

A DERMATITIS CAUSED BY "DI-NITROCHLOR BENZOLE."

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WHILST many of the organic compounds of chlorine are known to have toxic effects of various kinds, the above-named substance, which is used in the manufacture of certain dye stuffs, produces characteristic—and I believe specific—effects on the skin, and to a lesser degree on the mucous membranes, of those who work with it. This substance consists of lemon-yellow crystals giving out an odour of bitter almonds. It does not dissolve easily in water or acids or alkalis, and is, in fact, not used in solution. If a few particles are allowed to touch the skin they produce almost immediately a burning and stinging sensation; if the fingers which have touched the crystals are allowed to touch any part of the face, especially in the neighbourhood of the eyes, the smarting sensation becomes almost intolerable. If the skin is moistened with water beforehand the smarting is more immediate and greater, and the effect is still more intense if the skin is greased beforehand with a neutral fat. This, no doubt, is due to the particles adhering more firmly and closely to the moistened skin than to the dry skin. It leaves for a little while a redness over the part. Among some, on merely smelling at it—or rather repeatedly sniffing it—it causes a mild coryza.

Amongst workmen who handle it, or even only work in the same room—as in the case of a fitter who had to do some repairs, and also of a manager who apparently had only occasionally to go into the room—a violent dermatitis is produced. It takes the form of an erythema with much oedema, but the affected skin has a distinctly yellowish tint—especially in the face. This is accompanied by a few scattered papules and vesicles. There are intense itching and smarting, causing loss of sleep. The forearms are first affected, then the hands, and then the face and neck; in the bad cases it also attacks the feet, and in one case there was a history of its having been on the chest. In no case does there appear to have been any constitutional disturbance; the urine was examined in the worst cases and found normal. The men attacked were nearly all new to the work; they had only been at the place for a month or less.

The following are details of cases I have seen during a period extending over a period of about two years. They were, I believe, only those who were actually disabled from work; I understood that many suffered in a slighter degree without being actually disabled.

CASE 1.—A. B., aged 28, labourer. Suffers from an erythematous papular rash on backs of hands and wrists, and scattered papules up forearms. Started ten days ago.

CASE 2.—C. D., aged 34, labourer. Has an erythema of both forearms and a little way up into upper arms; the right hand is also swelled; face and neck also affected. Very few papules. Started one week before being seen.

CASE 3.—E. F., aged 45, labourer. Both forearms affected, the left being worse; hands in a slighter degree. Started one month ago, about five weeks after commencing present work.

CASE 4.—G. H., aged 32. The flexor surfaces of forearms only affected. Duration of complaint not noted, but had been only eight weeks at work.

CASE 5.—I. J., aged 45, labourer. Forearms and face affected, the latter being oedematous only. Duration five days; about a fortnight after beginning work.

CASE 6.—K. L., aged 35, labourer. Backs of both hands affected. Duration six days; three weeks after starting present employment.

CASE 7.—M. N., aged 33, sub-manager. Palms of hands mostly affected, the dorsa only very slightly; also a small space above each elbow slightly affected. Duration two weeks.

CASE 8.—O. P., aged 35, labourer. Parts affected: Right side of face, particularly the lower eyelid, which had many vesicles on its surface; back of right hand; extensor surfaces of wrists and forearms; extensor surfaces of both upper arms; also the anterior portions of the dorsa of the feet, the left foot being the worst. Duration only two days.

CASE 9.—Q. R., aged 50, fitter. Considerable oedema of face and hands. It has been on chest and neck. Urine sp. gr. 1010, no albumin. Started four weeks ago, four weeks after commencing work.

All the cases were very amenable to treatment—simple soothing and antipruritic remedies—and rapidly recovered. In only one case (No. 8) was there a relapse when the patient was nearly recovered, but that was caused by indulgence in drink. He was, in fact, longer in getting over the effects

of the relapse than the first attack. It does not seem that the men are liable to second attacks. Some sort of immunity, indeed, appears to be set up by the first attack.

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BILATERAL OPERATION FOR INGUINAL HERNIA:

ITS ADVANTAGE IN OPERATING FOR RADICAL CURE IN YOUNG SUBJECTS.

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DURING recent years opinion as to the nature of hernial sacs has changed considerably. It is now generally recognised that "acquired" hernial sacs are much more uncommon than they were formerly supposed to be, and that many people have hernial sacs into which no "contents" have ever passed. Clearly these empty sacs cannot be formed by peritoneum, which has been pushed down from the abdominal cavity; they must be the remains of some part of the funicular process of peritoneum which has failed to become obliterated in the course of development. I believe that all oblique inguinal hernial sacs in children and young adults are formed in this way and that they are really never "acquired."

Such being the case, there is a possibility, or even a probability, that a person with a hernia on one side may also have an empty or "latent" sac on the other side. It is by no means uncommon for a person who has been operated upon for radical cure of hernia to return a year or more later to be operated upon for a similar condition on the opposite side of the body. Quite recently a young man was admitted under my care with a strangulated hernia on the right side; only a few months previously he had been successfully operated on for the radical cure of a left inguinal hernia at another hospital. At that time there was no evidence of any hernia on the right side, but it is quite certain that if both sides had been operated on he would have been spared the inconvenience, suffering, and risk to life due to the attack of strangulation which brought him under my care.

For the last 18 months, when operating upon inguinal hernias in children and young adults, I have made a rule of looking for a sac on the other side. On referring to my notes I find that I have looked for a latent sac in 18 cases. In 10 cases I found a sac varying in length from half an inch to 2 or 3 inches. In the other 8 cases no sac could be found. These figures are, of course, much too small to determine the frequency of latent sacs, but they suffice to show that the condition is quite common.

In searching for a latent sac it is necessary to proceed on a definite plan. It is one thing to find a sac which is known to be present, but it is quite another thing to search the canal and to be able to say with certainty that no sac is present. In some cases the latent sac is 2 or 3 inches long, and is then found as easily as one finds the sac in an ordinary hernia; but in several cases I have found a sac not more than half an inch long, and about large enough to admit the tip of the little finger.

The method which I adopt is as follows. The usual incision is made, and the external oblique and external ring are thoroughly cleaned up and defined. The external oblique aponeurosis is split up as far as the position of the internal ring, care being taken only to divide the transverse or intercolumnar fibres; the aponeurosis is cleanly separated from the subjacent cremasteric fascia. The latter is then seized opposite the external ring with two Spencer Wells forceps, drawn down towards the pubic spine and spread out. It is then neatly divided in its whole length. If an ordinary sac is present it is at once seen, but sometimes one finds a collection of yellow granular fat, and on tracing this up to the internal ring one discovers a small but very definite sac. If no sac is found after looking in this way one may feel sure that no sac is present. The external oblique is then repaired with four or five interrupted sutures and the wound closed. This performance adds practically nothing to the risk or severity of the ordinary radical cure, and insures the patient against the possibility of a second operation.

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