position, where we might expect direct contact with the abdominal wall, and a further 0.5% were described as post-ileal, in which position there is a possibility that part of the appendix might be in contact with the abdominal wall. They do not describe the paracaecal position.

What, then, is the connecting link between pressure on the left iliac fossa and an inflammatory lesion in the right iliac fossa? Is it a central reflex? It seems unlikely. So it must have a peripheral explanation. In the three cases explored under local analgesia Rovsing's sign was abolished after the analgesic was inserted, and yet the rebound phenomenon remained. The most likely explanation therefore seems to be some movement which causes a temporary friction between the inflammatory lesion and the parietal peritoneum (cf. dry pleurisy), such as a wave of vibration passing across the lower abdominal wall, or a temporary displacement of the abdominal wall or contents, such as one might expect from pressure on the left iliac fossa. Indeed, two of the patients with a positive Rovsing's sign described the pain as "shooting across to the right side," and one said, "I can feel the vibrations on my right side."

In all cases where Rovsing's sign was present, rebound tenderness was present also. When Rovsing's sign was abolished in the three patients explored under local analgesia, rebound tenderness remained. It is considered that the mechanism of pain production in the rebound phenomenon is similar to that in the Rovsing's sign but that the rebound phenomenon is more easily produced, as the displacement of the abdominal wall is more abrupt and therefore provides a more efficient stimulus.

In rebound tenderness it may well be that the peritoneum lining the right iliac fossa, as well as the peritoneum on the posterior aspect of the abdominal wall opposite the right iliac fossa, is moved and stretched. This would explain the reason why it is not abolished by an anterior field block.

Conclusions

Rovsing's sign is not common.

When positive it indicates that an inflammatory lesion in the right iliac fossa lies in direct contact with the parietal peritoneum lining the anterior abdominal wall in that region.

The probable explanation is a momentary vibration or displacement of the abdominal wall or abdominal contents initiated by pressure on the left iliac fossa and passing across to the right iliac fossa, causing friction between the inflamed viscus and the overlying anterior peritoneum with resulting pain.

It is considered that there are no grounds for Rovsing's statement that the sign is of help in differentiating between inflammation of the appendix or caecum from other lesions causing inflammation in the right iliac fossa.

When Rovsing's sign is present, and the diagnosis is thought to be acute appendicitis, that organ is probably lying in such a position that part of it at least is in direct contact with the anterior abdominal wall.

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The British Empire Leprosy Relief Association has received nearly £1,500 from the pharmacists of Great Britain in response to an appeal launched by Mr. E. A. Brocklehurst, Sheriff of Kingston-upon-Hull, when president of the Pharmaceutical Society.

Medical Memorandum

An Example of Painful Subcutaneous Tubercle

Picard's aphorism that recognition of a rarity demands only that it be borne in mind was exemplified recently in a clinical diagnosis of subungual glomangioma. Although glomangiomas were described in 1812, histological identification by Masson was delayed until 1924.

CASE REPORT

A man attended at the out-patient department complaining of a painful finger. As he put it, "there seemed no reason for the severe pain in the nail" of his right index finger. The slightest change in position of the hand caused agonizing shooting pain from the tip of the index to the hand.

On examination a bluish circular area the size of a small pea was visible beneath the hard nail. Pressure on this area produced the agony of which he complained. The colour of the area did not alter with change of posture. An x-ray film was not taken pre-operatively, but at operation a tumour on the under surface of the nail-bed was found to have caused pressure erosion of the phalanx. Histological examination verified the clinical diagnosis of glomangioma.

COMMENT

Origin and Site.—The normal glomus body is a convoluted arteriovenous communication with a characteristic perivascular cuffing of cuboidal epithelium-like cells. The narrow channel with its thick coat of cells is also known as the Sucquet-Hoyer canal. Although it is recognized that such glomera occur in the integuments of peripheral parts of limbs their function has not been explained satisfactorily. The undoubted occurrence of tumours of the glomus body in the face, trunk, muscles, and even in the stomach shows that glomera are of wider distribution than was at first supposed.

There are two types of glomangioma: (1) the vascular type with relatively few intervacular and perivascular cells; and (2) the cellular type (Masson's pauci-vascular form) where masses or sheets of large epithelium-like cells occur with relatively few blood spaces in the field. The typical glomus cell is uniform in size, is polyhedral, and contains a rounded darkly staining nucleus. The cells have distinct walls. In addition to blood spaces and glomus cells there are varying amounts of connective tissue, smooth muscle, and nerves.

The *glomus cell* is the cause of great controversy, for it is suggested that it is akin to the muscle cell in an arteriolar wall. The ordinary muscle cells of the afferent vessel to a glomus body change gradually to typical glomus cells. The *glomeric arterial segment* makes a sudden appearance and differs from the afferent vessel by the disappearance of the internal elastic lamina. Glomus cells appear where normally muscle cells would be found and, congregated there, form a broad cuff of cells.

CONCLUSION

Pain due to a glomangioma may be described as agonizingly acute in spite of there being very little to see.

The nail-bed and pulp are the commonest sites of occurrence, and because there is little room for expansion the nail-bed site is particularly painful.

Autonomic disturbances have been associated with glomangiomas, but no Horner syndrome was present in this case.

The pain of a glomus tumour is not related to its neural content.

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