bility of operative interference in lesions of the cord, appears to me to warrant the publication at the present time of the above scheme, even should it prove not to be strictly accurate in all details.

A CASE ILLUSTRATING THE VALUE OF SURGICAL TREATMENT OF PULMONARY CAVITIES.

By J. DELPRATT HARRIS, M.R.C.S.,
Surgeon Devon and Exeter Hospital.

A GENTLEMAN, aged about 33, in the winter of 1887, about December, having for years passed cloudy urine, with mortar-like pieces of calculous material, and albumen, from the left kidney, developed symptoms of renal abscess. The abscess broke in four or five places in the back on the left side, and discharged much matter and watery fluid. Throughout the months of February and March, 1888, these wounds were thoroughly drained by india-rubber tubes, and well syringed with disinfecting lotions, and under this treatment the wounds gradually healed, with the exception of one place, which allowed a few drops of thin watery fluid to escape throughout. The patient, being now convalescent, was sent to the seaside to complete his recovery.

Up to this time, March, 1888, there was nothing whatever to point to any pulmonary trouble. The matter which came from the fistulous passages was never particularly offensive. On his arrival at the seaside he was seized with a rigor, and, having remained there short of a week, he returned on March 18th. The cause of the rigor was open to some doubt at first, and it was thought to be probably due to a fresh abscess formation around the left kidney. But in a few days (about two) shortness of breathing, with cough, came on, and it was then evident that the left lung was in a state of pneumonia. At the same time the old wounds in the back broke open, and discharged copiously the same thin matterly fluid; this they continued to do throughout the remainder of the illness.

At first the pneumonia seemed disposed to run a favourable course, but, by April 24th, profuse night-sweats, dyspnoea, amounting to orthopnoea, urgent cough, and other symptoms raised the fear that the exudation, instead of undergoing resolution, would break down and form one or more abscesses. During the month of May, 1888, every care was taken of his general health, but emaciation took place rapidly, accompanied with incessant hacking cough, with considerable expectoration, which towards the end of the month became foetid. There were now all the physical signs of a cavity of the lung posteriorly, just below the angle of the scapula and to its inner side. Pectoriloquy, both spoken and whispered, was very distinct, whilst crepitation could be heard at a slight distance around the point of greatest intensity. During the month of June egophony occurred below the point where the pectoriloquy was best heard. Considerable interest attaches to the value of this sign for diagnostic purposes, but it was my own opinion, as well as that of Dr. Blomfield, who was now associated with me in the case, that the pulmonary pleura was subjected to irritation from the propinquity of the abscess walls, and that effusion had taken place to some extent; the character of the effusion we could not accurately determine, as the temperature could not be relied on, being equally the chart of abscesses around the kidney.

The patient was now in a highly critical condition; the pulse never below 140, whilst the temperature kept very high (102°), and only came down when profuse night sweating occurred; and more especially the incessant cough weakened him, and the free expectoration of putrid material seemed to poison him, whilst the odour of the room was sufficiently noxious to cause *malaise* in his attendants.

Disgust for food helped to run him down, and emaciation was advancing rapidly. By the end of June, on explaining the nature of the procedure, we readily obtained his assent to the operation for exposing the pleura, and making an opening into the abscess cavity with a view to draining it through the chest walls.

On July 2nd, without any anæsthetic, the operation was done. An incision being made through the skin at the lower border of the intercostal space which ran through the centre of the area of loudest pectoriloquy, an aspirating needle, with bottle attached, was plunged in to a depth of three or four inches. This was done

gradually, the sharp point being retracted. Matter flowed freely through the tube. The tissues were now cut through down to the pleura. The latter was cut through, and found slightly adherent to the pulmonary pleura in places; the lung seen, and a scalpel thrust in, using the aspirator needle as a director. A drainage tube of silver was used at first, shaped like a tracheotomy tube, but flat. This was found too short, and on the fourth day a piece of gum elastic catheter was introduced, not less than six inches in length, for it was evident that the cavity had been opened at its extreme lower limit, and the way the elastic catheter slipped in showed very clearly that the cavity was of more than one inch in diameter, possibly more than two. The amount of discharge which came away during the first few days was quite surprising, being enough to thoroughly saturate the Lister dressing applied. The cavity was daily syringed out with very weak solution of carbolic acid, until the fœtor was somewhat checked, when Sanitas fluid was substituted, mixed with warm water. It was most noticeable how the cough seemed to cease after the counter opening was made, as soon as free discharge occurred through the tube.

