are well known to occur in diabetes, as well as grosser surgical lesions, such as boils, carbuncles, sloughing, and gangrene.

The curious shortening of the feet, in these cases, has been strangely overlooked. It is not noted in Holmes's *System*, or in the works of Erichsen, Holmes, Bryant, Keetley, or Pepper. At first, I thought it had never been described; but, with the aid of Dr. Neale's valuable book, I found that Mr. Biggs and Mr. S. Jones¹³ had both noted cases. Mr. Edmund Owen, during the discussion on Messrs. Savory and Butlin's paper, also described two cases of deformity of the toes. Mr. Sydney Jones designated the shortening of the feet, in his case, as symmetrical; but evidently did not consider the ulceration in any way peculiar, as no mention is made of it. Mr. Biggs afterwards wrote, in the *Lancet*, that these cases are not uncommon in Wiltshire and Dorsetshire; and referred to a mother and son under his observation. This is doubly interesting, as females are rarely affected. Dr. Ogston¹⁴, Mr. Treves¹⁵, and Mr. Marrant Baker¹⁶, have also noted these ulcers in women. The shortening usually seems to occur from disintegration of the metatarso-phalangeal joint, the ulcers often being to the side, and not at the seat of most pressure. How does the shortening come about? Is the bone gradually ulcerated away, the detritus exuding in the form of sanious pus, or has the dead bone to be removed by operation for healing to take place? Mr. Biggs says he has never seen a sequestrum; on the other hand, bone (? dead bone) has been removed in these cases by Vésignie, Wilks, S. Jones, Ogston, and Heuser. Whether the bone was dead, or only bare and ulcerated, the authors do not with certainty say; and yet, the question is an important one as to the starting-point of the disease. In the case you have seen to-night, I would submit another element in the shortening of, for example, the little toe of the right foot—that it is due to interstitial absorption; for it is impossible that a whole phalanx, and a half of another, could come away as detritus, in the short time of two weeks, during which the incised wound discharged; and there is no plantar scar to account for a possible outlet in that direction. Hill also distinctly states that the toe has gradually become smaller and shorter since the wound healed. Had there been no wound at all, one would have felt tempted to consider this analogous to those cases of *pie'd tabétique*, described by Charcot and Féré.¹⁷

That recovery can take place without any dead bone coming away is evident from a study of the case before you, and of the two cases of Charcot's joint-disease reported by me in the *Medical Chronicle* for April of last year. Both these latter exhibited scars on the soles of the feet, and gave a typical account of perforating ulcer without any history of sequestra. All these cases also show that the disease, in some instances, undergoes spontaneous cure. This is important, as such serious and radical operations have been advocated and practised for its relief. Neither of the two cases above mentioned are bedfast, or incapacitated from taking moderate exercise; therefore, it is not simply "enforced rest" which has preserved the feet from further ulceration.

The fact, then, that spontaneous recovery may take place encourages us to persevere in local treatment, such as has been specially recommended by Mr. Treves,¹⁸ and not to hurriedly resort to operative measures, which, however slight, such as the removal of the big toe, are by no means devoid of danger, witness the case recorded by Mr. M. Baker, where death occurred on the twelfth day.

Of course, the operative treatment depends, in great measure, on the theory of causation held in each individual case. If one agree with Mr. Erichsen that it is simply a suppurating corn, free incision is indicated. Mr. Bryant, doubting all nerve-causation, simply backs up Mr. Hancock, and would remove all dead bone. Messrs. Savory and Butlin, believing in local nerve-disturbances, would amputate above the anæsthetic region, as partial operations have been proved to be perfectly useless. If the disease be recognised as a premonitory symptom of locomotor ataxy, local treatment, combined with the internal administration of iodide of potassium, or nitrate of silver, is surely indicated.

As the pathology is thus as imperfectly understood as the treatment is unsatisfactory, I think every one who meets with a case is in duty bound to put on record a faithful account of the concomitant symptoms and progress of the case, so that, in time, a more definite idea of the disease may be found.

DISPLACEMENT OF THE HEART OCCASIONED BY TRACTION.

By ALEXANDER M. McALDOWIE, M.D., Stoke-on-Trent.

It is not, as a rule, difficult to discover the cause of displacements of the heart, which are due to disease. The following cases are rather remarkable in this respect, as both patients denied having suffered at any time from any acute or severe malady that could in any way account for the changes in position of the heart which physical examination revealed. As neither cirrhosis of the lung nor emphysema was detected in either case, I am inclined to think that both were due to retraction of the right lung, the result of a pre-existing attack of chronic or subacute pleurisy, in which the symptoms had been latent, or not severe enough to interfere with the pursuit of their ordinary avocation.

