colon, and barium issued from the colostomy opening. No sign of an obstructive growth of the colon was seen, and a tentative diagnosis of volvulus was made. Uncertainty as to the exact nature of the obstruction, his advanced years, and his erstwhile moribund condition were the factors that led to a decision to send him home with a colostomy belt and with the proviso that if all went well his case was to come up for review in three months' time.

Three weeks after this there was a prolapse of about 2 in. (5 cm.) of gut through his colostomy opening, which we successfully reduced. On Jan. 13, 1946, we were hastily summoned and found more than a foot (30 cm.) of gut prolapsed through the colostomy opening. The appearance was that of a dark sausage-like mass issuing from the colostomy. We endeavoured on two occasions in the next few hours to reduce the intussusception without success. The patient was in good condition, without pain or even discomfort. Mr. Hamilton Bailey came down and wrapped the intussusception in a towel and squeezed it for some moments in order to reduce the oedema. This appeared moderately successful. He then proceeded to attempt to reduce the apex in accordance with the orthodox method of reducing a paraphimosis. This also was partially successful, but about 4 in. (10 cm.) still remained without. Up to this time the patient had had but little pain. An effort was made with greater force, and the surgeon's thumb passed right through the mucous membrane and entered the peritoneal cavity, some clear peritoneal fluid escaping. Shortly after this some of the intussusception which had been reduced was extruded. The patient was sent to hospital. Under general anaesthesia Mr. Bailey freed the colostomy opening (with the intussusception protruding therefrom) from the abdominal wall and delivered 18 in. (45 cm.) of distal redundant colon and about 8 in. (20 cm.) of proximal colon. The intussusception had begun in the colon proximal to the colostomy opening. Before proceeding further it was ascertained by intra-abdominal palpation that there was no growth or other abnormality to account for the original obstruction. The two limbs of the colon were anastomosed by the Paul-Mikulicz procedure, and the intussusception, together with the redundant portion of the colon, was excised. The total length of colon removed, which included the intussuscepted portion, was nearly 3 ft. (90 cm.). The patient made a good recovery.

COMMENTARY

Intussusception is usually seen only when the abdomen is opened by the surgeon on the operating table, but the exceptions are the rare types that extrude through a colostomy or similar artificial opening, and those rare ones seen passing out through the anus. Very few cases of the former type have been recorded—one, by Milligan (1926) of an intussusception through an enterostomy and one by Turner (1936) in an article on the various complications of colostomies. The latter case was the only one in 175 cases of various complications of colostomies. Both these cases were treated in the same way as the one described above.

We are indebted to Mr. Hamilton Bailey for his co-operation and kind help in the preparation of this report.

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A. LIONEL ROWSON, M.R.C.S., L.R.C.P.

REFERENCES

- Milligan, E. T. C. (1926). *Brit. J. Surg.*, **13**, 169.
Turner, J. (1936). *Royal Melbourne Hosp. Rep.*, **7**, 90.

Plant Dermatitis in the Bahamas

The shrub *Metopium toxiferum*—"poison wood" or "poison bark"—flourishing throughout the open spaces of the Bahama Islands and in southernmost Florida (where it is also known as "doctor's gum"), has attracted little attention outside the immediate vicinity. Yet it contains a toxin at least as powerful as that of the well-known North American "poison ivy" (*Rhus toxicodendron*), thereby entitling this colonial product to at least a short note.

Botanical Note.—The plant *M. toxiferum*, of the family Spondiaceae (Small, *Florida Trees*, p. 60), varies in size from a small shrub to a tree 40 ft. (12.2 m.) high (Britton, *Bahamas Flora*, p. 244). The bark is thin and brown, with a moist, green, shining layer beneath, which becomes orange with increasing age. Its branches are widely spreading, and the leaves, up to a foot (30.48 cm.) long, alternate, with three to seven ovate, pinnate, glabrous leaflets, bright green and shining on top and dull on the under surface. The efflorescence is a many-flowered compound raceme with short pedicel. Florets have five short ovate sepals, five white separate petals, and five separate stamens with large anthers. The fruit is a green drupe, becoming yellowish when ripe.