The tube was kept in for one month, when a rubber tracheotomy tube was substituted. At the end of the second month the tube was removed, and all discharge ceased. The cough was quite gone, and the wound quickly healed. Large tracts of the lung, previously dull to percussion and impervious to air, recovered themselves. The patient gradually regained two stone in weight, and the renal fistulæ in the back healed a second time; and at Christmas, 1888, only one small aperture existed, the patient being about to resume his employment.

The fact of this case occurring in one suffering from renal fistulæ and ending successfully lends an additional interest to this mode of treating abscess cavities in the lung surgically.

NOTES OF A CASE OF SCLEREMA NEONATORUM.

By ALFRED G. BARRS, M.D., M.R.C.P.,
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in the Yorkshire College of the Victoria University.

ON March 6th, 1888, A. Y., aged 1 month, apparently in good health, was brought to me for an intense livid redness of the nates, corresponding pretty much to the surface covered by her napkin, and extending downwards well into the popliteal spaces. The surface, which was uniformly affected, was dry and polished, and the redness disappeared to a great extent on pressure. The appearances were obviously not due to any eczematous condition. The lower limits of the condition tailed off into papules of varying size, which had not the same characters as the general body of the disease. Looked at more closely, the change was seen to affect the parts limited above by the iliac crests; below by the lower borders of the popliteal spaces, and laterally by the line of the ilio-tibial band. Over the whole of this area the skin and subcutaneous tissue, and it almost seemed the still deeper parts, felt as though infiltrated and welded together by some solid material, producing a very close resemblance both in colour and consistency to that of an uncooked ham. The firmest pressure produced not the slightest pitting. The pudenda were not affected. The cleft of the nates had been reduced to a mere line by the mutual pressure of the two sides, converting its naturally rounded surface into a sharp rectangle. It was quite impossible to separate the skin from the subjacent parts at any point in the affected area. One or two isolated patches of a precisely similar nature were found in the right deltoid region. There was nothing in the family history, or in the child's condition, to suggest syphilis or any diathetic or local cause for the disorder. The mother stated that the condition had been first noticed on the fourth day after birth (though it might have been there earlier) on the back of each thigh, just above the popliteal space, and had gradually spread till it had attained the limits above described in the course of about ten days, since which time it had been stationary or nearly so. I ordered the parts to be protected as much as possible from any excoriation by the napkin and excretions, and half a grain of grey powder to be administered night and morning.

On March 13th, the redness was a little less marked, the surface was still dry and polished, and except that there was only a slight disappearance of the condition at its lower part, the

brawny state continued the same in character and distribution. The child's general condition continued to be quite good.

On March 20th, the child was growing and thriving, and was clearly not in the least affected by the local condition. The hardness was disappearing, its margins retiring towards the centres of the buttocks. The redness was much less.

On April 3rd the condition had almost entirely disappeared, and on May 1st the child was reported to be quite well in every way.

I have very little doubt that this case was an example of the condition known as sclerema neonatorum, as distinguished from œdema neonatorum, both of which are exceedingly curious and rare disorders. The case related would appear to be exceptional, in that the lesion was limited to the lower parts of the body, and in the ultimate recovery of the child. I may mention that a medical man who happened to be present when I was seeing the case said he had seen a precisely similar condition, though he had not recognised its nature, in a newly born infant, terminating fatally by rapidly involving the whole body.

SURGICAL MEMORANDA.

THE TREATMENT OF INGROWING TOENAIL.

As I have had some very troublesome cases of the above to treat, I may be allowed, perhaps, to supplement Mr. Scott Battams's memorandum by advice which will, I trust, not only aid in the cure, but, what is far better, prevent the occurrence of this troublesome complaint, and, when cured, prevent its recurrence.

In the first place, I never remember seeing a case where the inner side of the great toe was affected. As a rule, it is the outer side. I believe the complaint is due to pressure of the great toe on and against the second toe, by narrow-toed boots; this naturally has a tendency to push the flesh over the outer angle of the nail.

In the second place, I am inclined to think the complaint is caused, and certainly it is aggravated, by cutting the nail down at the corners, and not allowing it to grow square; this, *plus* the pressure of the boot, may account for the inner side of the toe becoming affected.

Recognising these as the two main causes of the complaint, the preventive treatment is obvious, namely, allowing the nails to grow square, never to cut down at the corners, and the wearing of boots sufficiently wide and deep to prevent any pressure on the toes. For the cure of the complaint I would recommend an elongated wedge of cotton-wool, lint, or soft linen rag (as more likely to be retained than sponge) carefully tucked in (with a wooden match, flattened at one end) between the flesh and the nail, the end of the wedge being tucked under the angle, as far as possible, of the offending nail, which may sometimes be found buried away under the granulations. The relief at once is great, and a complete cure usually results in a week or so.

