unusual features of adeno-acanthoma. Whether her ill-defined endocrine disturbances or surgical intervention had any bearing on the development of carcinoma is mere conjecture.

Summary

A case of adreno-genitalism is described in which over a period of 16 years surgery was necessary on three occasions: (1) to remove a hypertrophied adrenal gland; (2) to remove an egg-sized follicular cyst of the ovary; and (3) to remove the uterus for carcinoma (adeno-acanthoma). Hormone excretion levels were recorded before and after hysterectomy, but no unusual level was obtained.

I wish to thank Professor Hilda Lloyd, P.R.C.O.G., and Professor A. P. Thomson for the opportunity of reporting this case, and also Dr. A. M. Hain for the biological assays and help in their interpretations. Drs. W. St. C. Symmers and C. W. Taylor reported on the pathological sections, which were prepared and photographed by Miss M. E. Attwood.

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ERYSIPELOID OF ROSENBACH EIGHT CASES TREATED WITH PENICILLIN

BY

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Erysipeloid, while not a common condition, occurs often enough for it to be borne in mind, particularly in any large clinic dealing with septic hands. Recently there have been several papers on this subject in this country (Hodgson, 1945; Singer, 1946; Barber, Nellen, and Zoob, 1946; King, 1946; Bush, 1949), and in America, Klauder (1938) records his experience on 100 cases which he has observed.

It is significant that, in spite of the increasing awareness of this entity, many cases must be missed or misdiagnosed, and the condition is not even mentioned in the second edition of Handfield Jones's *Surgery of the Hand*. I therefore wish to record eight cases occurring over the past 12 months (December, 1948, to December, 1949) among a total number of 385 septic hands seen at the clinic—that is, 2% of cases.

The responsible organism is *Erysipelothrix* (or *Bacillus rhusiopathiae*) (Browning and Mackie, 1949), which causes a disease in pigs known as "swine erysipelas." It is a Gram-positive bacillus, and human infection is mainly manifest by an erythematous lesion of the skin of the fingers, hand, or forearm. The bacillus is found among decomposing nitrogenous products. The condition is particularly prevalent amongst fishmongers, butchers, and housewives, who contract the infection by minor traumata to the fingers or hands while handling meat bones, poultry, or fish.

Case Reports

Case 1.—A man aged 32 punctured his left little finger while handling boxes of fish on December 12, 1948. He was seen by his own doctor on the 14th, when he complained of swelling

of the finger. There was no constitutional upset. Injections of penicillin were given by his doctor twice daily, 200,000 units at a time, from December 17, when the condition appeared to settle, and he was allowed to use his hand from the 21st. The condition recurred on December 24, and his doctor then sent him to the casualty department as a "query bone infection of the finger." The little finger was swollen along its whole length, with a typical erythematous reaction of the skin. There was no heat in the part, the site of injury was healed, and there was no constitutional upset. The x-ray film of the finger was negative. He was given procaine penicillin, 300,000 units daily, from December 28 to January 5 inclusive, the hand being rested in a sling. On January 6 the condition had cleared, leaving a slight residual tenderness over the terminal interphalangeal joint.

Case 2.—A fishmonger aged 15 first attended the out-patient department on July 20, 1949. He had pricked his right index finger with a fish-bone on July 14, and had had intermittent inflammation since. On examination typical redness and swelling of the right index finger characteristic of erysiploid were seen, and pronounced tenderness was present over the terminal interphalangeal joint. There was no lymphangitis, glandular enlargement, or constitutional upset. He was given 300,000 units of procaine penicillin daily by intramuscular injection for five days, when the condition rapidly subsided.

Case 3.—A butcher aged 20 first attended the casualty department on September 28, 1949, with a "septic" left middle finger, sustained from a scratch from a bone eight days previously. The day after injury the finger felt sore, but it improved until September 27, when it became inflamed. On examination of the middle finger of the left hand there was the typical erysiploid reaction, localized particularly over the proximal interphalangeal joint. There was no fluctuation, lymphangitis, or lymphadenitis. He was given 300,000 units of procaine penicillin daily, antiphlogistine was applied to the finger, and the hand was rested in a sling. Penicillin was discontinued on October 1, and the patient was discharged on the 3rd. He returned the next day with a recurrence of the erysiploid on the third finger, but this time spreading also to the fourth finger over the dorsum of the hand. After a further course of penicillin for five days the condition cleared completely.

Case 4.—A butcher aged 21 first attended hospital on October 5, 1949, having scratched his right hand with a meat bone in the region of the dorsum of the metacarpo-phalangeal joint of the little finger on September 26. He had swelling and pain in the hand, with the usual erysiploid reaction. He was given 500,000 units of procaine penicillin immediately, and continued with 300,000 units daily for five days. He was then discharged cured.

Case 5.—A housewife aged 36 first attended hospital on October 5, 1949. She had scratched the third finger of her left hand on September 30 while cutting up fish. There was an erythematous infiltration of the finger. The customary dosage of 300,000 units of procaine penicillin was given daily up to and including October 12. The patient was discharged cured on October 13.

Case 6.—A fishmonger aged 38 attended hospital on October 16, 1949, having injured the dorsum of the proximal interphalangeal joint of his left ring-finger on October 9 while cleaning out ice from a fish box. The typical erythematous appearance of the skin was present. Procaine penicillin, 300,000 units daily, and local antiphlogistine were given. He was discharged on October 27 with the condition healed. There was a scaly desquamation of the skin, and full movements of all the finger-joints were present.

