

them I appear as an angel of light, but to others a rock of offence. At times, instead of giving a definite judgment at once, I admit them to the sanatorium for a period of observation. If they are found then not to be suffering from tuberculosis that does not necessarily finish the case, as the next time they appear before a board for reassessment they have then, as added proof of the presence of disease, the fact that they have been in a sanatorium.

Another source of error is that at times indefinite cases present themselves before a board on which there is no member who has had special experience in the difficult branch of chest work. Such a board is usually timorous and doubtful of its own experience. It plunges for tuberculosis every time. It does not fully realise the weight its decisions carry. At other times the board may have had the assistance of a tuberculosis "expert." Such an individual usually sways the judgment of the board, as he does the examination, and the other members do the clerical part of the work. The assistance of the expert does not always improve matters. Tuberculosis experts are divisible into two classes, wise and unwise. The latter, suffering from grandiose ideas, are prepared to diagnose pulmonary tuberculosis at a moment's notice anywhere and everywhere, and if one such becomes the guiding spirit in a medical board still further confusion may result.

A Special Chest Board.

In order to improve the present condition of affairs, all chest cases, tuberculous and non-tuberculous, should be dealt with by a board composed of members all of whom should be experienced in chest work. Not less than two should examine every case, and when any doubt exists the opinion of all the members would, of course, be obtained. All chest disabilities discovered or suspected by the other boards should be referred to the special chest board for final decision. All new claims of chest disabilities by demobilised men should be dealt with by the chest board.

Whenever a man has had sanatorium or dispensary treatment this board should be authorised to ask for a special report on the man's case from the tuberculosis officer for the district in which the man comes from. There should be no difficulty in this, as I think we all file the discharge report of our sanatorium cases. If such report were received by the special board it could be placed with the man's papers and kept as a permanent record.

The special board should not be asked to work in the same room in which two or three other boards are working and where the men are undressing. It is quite impossible often to do good work owing to the noise, and more particularly is this so if any of the other boards happen to be an aural one. The chest board might reasonably occupy rooms at one of the tuberculosis dispensaries, where an X ray installation is at hand and where there are facilities for the examination of sputum.

Such special boards should be asked to pay particular attention not only to the presence of any lesion, but to its activity and to the amount of disability arising. As indicative of activity the board should demand in preference to symptoms signs, such as rapid or marked loss of weight, a medical certificate of hæmoptysis or fever, the presence of tubercle bacilli in the sputum, and the presence of persistent localised crepitations.

Too much stress should not be laid on slight impairment of the percussion note in the right apex or the presence of broncho-vesicular breathing or

apical retraction. These may quite truthfully represent a lesion, but the important points are activity and disability. Such a board might also very properly form a final court of appeal in all doubtful cases seen by the medical referees.

Throughout this paper I am not discussing the genuine consumptive, but rather the indefinite case simulating pulmonary tuberculosis. The man should have the benefit of any doubt after exhaustive examination and be given a high assessment. The period between examinations for reassessment should, as a rule, be not more than six months. As the cases come up for review and pass into the quiescent or arrested condition they should be reduced by 10 or 20 per cent. at each examination, so that the reduction in pension would correspond with the permanent improvement in health.

Could such a board as I visualise be instituted for each large centre, I am confident it would at once justify its existence and be a source of strength to all engaged in this most difficult and trying work.

Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A BONE CONDITION ANALOGOUS TO RICKETS IN A CHILD OF FIVE MONTHS.

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IN view of recent discussions on the ætiology of rickets the following symptoms occurring in a breast-fed infant appear to be worth recording.

A girl, born July 16th, 1919, the sixth child of a mother aged 31 years, was brought to one of the Salford corporation guilds. At the age of 4 weeks, when first weighed, the baby was a healthy, normal, breast-fed child weighing 8 lb. 1 oz. For three weeks she continued to gain normally, weighing 9 lb. 5½ oz. at the age of 7 weeks. From that time progress was less satisfactory and the weight fell below the normal. At the seventeenth week, when the child weighed 10 lb. 7 oz., symptoms analogous to those of rickets were observed. Three weeks later the infant was brought to the clinic for special medical examination. At this time the mother had noticed a considerable decrease in activity (the child showed no inclination to kick, and lay listless all day). The forearms were bent with an outward curve. There were comparatively large swellings at the distal ends of the radius and ulna in either case. The radial swellings were the greater, and those of the left forearm were more marked than those of the right. In the lower limbs the tibiæ exhibited marked forward and outward curves, each tibia having an obvious swelling of the anterior part of its distal extremity. Another swelling occurred on the right tibia at the lateral and anterior part of its proximal end. The head was normal in shape and size, and the spine presented no unhealthy symptoms. The skin of the whole body was dry and slightly rough. Constitutional symptoms (slight sweating of the head at night, listlessness during the day, enlarged abdomen, slight alimentary disturbances, &c.) were commencing but were not marked. The child was still breast-fed only and weighed 10 lb. 13 oz.

History of the mother.—As the child had been breast-fed it was thought advisable to inquire into the history and condition of the mother. The latter had had six living children, as follows: the first at the age of 22, the second at 24, twins at 26,

a fifth child at 28, and the girl referred to above at 31. Of these, she lost two, one of the twins and the fifth. The mother herself is thin but muscular; she is one of nine healthy children all living. The last confinement was normal. The financial circumstances of the parents were fair, the husband being in the army, and the mother had apparently been well nourished during pregnancy. Her diet included no butter, but she had a pint of milk every day during the whole of her pregnancy and after. Her breakfast consisted of bread and margarine, bacon (sometimes), and any other thing that could be got at the time. Dinner consisted of fish or meat stews, potatoes, and vegetables of all types. Tea—bread and margarine. The pint of milk daily was used between meals in the form of gruel. During the first four months of pregnancy the mother was a waitress at a nurses' canteen and got very good food. The money she saved helped her through the other months and her confinement. The lungs and heart were normal and the urine free from albumin and sugar. The mouth had been well cared for and was free from any trace of pyorrhoea.

