sutures. Access to the depth of the wound is made easy, and the insertion of catgut sutures for the repair of the vaginal mucosa and deep muscles made relatively accurate. After the catgut sutures have been inserted and tied the skin is closed by tying the free ends of the silkworm sutures.

COMMENTARY

The value of this technique lies in the fact that (1) it renders the single-handed repair of an episiotomy or laceration moderately easy; (2) the sutures are in place should laceration occur; (3) if there has been no laceration or episiotomy, but considerable stretching of the parts has caused injury to the deeper tissues, these separated deep tissues are held together by the sutures.

I am aware that self-retaining retractors have been devised to facilitate perineal repair. These are more satisfactory when stitching is done with the patient in the dorsal position, but their use also implies introduction of instruments into a fresh wound in that area.

Broomhill, Selkirk.

D. CHARTERIS GRAHAM, M.B., Ch.B.

Transverse Rupture of External Auditory Meatus

Recent reports in these columns of minor but interesting and unusual injuries prompt me to record a case of traumatic transverse rupture of the external auditory meatus. I have not previously heard or read of this injury. In the present case the nature of the causal trauma was no doubt a shearing force transverse to the line of the meatus.

CASE HISTORY

A girl aged 9 was knocked down by a motor car. In the casualty department a small and superficial cut behind the right auricle was cleansed and sutured, and the patient was admitted to the ward for observation in case of intracranial injury. No evidence of serious injury was found, however, but blood was seen to be escaping from the right auditory meatus. Examination with the auriscope revealed a complete annular laceration of the skin tube at a depth of 5 mm. from the bottom of the concha. The inner part of the meatus had retracted and was visible only as a small circular skin edge, round which lay the damaged supporting cartilage. Repair was undertaken under general anaesthesia. The cut behind the auricle was reopened, excised, and extended, and then deepened anteriorly so as to expose the divided ends of the meatus (see Fig. A). After excision of all tags of tissue, including loose pieces of cartilage, the ends of the skin-cartilage tube were found to fit neatly together and were sutured with five fine catgut stitches, passing through skin and subcutaneous tissue (Fig. B). Sulphanilamide powder was

Showing the external meatus (A) before and (B) after repair.

inserted, and the retro-auricular wound closed with a small rubber dam drain through its lower end. A flavine-in-glycerin pack was inserted into the now continuous meatus. Healing took place rapidly and without sepsis, and a slight tendency to stenosis was subsequently treated by repeated dilatation.

DOUGLAS R. K. REID, M.D., F.R.C.S.,
Dunedin Hospital, New Zealand. Surgical Registrar and Tutor.

A Case of Reiter's Disease

Practically all the articles on Reiter's disease during the past three years have appeared in American or Canadian medical journals. I understand from colleagues that cases with symptoms that correspond to the recognized syndrome of poly-arthritis, urethritis, and conjunctivitis are not rare in this country, especially in V.D. departments, but as very few cases have been recorded the following typical case may be of interest. As an allergic reaction to bacillary dysentery may be the cause in some cases (Reiter's original case was associated with diarrhoea and blood in the stools), it is interesting to note that this patient had not had diarrhoea in the year preceding the onset of his illness, during which time he had been in this country.

CASE HISTORY

The patient, an Englishman aged 34, served in various parts of the Middle East from November, 1940, to January, 1945, when he returned home. He had three mild attacks of diarrhoea during that time, the last in 1944. No attack lasted more than three days, there

was no blood in the stools, and he was not admitted to hospital. He believes he had conjunctivitis in both eyes in December, 1944, which persisted for about two weeks. A dental abscess developed in December, 1945, and a tooth was removed on Feb. 5, 1946. In January, 1946, he experienced pain in the left side of the back, and a week later there was a slight urethral discharge, but no dysuria or frequency. The following day he had conjunctivitis of both eyes. Two urethral smears showed many pus cells and some mixed organisms, but no epithelial cells or Neisserian organisms. He denied any chance of exposure to venereal infection before the onset of his illness. Non-gonococcal urethritis was diagnosed, and a course of sulphathiazole (27 g. in ali) was given. Ten days after the onset of the urethral discharge his right ankle became swollen, and a few hours later there was swelling and pain in the left knee. Next his back became stiff, and pain and stiffness in the shoulders, elbows, and fingers began; none of these latter joints became swollen. He was admitted to hospital on Feb. 9, two weeks after the onset of the urethral discharge.