The Toxin.—This is contained in the "milk" beneath the bark, in the leaves, and in the fruit. On the bark and leaves it frequently oozes up to the surface, where it or some other product associated with it in the juice becomes oxidized and produces black stains. It is a type of gum resin, very similar to that of poison ivy.

CLINICAL NOTE

Many R.A.F. personnel engaged on clearing undergrowth around the station were affected. Among the white residents there is regularly at the New Year a crop of cases of poison-wood dermatitis, following the incautious gathering of Christmas trees.

After contact with the toxin there are usually no symptoms for a few days, when small papules, rapidly becoming vesicular, appear at the site of contact, with considerable itching and variable surrounding erythema. Superficial ulceration of these vesicles occurs, and the rash spreads both locally and to distant parts of the body. Crops of small, deep-set papulo-vesicles appear on face, trunk, and legs. Local weeping and crusting eczematization may occur, and the whole process continues for weeks after the initial contact. Sometimes the reaction is more urticarial, with gross erythema and oedema affecting and directly spreading from the contact area. In less sensitive people retrogression of the rash may occur at any stage. In one patient blisters up to an inch (2.5 cm.) in diameter formed over hands, forearms, body, face, and legs, breaking down to superficial ulcers, some of which became secondarily infected. The appearance resembled a papulo-necrotic tuberculide. He was febrile on admission, and remained in hospital 20 days.

SENSITIVITY TO THE TOXIN

One drop of juice from the underbark of a plant 5 ft. (1.52 m.) high was placed on the forearm of each of twenty volunteers. One developed a generalized spreading rash lasting several weeks, one a severe local erythematous reaction, 12 local papulation of varying degree, and 6 were unaffected. On my own arm itching occurred a few minutes after application, followed by the characteristic black staining and the development of a small papule by the next day. The local area became eroded after four days, with superficial ulceration and surrounding vesiculation. Resolution started on the seventh day. One drop of berry juice, however, caused a widespread erythematous vesicular eruption lasting some weeks. (This was not due to acquired hypersensitivity, since subsequent drops from the bark actually produced less reaction than the first.)

The phenomenon of generalized spread to non-contact areas seemed to indicate the production of a general allergic cutaneous tissue reaction of systemic dissemination. However, the possibility existed that the original toxin or product of it lurking in the blister fluid at the contact site was carried over the body by the patient's finger, producing multiple local reactions. Blister fluid from one patient with the disseminated rash was therefore tested on other parts of his own skin and on the skin of other sensitive subjects, with and without previous excoriation of the skin by a needle. In no case was any lesion produced, so that the hypothesis of contact spread would seem to be disproved.

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Traumatic Axillary Venospasm

This condition has been described by various people, especially Matas, and was first recognized about 60 years ago. It occurred most commonly on the right side, and various theories have been advanced to account for it. Sudden abduction of the arm may cause trauma to the axillary vein by contact with the subclavicular muscle; this may either give rise to a generalized venospasm or actually damage the intima of the vein, with venospasm and thrombosis, hence the name "traumatic axillary vein thrombosis." Matas says that there is a polyvalent causation, in indirect trauma to the vein and its immediate environment, including lymphatics and perivenous sympathetic plexus, and that thrombosis is not essential.

The case described below is one of traumatic axillary venospasm without thrombosis, and in this instance the opportunity of observing the veins and brachial artery was taken. The brachial artery was very sensitive and the slightest handling was sufficient to put it into spasm, so apparently there must be a generalized increased sensitivity of the neurovascular make-up of this particular patient to account for the condition. The treatment adopted—cervical sympathetic block—does not claim to be original, but I have not seen any reference to it. The cervical sympathetic block has a twofold effect—viz., it relieves the venospasm, and also the arteriospasm, which in time will increase the venous return.