CASE I.—Samuel B., aged 48, a tailor, came to me complaining of pains and beating in the right mammary region, and a bulging on the right side of the chest. He had suffered, for the past five years, from lancinating pains in the right mammary region, shooting to the back and the right shoulder. These began insidiously without any known cause, and had been gradually growing worse. The pains were generally worst during the afternoon; easy when lying down; aggravated by exertion. Previously to the onset of the malady, the patient had always been healthy; he never had any severe nor acute illness. There was no cough, dyspnoea, nor dysphagia. The patient was ill-nourished; there was no cachexia. A circumscribed bulging was seen on the right side of the chest over the mammary region. There was visible pulsation in the third right interspace to the inner side of the nipple-line. On percussion over the right side, absolute dullness extended from the lower border of the second rib downwards in the nipple-line for four and a half inches (see diagram). Transverse

Samuel B.—Area of Cardiac and Hepatic Dullness.

dullness extended from the right border of the sternum outwards for five inches, at the level of the third rib. All the other regions of the chest were quite resonant on percussion, including the left inframammary region (where the normal cardiac dullness could not be detected) and the space between the above-mentioned dullness and the hepatic dullness. The heart's impulse could be felt over the bulging on the right side, most strongly marked to the outside and a little below the nipple. The impulse was strong, and was quite different from the heaving, or uniform distension, which is characteristic of aneurysm. No impulse nor apex-beat could be felt in the normal situation. Both sounds of the heart were normal in character; the first was heard, but rather faint and distant, over the inner part of the area of dullness, transmitted over as far as the left border of the sternum; the second was heard, very loud and distinct, over the whole of the dull area, fading away towards the right and the left. No *bruit* could be heard in any part of the chest. The lung-sounds were normal. The respiratory murmur was audible over the usual position of the heart. Pulse 88, small, regular, equal at both wrists. The pupils were equal, eyesight good. Nothing abnormal could be detected in any other part of the body. The patient remained under observation nearly two months; no change was noticed in his condition.

¹³ *Pathological Society*, November 7th, 1876.

¹⁴ *Lancet*, vol. ii, 1876, p. 13.

¹⁵ *Lancet*, October, 1882, p. 653.

¹⁶ *Clin. Soc. Trans.*, vol. xviii.

¹⁷ *Le Progrès Méd.*, No. 31, 1883.

¹⁸ *Lancet*, November 29th, 1884.

CASE II.—Henry R., aged 32, potter, had suffered from debility, palpitation, and pains in the chest for several years. The symptoms came on after he had been employed in some heavy work. He had been troubled with cough for several months. Expectoration was muco-purulent, occasionally streaked with blood. He had lost flesh lately; no night-sweats. He never had rheumatic nor scarlet fever, nor any severe illness. The patient was pale and ill-nourished. The impulse of the heart was felt to the right of the sternum in the fourth and fifth interspaces. On percussion, the cardiac dulness was found to extend transversely from the left border of the sternum to about an inch within the right nipple-line at the level of the third interspace (see diagram). Over this area the heart-sounds were heard, sharp and

Henry R.—Area of Cardiac and Hepatic Dulness.

valvular; both sounded exactly alike. At the base, the first sound was faintly heard, the second was also rather feeble. Pulse 120, feeble. There was no dulness over the lungs; the respiratory sounds were harsh on both sides. Temperature normal. Nothing abnormal was detected in other parts of the body.

RECURRING FIBROID OF THE SKIN.

By H. T. BATCHELOR, M.R.C.S., L.R.C.P., L.S.A.,
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THE following notes will be of interest if read by the light of a recent publication by Mr. Jonathan Hutchinson. Mr. Hutchinson there states, that, he has "never seen the recurring fibroid of the skin, on the upper extremities, on the head, nor, with one doubtful exception, on the upper part of the trunk." Supposing my diagnosis to be correct, the case I am about to relate will be one of recurring fibroid of the skin of the neck.

The patient, an elderly, spare man, with iron-grey hair, and dry skin, requested me to remove a small tumour from behind the ear. He told me it had been cut out by another medical practitioner twice within four months. The tumour was not large, not much bigger than a hazel nut, and my note of the operation runs, "removal of tumour from behind the ear, and two wart-like growths below it." The operation was done without an anæsthetic, and it appeared to me to be the simplest thing possible, to cut it out, in such a way that it would not return. The growth was distinctly in the skin; it could be taken up between the fingers of one hand as easily as a marble could be picked up, and it was felt to have no deep attachments. The removal was effected March 31st, 1885.