On examination he was seen to be a well-developed adult male. He had severe bilateral purulent conjunctivitis. There was some pain and stiffness in the lumbar region on movement. The right ankle was red, hot, and swollen. There was some limitation of flexion of the right knee but no swelling. Movements of the arm-joints were full, but he could not flex the fingers of the right hand owing to pain. His oral temperature was 101° F. (38.3° C), pulse rate 100, and respirations were below 20; his pulse was regular. The blood pressure was 130/85. The throat was clean, and the teeth showed no obvious sepsis. There were no abnormally enlarged glands and no sign of abnormality in the chest or abdomen. Smears from the eye swabs showed a few polymorph pus cells but no organisms, and cultures were sterile. The blood count showed: haemoglobin, 14.8 g. %; R.B.C., 4,640,000; W.B.C., 6,800 (polymorphs 66%, lymphocytes 34%). He was given sod. sal. and sod. bicarb., aa, 30 gr. (2 g.) four-hourly, and the eyes were treated with irrigations and atropine instillations. On Feb. 11 the B.S.R. was 75 mm. per hour. The urine contained a fair amount of pus: a stained deposit showed a few Gram-positive diplococci. He continued to run a mild pyrexia of 99 to 100° F. (37.2-37.8° C). On Feb. 22 the prostatic smear was crowded with polymorph and epithelial cells. Only a very few staphylococci were seen in the fresh smears. The urethral discharge was very scanty by this time. Next day he was given 200,000 units of penicillin in beeswax and peanut oil. He had no further urethral discharge after this. During the next two days there was a definite improvement in the eye condition, but the temperature and joint pains remained unaltered. Sodium salicylate was stopped on Feb. 28. On March 1 the B.S.R. was 74 mm. per hour.

The temperature had not settled by March 9, and he was still getting pains in the left lower back and across the shoulders and some pain and stiffness in the legs. Penicillin, 30,000 units intramuscularly, was given, followed by 15,000 units three-hourly. This was continued for six days, when a total of 645,000 units had been given. The temperature was not affected and the pulse rate remained at between 80 and 100. On March 13 the blood showed Hb, 13.3 g. %; R.B.C., 3,720,000; W.B.C., 8,100 (polymorphs 66%, lymphocytes 29%, monocytes 4%, eosinophils 1%). Mist. ferri ammon. cit. was given and he was sent to a convalescent home on the 15th to remain in bed there. The temperature became more settled about the end of March, and early in April it was mainly normal, with occasional rises to 99° F. (37.2° C). The pulse was steady, between 80 and 90. While at the convalescent home he had toothache.

The patient returned to hospital on April 15 complaining of pain in the right shoulder, down the right arm, and in the right ankle. He still had conjunctival injection after sleeping. His blood count now was: Hb, 16.3 g. %; R.B.C., 5,200,000; W.B.C., 7,500. Wassermann, Kahn, and gonococcal complement-fixation tests were negative. B.S.R. 36 mm. Urine: pus cells two per field, no organisms seen. Examination showed slight injection of the left conjunctiva. Right ankle: full movements, but skin reddened over the outer part. He still complained of pain in the right ankle, but skiagrams revealed nothing abnormal. On April 22 he complained of some tenderness in the left ankle and slight puffiness. He still had toothache, and a skiagram on the 26th showed some bone infection near the root of —²⁴. On May 2 —²⁴ were extracted under gas. B.S.R. 30 mm.

On June 9, four months after admission, he was feeling better, but still had occasional joint pains and slight conjunctival injection in the morning. B.S.R. 9 mm. Urine: no albumin, no pus, blood, or casts, no organisms seen. He started to get up, and sulphacetamide ointment was applied locally to the eyes, without improvement. He was discharged from hospital on June 28. The temperature was normal, rising very occasionally to 99° F. (37.2° C), the pulse rate between 70 and 90, and the B.S.R. 8 mm.

He was seen on three occasions as an out-patient, the last time on Oct. 26—nine months after the onset of his illness. He still had some mild aching in the joints, especially of the right arm and right ankle, and also occasional pains in the lumbar region and the back of the neck, which varied with the weather. A skiagram of the right ankle showed no evidence of structural change in the joint. He had no urinary symptoms, but was still getting slight injection of the eyes on waking. B.S.R. was 8 mm. per hour.

I wish to thank Dr. Ronald McD. Cairns, who was in charge of the case, and at whose suggestion I have written it up, for permission to publish this report.

DUNCAN FORBES, M.B., Ch.B.,
Resident Medical Officer,
Leicester Royal Infirmary.