CASE REPORT

The patient was a female aged 35, married, but with no children, and was admitted complaining of swelling of the left arm, which was tense but not very painful. She said that four hours ago, when putting her left arm into her overcoat sleeve, she felt something

catch in her axilla, and that almost immediately her whole arm began to swell and felt useless, tight, and tense. There was no previous history of a similar condition.

On examination her general condition was seen to be good. Her temperature was 98° F. (36.7° C.), and her pulse rate 70. The left arm was diffusely swollen, tense, and blue from the middle of the deltoid muscle to the finger tips. The superficial veins on the dorsum of the hand were congested, and failed to empty on elevating the arm above the head. The upper chest veins were congested, but emptied on compression. The axillary vein was not palpable. The radial pulse was diminished in volume in comparison with the opposite side. There was no increase in heat of the limb. A small laceration was visible over the lower part of the cubital fossa, which had occurred about ten hours previously.

Operation.—A general anaesthetic was given, and it was decided to explore the laceration in the lower part of the cubital fossa to see the state of the vena comitans of the brachial artery. All the veins encountered were in a state of spasm and failed to bleed on cutting. The brachial artery was seen and appeared normal. It was retracted very gently and immediately went into spasm, showing the excessive sensitivity of the neurovascular system. The radial pulse at this stage disappeared, so it was decided to close the wound. The patient was then turned on her right side and a cervical sympathetic block was performed. The stellate ganglion and the second and third left thoracic ganglia were injected with 10 ml. of 2% procaine each by the posterior approach. On turning the patient on her back it was noticed that the hand was now becoming pink and that the radial pulse, which had disappeared after the brachial artery spasm, was now returning.

One hour later the radial pulse had fully returned; the hand was now pink and the superficial veins were empty. Twelve hours later the swelling of the hand and forearm had disappeared and the colour was normal. The upper arm, however, was still discoloured pink rather than the previous blue, and still swollen, but not so much as it had been. Twenty-four hours after the sympathetic block the whole arm was back to normal, and after that the patient made an uninterrupted recovery. X-ray examination failed to demonstrate any sign of cervical ribs.

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A Case of Secondary Syphilitic Iridocyclitis

Duke-Elder states that a severe and acute iridocyclitis is not uncommon in the early secondary stage of syphilis; thus, among 10,000 syphilitics studied by Moore (1931) at the Johns Hopkins Hospital, the expectancy of its development with the generalized secondary outbreak was 4.5%. I have not seen any comparable R.A.M.C. figures, but have the impression from R.A.M.C. venereologists that the complication is much rarer than this, and therefore the occurrence of a case is interesting enough to report. It is the first one I have personally seen in 3½ years in the Army.

CASE HISTORY

B. W. reported on Feb. 21, 1946, that both eyes had been inflamed for two weeks. He was found to have a mild bilateral iridocyclitis with fine keratitis punctata in each eye, a roseola of fine blood vessels on each iris, and posterior synechiae in the left eye only. He had a history of venereal infection two months ago, and gonorrhoea two years ago. General examination revealed secondary syphilis: the prepuce had an irregular margin and multiple ulceration round the edge; there were moist papules at the peno-scrotal junction; condylomata were present in each groin, with inguinal adenitis; no generalized rash was seen; the tonsils and pharynx were both congested. The Kahn test was positive.

Sodium penicillin 10,000 units 3-hourly for one day gave no Jarisch-Herxheimer reaction, so the dosage was increased to 40,000 units 3-hourly for 7½ days. With the penicillin were given daily mephar-side injections to a total of 0.56 gr. (36.4 mg.) in 15 days. Atropine ointment and heat were used for the eyes. In one week they were much improved, with disappearance of the roseola, and in two weeks the ocular condition had entirely subsided, the only sequelae being a few pigmented dots of keratitis punctata, one posterior synechia, and a little pigment on the anterior line capsule in the left eye.