This man came back to me on June 2nd, 1885, when I again cut it out. He returned, November 8th, 1885, when it was removed for the last time by me. I have two of these growths in spirit. Each time the man presented himself the growth was larger. The measurements of the last are one inch and a quarter by length and breadth, irregularly round, and five-eighths of an inch in thickness. The last time I exposed the muscular structure of the sterno-mastoid in getting below it, and its situation corresponded with the apex of the mastoid process, and it invaded the posterior surface of the lobe of the ear. It began as a pimple, which the patient was in the habit of picking. He lived very much exposed to the heat of the sun, and wind and dust, in following his occupation. When last I saw him he was dressing it with an ointment, which had been recommended to him, as good for

cancers, and its surface was ulcerated, fungating and bleeding. After removal, it generally healed up quickly, and began again in the scar. The last time it began to grow from the centre of the wound, as a sprout, before healing was complete.

It caused little or no pain, and there was no enlargement of glands. It will be remarked then, that a small tumour situated in the skin, freely movable, was five times removed by two different surgeons during the space of eighteen months; and that, at first, it was about the size of a marble, and at the last time only measured one and a quarter inches in diameter; the position of the tumour being on the neck, just behind and below the ear.

After these ineffectual efforts on my part, I began to grow faint-hearted, and concluded that nothing short of amputation of the head would meet the case. The man himself also displayed an unwillingness to be "cut about" or "hacked about" any more, and as I did not feel justified in suggesting the major operation, the case stands thus:—he has his tumour and I cannot rid him of it.

ON THE MANAGEMENT OF INCOMPLETE ABORTION.

Read at the conjoint meeting of the East and West Sussex Districts of the South-Eastern Branch.

By ARTHUR W. EDIS, M.D.Lond., F.R.C.P.,

Obstetric Physician to the Middlesex Hospital; Physician to the Chelsea Hospital for Women, etc.

THE subject of incomplete abortion, or imperfect expulsion of the whole of the ovum, cannot fail to prove of interest to all who have to deal with the emergencies of general practice. The risk to the patient, whether from primary hæmorrhage or from septicæmia, is often very great; a fatal issue is by no means unfrequent, and even where this does not result, the general health may become seriously affected from the prolonged hæmorrhage, septic absorption, or uterine disorder ensuing in consequence. Apart from this, the anxiety experienced by the practitioner—the risk of his reputation suffering, even should he escape prosecution for malpraxis—renders the subject one of unusual importance, and, therefore, well worthy of consideration.

The consequences of incomplete abortion are far more serious than at first might be imagined. Many a young life has been prematurely cut short, the hopes of maternity blighted, or prolonged uterine trouble induced, in consequence of an early miscarriage, within a few months of the commencement of married life, not having been properly managed.

It will be beyond the scope of the present communication to allude even to the causation, symptoms, diagnosis, prophylaxis, or treatment of abortion generally. My remarks will be confined solely to the management of incomplete abortion, where the ovum has ruptured, the embryo been expelled only in part—the placenta, either entire or in fragments, being retained in utero, and giving rise to hæmorrhage or septicæmia in consequence.

The principle of early and complete evacuation of the contents of the uterus, where the vitality of the ovum has been destroyed, and abortion is inevitable, although generally accepted by everyone competent to give an opinion, is yet too often neglected in actual practice, and leads to the most calamitous results. The following cases will illustrate this.

M. T., aged 27, single. When first seen in consultation with her medical man, who had only been called in a few days previously, I found her lying in bed, on her back, with the knees drawn up, the abdomen tympanitic, very tender on the least pressure. The pulse was 144, very feeble; temperature 103.2° Fahr. The tongue was thickly coated, red at the edges, and inclined to be dry. She was delirious at times, but could be roused to answer questions. There was persistent fetid diarrhœa, constant sickness, and much pain complained of all over the abdomen. On vaginal examination, a sanious sanguineous discharge was found exuding from the os uteri, which was somewhat patulous. The uterus was enlarged, fairly mobile, retroverted. Thus far, no history had been obtained explaining her symptoms. Seeing that the patient was in a most critical condition, evidently suffering from septic peritonitis, I elicited from her paramour that she had had a miscarriage, procured some ten days previously by a midwife. She had missed two periods, and came up to town for the purpose of being set right. Two days afterwards, she had severe pain and profuse hæmorrhage, but I could get no well-marked history of any substance having passed. She became very feverish, and was compelled to keep in bed. It was not until nearly a week after this that a medical man was called in, and then he was told nothing beyond that she was losing blood.

The patient was too ill to bear much interference. The uterine