Samples of breast-milk were taken on Dec. 12th, 1919. Mr. G. D. Elsdon, Salford borough analyst, was kind enough to examine these, and to supply me with the following figures:—

	Right breast.	Left breast.
Fat	1.9 per cent.	0.3 per cent.
Proteins	1.2 "	0.9 "
Ash	0.2 "	0.2 "
Sugar	7.3 "	7.3 "
Total solids ...	10.6 "	8.7 "

In comparison with the averages of Pfeiffer and of Luff this milk is particularly deficient in fat (the sugar percentage is slightly above normal, the protein sub-normal).

Massage treatment.—When the infant was first noticed to have rickets-like symptoms (Nov. 11th, 1919) massage treatment was begun. Until Dec. 2nd, 1919, breast-milk was the sole food, but as progress was still unsatisfactory, alternate feeds of boiled cow's milk with water and of breast-milk were then ordered. Within a week an obvious improvement took place, the child having gained $6\frac{1}{2}$ oz. Since the analysis of the mother's milk the child has been weaned gradually, and boiled cow's milk substituted. The massage has been continued to date three times a week. Apart from a general improvement in health, all the affected bones of the limbs have become considerably straighter, and the wrist and ankle swellings have been correspondingly reduced. On Jan. 6th, 1920, the child weighed 11 lb. 14 oz.

Present condition (March 9th, 1920).—The child now weighs 13 lb. $8\frac{1}{2}$ oz., and is in very fair condition. The bones are practically normal in shape, but rather soft, and the flesh is not yet very firm. However, the child is bright, active, and contented. The teeth are appearing, though none are yet quite through. Massage is being given twice weekly. The child has had a small quantity of virol for the last few weeks, otherwise the diet is boiled cow's milk. No cod-liver oil has been given.

The term "analogous to rickets" is used to prevent controversy as to terms. There seems to be a current belief that typical rickets cannot occur in a child so young; however, the signs in this case were as typical as any I have seen.

TWO CASES OF ICHTHYOSIS HYSTRIX IN THE SAME FAMILY.

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THE following two cases are of interest for several reasons. Firstly, the comparative rarity of the disease; secondly, its congenital origin; and thirdly, the unusual positions of the warty growth. The two cases were found during the medical

inspection of the schools in the county, the patients being brothers.

Family history.—The father's brother married the mother's sister. History of tuberculosis on father's side. No history of skin trouble or of illness of importance on either side. The mother's sister has four children, two of whom—the eldest daughter, aged 10 years, and the baby, aged 10 months—have typical ichthyosis.

Origin of disease.—The mother describes the condition of the two boys at birth as follows: "They were born with their hands and their feet covered with a film, as if whitewashed." The white film refused to be washed off, but later, when the superficial layers had loosened, the underlying skin was rough and dry. When about one year old warts were first noticed on hands and feet, and these gradually spread and increased over rest of body. The other two children, who are unaffected, have been sleeping with them, and using the same towel. The mother has paid great attention to washing the boys.

Present condition.—The two brothers are aged 12 years and 9 years respectively. The skin of the face is dry and scaled, but clear of warts. Above the collar is a definite ring of greyish warts. The rest of the skin of the body is dry and scaly, and superimposed are numerous warts, varying in number in different localities. In the neighbourhood of the joints, dorsal surface, and palms of hands and axillae the warts are especially numerous, and so closely packed that no normal skin can be seen. The penis also of the younger boy is covered with warts. The warts are greyish in colour, and measure about 2–3 mm.

The great number of the warts can be emphasised by the fact that the previous diagnosis made was "warty growth of skin." The boys have been sent to hospital, but no good result has been obtained. The present treatment consists of washing with cuticura soap and the application of olive oil.

TOTAL INVERSION OF THE PARTURIENT UTERUS.

By W. G. EVANS, L.R.C.P. EDIN.

THE interesting case of total inversion of the parturient uterus reported by Drs. H. Townsend-Whitling and Norman Glover in THE LANCET of Feb. 28th induces me to report a similar case that occurred in my work last summer.

My case was also a primipara aged 28 years, which followed a normal and easy course until the birth of the child, when an alarming gush of hæmorrhage occurred which caused me to direct my attention to the condition of the fundus; failing to find it, I concluded that I had to deal with concealed hæmorrhage, and on looking to see if any loss was going on I found the whole uterus extruded with the tubes standing out at either side as tense hard cords. The placenta was lying on the sheet and there was no hæmorrhage. Realising that time was of the greatest importance, my right hand being gloved, I placed a finger and thumb on the outside of the stretched tubes as far up as I could, being careful not to grasp the neck of the tumour; I pressed upwards as firmly as I could and the whole thing slipped back at once. Passing my hand into the uterus to feel if the inversion was fully reduced I found a tumour, the size of a small apple, with the central cavity the depth of the first phalanx of my index finger. Supporting the fundus with my left hand on the abdomen and pressing my knuckles against this, it spread out at once. There was no shock or hæmorrhage and convalescence was normal.

The absence of all serious symptoms was due, I believe, to the promptitude with which the condition was relieved, the reduction not taking more than from 20 to 30 seconds, and the involution not lasting more than about two minutes.

Beckington.