The nitrate of silver or other caustic may sometimes hasten the cure, but I have never found it necessary to use strapping over the cotton-wool, as this must cause some pressure when walking, and, if a proper quantity of wool be tucked in firmly but gently, it will be retained till the following day, when it should be changed.

G. F. POYNTER, Surgeon M.S.

IN the JOURNAL for April 13th, 1889, Mr. Scott Battams offers some useful suggestions as to the treatment of "ingrowing toenail."

I beg briefly to narrate a form of treatment I have pursued for a considerable length of time, which has uniformly succeeded and speedily remedied the evils very well known as accruing from what is too often called "ingrowing toenail." I purposely thus write, believing this to be a false appellation, inasmuch as I have never regarded the nail as being primarily in fault; and in treatment have never been obliged to have recourse to avulsion of the nail.

The state of things is so often before our observation that it is hardly necessary to say that in these cases the cushion of soft tissues by the side of the nail is often hypertrophied so as to overlap the nail more or less. For this, however, the nail is in no wise to be held in fault, but rather the soft tissues, which, from long-continued congestion, due to pressure and compression at the side of the toe, have become increased in bulk, altered in structure, of a gristly nature, presenting almost

invariably a sore granulating surface on that portion adjacent to the nail. If further neglected, the sore surface invades the bed of the nail on its lateral margin, a granulating growth oftentimes appearing underneath the terminal extremity of the nail.

In such a condition of things I find removal of the redundant tissue followed by a speedy cure. The part is first frozen by ether spray, and the abnormal hypertrophied tissue is removed by scalpel. Nitrate of silver is applied to the cut surface near the margin of the nail, and the slight hæmorrhage resulting from the cut is soon controlled by the pressure of a little dry lint under a narrow bandage.

The patient walks home after this has been done more readily than he walked to the hospital, and generally in ten days the toe is sound and well, and never likely again in like manner to trouble the sufferer, the nail at the same time being left intact.

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CLINICAL MEMORANDA.

FOREIGN BODY IN SCALP, CAUSING NECROSIS OF SKULL.

THE following case is interesting, as showing an unusual and somewhat rare result of leaving foreign bodies in the tissues.

A boy, aged 7 years, was brought to the hospital with the history of having, about one month previously, fallen down at school whilst carrying some slate pencils, one of which, as he fell, ran into his scalp and broke off. It was not removed, and, besides poulticing it, nothing was done. On examination there was found to be a swelling near the anterior fontanelle, at the lower part of which was a small discharging sinus. A probe passed in discovered a foreign body, which, on removal with small forceps, was found to be a thin plate of bone three-quarters of an inch long and half an inch broad. On further examination a piece of slate pencil nearly one inch in length was found and removed. After this the wound soon healed, and the boy completely recovered, with the exception of having a depression of the size of a penny in his skull.

In this case the piece of pencil must have become embedded under the pericranium, and, setting up acute inflammation, cut off the blood-supply to the bone, so causing necrosis of the outer table of the skull. It would not, I imagine, have been able to penetrate the outer table and become fixed in the diploë.

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MILIARY PYURIA.

I HAVE ventured to suggest the above term as descriptive of a condition of which I have not been able to find an adequate account. It consists in the discharge in an acid urine of concretions of pus cells, of a very regularly rounded form, varying from one five-hundredth of an inch to one one-hundredth of an inch in diameter, with some few of rather larger dimensions. They are plainly visible to the naked eye, and resemble small millet seeds. Many of them have some tendency to degeneration or caseation in the centre. They are usually accompanied by a few free pus cells. There may also be red blood cells and epithelium from the ureter or pelvis of the kidney. It is probable that they may also occur when the discharge of free pus cells is more abundant, but their presence is then obscured and not readily detected. From their appearance they cannot have been thrown off in their rounded condition from a free surface, but must have undergone some process of rolling. They are too numerous for it to be likely that they should be miliary tubercles, and they show no trace of giant cells or of the structure called a giant-cell system. They seem to consist of somewhat inspissated pus, which has been well rolled either by passing down the ureter or by being washed about in the bladder. I have only met with this condition in two cases, but in each the miliary concretions were examined on many separate occasions. In each case there was pain in the back, with frequent painful micturition. As both were females, the possibility of the miliary concretions being derived from a vaginal discharge was excluded by the use of the catheter. As far as was possible, physical examination pointed to the absence of urethritis or cystitis. In the first case, some of the concretions were seen under the microscope to be plentifully covered with red blood corpuscles. In the second there were numerous epithelial