Case 7.—A fishmonger aged 22 attended hospital on November 1, 1949, with a swollen and reddened left forefinger. He could not bend the finger. There was no constitutional upset, enlarged glands, or lymphangitis. A week previously he had pricked his finger on the volar aspect of the base of the second phalanx. The finger swelled several days afterwards and was painful and red. After poulticing, the swelling subsided, but it recurred again and 300,000 units of procaine penicillin were given daily for seven days. The condition cleared, leaving no residual effects.

Case 8.—A fishmonger aged 35 first attended hospital on November 5, 1949, with a swelling of the right forefinger. There was some axillary adenitis. On October 31 his forefinger was painful and seemed "inflamed" (red) on the dorsum of the distal phalanx. There was no noticeable skin trauma. The next day there was some improvement, which continued until November 4, when the right forefinger became very painful, red, and swollen in appearance. He had kept at his work all this time. The usual course of 300,000 units of procaine penicillin with local antiphlogistine was given for five days, when the condition completely cleared.

Comment

Three well-defined clinical categories of *Erysipelothrix rhusiopathiae* infection in human beings have been described: (1) the localized cutaneous form (erysipeloid of Rosenbach); (2) a severe generalized cutaneous form; and (3) a septicæmic form with or without cutaneous involvement (Klauder, 1944).

Bacteriological proof of the infection can be established by "the microscopical demonstration of the organism in the lesions or blood and its cultivation from these sources" (Browning and Mackie, 1949).

In view of the ease in diagnosing the condition clinically, biopsy of the lesion is not justifiable. Herman (1946) rightly pointed out that the condition may be mistaken for a septic arthritis, for the maximum tenderness seems to centre around the interphalangeal joints. This tenderness in the region of the joints has also been commented upon by King (1946). Another characteristic of this condition is the spread of the erythema up one finger across the web, usually on the dorsal aspect of the hand, and then down the adjacent finger (Dolton, 1946).

Constitutional upset is very seldom seen and was not present in any of the eight cases recorded here, although glandular enlargement may occur and sometimes a mild lymphangitis. Sequeira, Ingram, and Brain (1947) attribute constitutional upset and the occurrence of lymphatic-node involvement and lymphangitis to any secondary infection which may accompany the initial inoculation with the *Erysipelothrix rhusiopathiae*. This fact would appear to be borne out by the first of the five bacteriologically confirmed cases described by Barber *et al.* (1946). Here the "response of the lymphangitis to sulphamezathine (sulphadimidine) suggested that some other organisms were responsible, as the erysipeloid itself was so strikingly unaffected by the sulphamezathine."

Suppuration never occurs, no matter how long the case may go without treatment. This important point should be borne in mind, for many an unwary house-officer may be tempted to incise the lesion at its most painful spot without any benefit accruing.

Erysipeloid is a self-limiting disease, and varying periods have been given for the length of time it may run its course before fading out if no treatment is given: seven days to eight months by Klauder (1938), and one to six weeks by Sequeira *et al.* (1947); and Stiles (1947) records a case of chronic erysipeloid of nine years' duration which was eventually cured by penicillin.

Cases 1 and 3 relapsed after an inadequate period of treatment. This feature of relapse and recurrence of the erysipeloid has been stressed by all writers on the subject, and confirms that no immunity is conferred by the first attack of the condition.

A notable feature was that six out of the eight cases were seen within five weeks, from September 28 to November 5, 1949. King (1946) has suggested a seasonal incidence for erysipeloid, with a predominance of the condition in the

autumn, when swine erysipelas is more prevalent in England, and flies may be a vector of the disease. The time of occurrence of the cases here recorded would tend to substantiate his claim.

Treatment

Treatment is essentially medical and penicillin is without doubt the choice. The sulphonamides are ineffective against this condition (Klauder and Rule, 1944), and serum therapy is not certain and is open to the objection that the patient is very liable to serum sickness. The earliest reports of penicillin treatment in human infection with erysipelothrix are those of Hodgson (1945) and Barber *et al.* (1946). I have found that 300,000 units of procaine penicillin given daily by intramuscular injection for at least five days will cure the lesion.

It must be stressed that for penicillin to be effective treatment must be adequate and prolonged. This conclusion was also reached by Bush (1949), Lowden (1949), and Erskine (1949). Local treatment may be given in the form of antiphlogistine and resting the arm in a sling.

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CORACOCALVICULAR JOINT A RARE CONDITION TREATED SUCCESSFULLY BY OPERATION

BY

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Anomalous joints between the clavicle and coracoid processes are occasionally reported as anatomical or radiological curiosities, and I have been able to trace 54 in the world literature, including one in this country. Of these, 49 are non-surgical cases, noted on skiagrams or at necropsy, three are recorded by Myer (1915-16), and two have required operation for relief of severe pain developing at the age of 34. The case recorded below has a similar age incidence, at 38.

Case Report

This patient, a talented organist aged 40, had undertaken fairly long hours of clerical work in recent years. He first developed symptoms two years ago, the earliest sign being faint "pins-and-needles" in the fingers of the right hand and later the type of numb feeling associated with pressure of the arm over the back of a chair. At first the attacks were spaced several weeks apart. Later an ache developed in the middle of the extensor surface of the forearm and later still in the middle of