I wish to express my thanks to Major R. S. Garden, R.A.M.C., A./O.C. 48 British General Hospital, for permission to publish this paper.

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REFERENCE

Moore, J. E. 1931). *Amer. J. Ophthalm.*, 14, 110.

The Manchester Ear Hospital has been at work for ninety years, and now receives patients from areas as far distant as Derbyshire, Wales, and London. Owing to staffing difficulties and redecoration of the wards fewer patients were admitted last year than in the previous one (744 against 849); but on the other hand 6,816 new out-patients were treated—an increase of 72.

Reviews

RARE DISEASES

Rare Diseases and Some Debatable Subjects. By F. Parkes Weber, M.D., F.R.C.P. (Pp. 174; illustrated. 15s.) London: Staples Press Ltd.

As Dr. Parkes Weber truly remarks, it has been repeatedly suggested to him during the last thirty years that he should write a book on rare diseases. It is, therefore, somewhat disappointing to find signs of hasty compilation. This detracts from the pleasure of reading but not from the value of the book. He recognizes that the importance of a rare disease lies not merely in its rarity but in the light it throws on less extreme departures from the normal and sometimes even on the normal itself. He shows how some of the rare syndromes may involve a large number of systems in the body, but minor versions of such syndromes occur, so that there is a continuous series from the complete form to *formes frustes*.

In the earlier part of the book a useful classification is observed according to which tissues are mainly involved. The real gist of his argument is explained best in Chapter 16, entitled "Inborn and familial tendency to the development of hepatic cirrhosis." This enables him to develop his views of the inborn tendency of an organ inferiority as the basis of most of the diseases he is considering. He speaks of these as the congenital-developmental class under the convenient inclusive term "dysbiotrophy." Here his comments on Kinnier Wilson's description of progressive lenticular degeneration combined with cirrhosis of the liver are of special interest. Familial incidence in this rare disease has been emphasized by Wilson himself as well as by later authors. The association between these two conditions seems curiously remote and yet there are other instances of this connexion. Some of these hepatic conditions may work in either direction; thus the telangiectases of the Osler type may occur in families and involve haemorrhage from the stomach without the presence of any skin lesions. In some of these cases hepatic cirrhosis has been found—presumably due to a congenital dysplasia of the small blood vessels, including those of the liver. Conversely, in advanced hepatic cirrhosis, spider-like telangiectases are common on the face and hands. Here they follow and do not anticipate the cirrhosis.

It will be seen that the book even in its present form is a mine of interesting information which may well cause us to think. Apart from our initial criticism we can cordially congratulate the learned author on putting on record so much that is helpful.

A PHILOSOPHY OF SEX

Sex, Life, and Faith. A Modern Philosophy of Sex. By Rom Landau. (Pp. 319; illustrated. 21s.) London: Faber and Faber.

The author is not a doctor or a priest, but certainly has a large experience and knowledge of life. From this he has learnt the basic material of how man and woman have approached the problems of sex and behaved in this respect throughout the ages in all sorts of communities and under all sorts of conditions of society. What makes the wealth of material expounded in this book so valuable is that the author has throughout been able to expound it without prejudice and with a sympathetic understanding of why any particular behaviour has manifested itself. Whether he is dealing with polygamy, polyandry, homosexuality, or any other manifestation of the sexual urges of men and women, he is equally open-minded and objective. Though maintaining that the monogamous union is the ideal he realizes that this cannot be reached unless the union itself is ideal in that it really satisfies the aspirations of both partners. There must be no repression, false shame, or reservation on either side, and he recognizes that without this the ideal of sexual behaviour is to all intents and purposes unattainable. Nevertheless, such an ideal is in the author's view attainable in certain conditions. First, it is necessary to sweep away all prejudices and false values such as are maintained by the puritans, the respectable, and the smugly complacent people who make up such a large proportion of our moralists and ecclesiastical experts. Secondly, it is necessary to recognize fully the importance, strength, and essential place in life of the sexual instinct and