in size, and by May 7th the cheek was normal. The child has subsequently remained in good health.

Recovery occurring without any loss of tissue negatives the view that it was a case of gangrenous stomatitis, and I have been unable to find any reference to cases of threatening gangrenous stomatitis undergoing spontaneous cure in the literature at my disposal. There was no evidence of its being a case of ulcerative stomatitis. When first seen it seemed very improbable that such a young child would make a perfect recovery from such an acute infection and in such a short space of time.

Guernsey.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF SUPPRESSION OF URINE SIMULATING CALCULUS ANURIA.

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In recording this case I wish in the first place to thank Dr. J. Lindsay for his clinical notes and Dr. R. Waterhouse for his help at the post-mortem examination and in the preparation of the microscope slides.

The patient, a spare, healthy looking man, aged 58 years, was admitted into the Royal Mineral Water Hospital, Bath, on August 21st, 1908. He was suffering from "rheumatism" in the wrist and pain and stiffness in the right hip, the latter being the result of an accident 12 months before. The heart and lungs were normal, and the urine had a specific gravity of 1015 and was free from albumin. Nothing occurred to call special attention to his case until he had been in the hospital a month. Then on Sept. 22nd he had a sudden attack of epigastric pain, followed by vomiting. On the next morning he seemed much better and, except for a little tenderness on palpation of the left kidney, nothing abnormal could be found, but he said that he had passed no urine since the attack of pain on the previous afternoon. The bladder seemed empty and this condition was confirmed by the passing of a catheter. More careful inquiries were now made into his past history, but beyond remembering that about ten years ago he had for a few weeks an attack of frequent micturition at a time "when his nerves were out of order," he could tell us nothing to throw light upon his case. He had had no urinary troubles since and at no time had there been any symptoms pointing to stone. From this time onward, until his death on Sept. 29th, there was an absolute suppression of urine.

The tenderness over the left kidney seemed to point to the fact that there, from whatever cause, was the seat of the trouble. Was that kidney blocked by a calculus? And, if

so, what was the other kidney doing? Were its functions suspended through reflex nervous agencies? Or was it non-existent? The usual treatment for suppression having been tried without success, I asked Mr. R. J. H. Scott to see the patient with me with a view to operation. This he kindly did, but after consultation it was decided not to operate, and the event proved that surgery would only have hastened the natural issue. There was a little muscular twitching the day before the patient died, and he was sick again, but except for this there had been an entire absence of symptoms, and I had found it very difficult to make his friends understand the serious condition he was in. There was no uræmic smell in his breath or skin, and his mind remained perfectly clear up to within five hours of his death.

At the post-mortem examination the bladder was empty and contracted. The right kidney was, for all practical purposes, absent, being represented by a small thin-walled irregular cyst containing some clear fluid, and its ureter was a solid cord. The left kidney was enlarged, weighing seven ounces, and there were many small cysts on its surface containing a turbid yellow fluid. On section it was engorged, the capsule stripped readily, and the pelvis was injected. There was no calculus or other form of obstruction either in the kidney or ureter, which was patent throughout. Microscopically in this kidney the epithelial cells of the convoluted tubes were small and misshapen, their protoplasm granular, and their nuclei indistinct; many tubules contained coagulated material; the glomeruli showed no noteworthy changes. There was much small-celled infiltration around the blood-vessels and an increase of connective tissue in the medulla.

This case is of interest as an instance of non-obstructive suppression occurring in a man with only one kidney, and not followed by the usual symptoms of uræmia. If a stone had been found the case would have been one of calculus anuria, and there would have been nothing especially remarkable about it. In calculus anuria a satisfactory explanation for the absence of uræmic symptoms has, I believe, not been given. Fagge suggested that this might be due to the still healthy kidney changing the chemical constitution of the waste products, and rendering them incapable of producing uræmia, notwithstanding that they are retained in the body. But, however this may be with a healthy kidney, it would hardly seem to explain the absence of symptoms in the present case where the only kidney was diseased.

Bath.

A CASE OF APPENDICITIS PRESENTING SOMEWHAT UNUSUAL FEATURES.

BY DAVID LIGAT, F.R.C.S. ENG.

A MAN, aged 40 years, a farm labourer, felt "out of sorts" on July 10th. The next day he felt rather better, but had to give up work on the 12th, when I first saw him. I found him in bed. He was moderately jaundiced. He had not felt sick nor had he vomited. He was not constipated. The fæces were of normal colour. The urine contained bile pigment. The tongue was dry and furred. He denied ever having had previous abdominal pain. The pulse was 120 per minute and the temperature was 102° F. There were tenderness and rigidity over the region of the appendix with the maximum point of tenderness midway between the crest of the ilium and the costal margin and to the outer side of the ascending colon. Rectal examination revealed slight tenderness on pressure upwards and to the right. I performed an immediate operation and found the parts in the following condition.

The appendix was about 3½ inches in length and ran vertically upwards on the outer aspect of the ascending colon. It was straight. Its distal third was gangrenous. Pouting from the antimesenteric border of the gangrenous portion was a foreign body. This afterwards proved to be a true enterolith of oval shape and of the size of a bean, quite hard, and giving a metallic ring when allowed to fall on a plate. The meso-appendix was also gangrenous and its vessels were thrombosed. About a teaspoonful of offensive chocolate-coloured pus escaped. There were no limiting adhesions. The appendix and its mesentery were removed and the cavity drained. The pulse and temperature did not fall after operation. There was no general peritonitis, the abdomen

³ R. Chlorate of potash, grs. x.; gly. acid bor., 3 iss.; aq. ad., 3 i.; m. f. lotio.