were clear straw-coloured fluid in the peritoneal cavity, gross oedema of the brain, and suprarenals which were smaller than usual.

Histology.—Liver: numerous spirochaetes were seen, but the usual unicellular fibrosis was absent. Portal fibrosis, oedema, and excessive haemopoiesis were present. Pancreas, placenta, and kidneys: these appeared to be normal. Lungs: considerable numbers of spirochaetes were present in both the tumour and the non-tumour areas. A chronic interstitial pneumonia was present. In the nodules of solid tissue the bronchi showed up well and in some places the alveoli were lined with cubical epithelium.

COMMENT

The gross lesions in this case of congenital syphilis were exclusively in the lungs. Although microscopically spirochaetes were found in the liver the reaction to them appeared to be minimal in this organ. The gross lesions found at necropsy and the H. and E. sections presented a puzzling picture, and it was only the presence of spirochaetes in the sections stained by Levaditi's method which finally established the diagnosis.

The classical diffuse pneumonia alba was absent, and reference to numerous modern textbooks of pathology gave little information on discrete congenital syphilitic lesions in the lungs; they usually confined themselves to such remarks as, "Gummata may occur." The histological appearances of the tumours in this case were not those of gummata. It would seem that this form of congenital syphilitic lesion of the lungs is now so rare as not to merit description, in the standard textbook at least. However, on reading the older textbooks it is obvious that such lesions as have been described here were frequently seen by the pathologists of former days. An example of their descriptions, which tally in almost all respects with the lesions here recorded, may be quoted (Lancereaux, 1869): "The pathological product in the lungs always showed itself in the form of tumours, more or less numerous, of the size of a pea or a walnut, and these tumours were perfectly circumscribed, firm or softened at their centre and usually of a yellowish colour." Syphilis is still capable of presenting atypical lesions, and its presence must always be borne in mind when unusual pathology is encountered.

My thanks are due to Drs. R. D. Reid and A. B. Bratton for their help with the histology, to the department of pathology, Essex County Hospital, and to the Medical Director-General of the Royal Navy for permission to publish this case.

P. W. EDMONDSON, M.R.C.S., L.R.C.P.,
Surgeon Commander, R.N.

REFERENCE

Lancereaux, E. (1869). *A Treatise on Syphilis*, 2, 160. London.

A Finger Bud

I first saw the patient, a man aged 59, warming his hands by an old-fashioned grate, fingers outstretched, with the red glow of the fire showing through them. After a pause he saw me counting and proceeded to give the following story.

The swelling started, without pain, as a small pink, smooth elevation of the skin. He has no remembrance of injury. It grew slowly, and a long time passed before it became an embarrassment to him at whist drives, before all of which he would ask his wife to bandage the finger. Finally, the point was reached when his social life was jeopardized and he determined to be rid of it. Various suggestions made by his workmates were acted on. First, he rubbed it down regularly with the business edge of a matchbox. Next he plucked a hair from a horse's tail (there is a drayman's yard of a local brewery near by) and tied it round the base of the offending swelling. Finally, acting on the advice of his 90-year-old mother-in-law, he buried a part of the meat ration (beef) at the bottom of his garden and awaited results.

One day, while the swelling was still fairly small, he accidentally cut it at its base with the edge of a tin. It bled

only a little, but afterwards its growth was fairly rapid, and it took on the angle shown in the photograph. By the time he came to the surgery (June, 1951) he had had the appendage for 10 years.

On examination the swelling was a little more than an inch (2.5 cm.) long, solid, and sausage-shaped. It was attached to the volar aspect of the middle finger, near the distal interphalangeal joint. The skin crease of that joint was obliterated, and the middle segment of the finger was thicker than that of the corresponding digit of the other hand. The grey-pink skin over it was thick and horny, particularly at its tip. In the acute angle it made with the finger the skin was dry and not infected. A small amount of painless movement was possible at the junction of bud and parent stem. A curious feature was the continuation for a short distance of the normal "whorl" pattern at its

base, but these characteristic markings rapidly gave way to a few short shallow linear creases, reminiscent of the "striae gravidarum." Although it was a cumbersome attachment the patient said he played darts and dominoes with ease.

A skiagram of the hand as a whole showed that there was no generalized or local bone disease, and that the tumour was in fact composed of soft tissue only. A tentative diagnosis of an implantation dermoid was made.

Benign tumours of the hand are uncommon. Mr. Norman Lake gives the following: lipoma and fibroma, cutaneous myxomatous cyst, implantation cyst, glomus tumour, enchondroma, exostosis and osteophyte, and osteoclastoma.

After a preliminary photograph the base of the finger was infiltrated with 2 ml. of 1% procaine hydrochloride on each side of the bone—"ring" block anaesthesia, as described so succinctly by members of the hand clinic at University College Hospital. The skin at the base of the swelling was incised elliptically; the swelling was transfixed by a ligature and retracted by the patient, using his other hand. It was seen that the tumour had a pearly white capsule. Gauze dissection was enough for its separation, and bleeding was slight. Separation of the proximal part in the substance of the middle segment gave no difficulty. Little dead space was left at the end of the enucleation, and after dusting the wound with sulphonamide-allantoin the skin edges were brought together with three interrupted nylon sutures without packing.

Healing was rapid and by first intention. The sutures were removed on the tenth day and movement at the distal interphalangeal joint became rapidly normal. Meanwhile, a section of the tumour revealed that it was a fibroma.

I thank Mr. John Hadland for the photograph; Dr. Jamison, of Watford, for his pathological report; and my senior partners, Dr. R. Fisher and Dr. D. Brown, for their encouragement.

RICHARD MAWSON, M.R.C.S.