MOLLITIES OSSIUM IN THE MALE, WITH SPONTANEOUS FRACTURES.

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THE extreme rarity of mollities ossium, in the male, induces me to bring under notice the following case. Concerning the rarity of this disease, Bristowe (*Theory and Practice of Medicine*, 1876, page 901) says: "It has been recognised only in women; and, for the most part, in women who are bearing children." Niemeyer (*Text-book of Practical Medicine*, vol. ii, page 565) says: "This is a rare disease; up to the present time, it has been observed almost exclusively in women." Trousseau (*Clinical Medicine*, vol. v), who names the disease adult rickets, does not specifically assert that it is never met with in men, yet, all the cases he mentions occurred in women; and he seems to assume that the disease is exclusively confined to women; particularly to women just after repeated pregnancies. Sir William Mac Cormac (Quain's *Dictionary of Medicine*, page 997) states that mollities ossium "affects the female sex almost exclusively; only occurs in adults, and during the period of child-bearing." He also says it "very rarely is observed in the male sex."

William G., aged 43, married, a schoolmaster, with no family history of any softening of the bones, about eight years ago began to suffer from severe pains in his knees, attributed to rheumatism. Then pains came in his feet and shoulders. He was also dyspeptic, and always of a costive nature. Four years ago, he began to be much troubled with pains in his hips, and difficult locomotion. These increased steadily till he was unable to walk erect; then he gave way on the right side so much, that he thought his right hip was either wholly or partially dislocated.

Coincidentally with these alterations in the hips, the hands began to undergo changes, which have ultimately resulted in the present state

Fig. 1.—Hands.

of things. There is a more or less complete absorption of the muscular tissue of the hands; the ungual phalanges are all shortened in a marked degree; the articular extremities of the other phalanges are enlarged at the base. This is most distinctly perceptible in the thumb, of which the base of the first phalanx is so much enlarged, that it causes the extensor tendon to run in a curved direction, something like the course of the string passing over the bridge of a violin; the obvious effect of this is to cause insufficiency of length of tendon, and so dislocation backwards of the ungual phalanx of the thumb; the pad of the thumb is thus placed transversely on the end of the thumb, and looks upwards, instead of forwards, towards the palmar aspect. (Fig. 1.)

The chest has altered much in shape. It is now more or less rounded in every diameter, compressed laterally, and bulging forwards, more particularly at the lower part. (Fig. 2.) There are well marked swellings at the junction of the ribs with the costal cartilages. The sternum is sickle-shaped, the handle being upwards, and the convex surface of the sickle looking forwards.

Two years ago, the patient sustained a fracture of the right humerus, through simply trying to prevent a man from jostling him in the street.

On December 29th last, the patient first came under my care. He was then quite unable to walk without a crutch and stick. He had been bending down to tie his boot-lace, when the right femur broke through the middle of its shaft. (Fig. 3.) The fracture united distinctly in six weeks. Meantime, the patient suffered from considerable pain in the

Fig. 2.—Chest.

left thigh, the muscles of which wasted. While he was still in bed, the left femur bowed outwards, and seemed to rotate on its axis, so that the front aspect of the knee turned outwards. Soon after its reunion,

Fig. 3.—Fractured Femur.

the fractured right femur became subject to very similar alterations in shape, though a little more marked.

The bones of the head remain unaltered. The organs are quite

healthy. The mental faculties are perfect. He has no cough, diarrhoea, or perspirations; no pyrexia or hectic.

REMARKS.—The above is a typical case of mollities ossium. Numerous views have been advanced as to the nature of this disease. Trousseau (*Clinical Medicine*, vol. v, page 81) says: "Ought we to consider that there is a similarity between osteo-malacia and rickets? I say, we ought. In my opinion, and in that of many other physicians, they are one and the same." This opinion, he supports by statements, for which I must refer readers to the article itself; but which, in my experience, are quite contrary to fact. For instance, in the case above described, there has been an entire absence of the constitutional symptoms which are characteristic of rickets: pyrexia, profuse sweats, soreness of the bones, derangements of the alimentary tract, and inflammatory affections of the respiratory organs. Again, in alluding to the occurrence of fractures in rickets, he says (*Ibid.*, page 81), there is a "greater rarity of fractures in the rickets of adults than in the rickets of children." This is quite contrary to my experience; for, unfortunately, in Preston, rickets is most prevalent, yet I never have seen a case of spontaneous fracture in any out of a very large number of cases I have attended. Moreover, rickets is generally traceable to some definite cause, chiefly dietetic; but, in the case described, there is a total inability to discover any predisposing cause.

Niemeyer, in discussing the etiology of osteomalacia, says (*Op. cit.*, page 566) that, in this disease, "bones which have been hard become soft from re-absorption of the salts of lime. This explanation of the disease at once shows its difference from rachitis, where the lime-salts do not disappear from the bones, but have never been deposited there." I think it is open to some doubt, and contrary to clinical experience, to say that, in rickets, the lime-salts do not disappear from the bones. In rickets, a bone, that has hitherto been rigid and unbendable, becomes soft and yielding; and, I think, it requires something more than a mere *ipse dixit* to say that, in such a case, there has been no reabsorption of calcareous matter already deposited. Niemeyer further says: "The exciting causes are unknown; we only know that the first signs of it, in most cases, appeared some time after confinement, so that pregnancy, parturition, or the puerperal state, undoubtedly have much to do with the etiology." The effect of this statement is undoubtedly very much weakened by the fact that, in the case described above, the patient is a male; which clearly proves one thing, at any rate, that osteo-malacia may occur totally independent of pregnancy; so that, as fixed factors in the causation of this disease, pregnancy, parturition, and the puerperal state, are non-existent.

DIPHTHERIA.

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MANY interesting communications have lately appeared in the BRITISH MEDICAL JOURNAL on the subject of diphtheria; notably the report of a paper by Dr. Astley Gresswell, on the chronic and recrudescent form of the disease, read before the Epidemiological Society.

I should like to state the results of my experience of diphtheria, as seen in a country practice during the past two years. In this period of time I have had fully 150 cases of sore throat, to which I venture to attach the specific name. Out of this number five died, three from extension of membrane to the larynx, and two from cardiac failure and vomiting; while in two other cases of laryngitis, ending fatally, I believe no membrane was present, though in the absence of *post mortem* examination I cannot be quite certain. But the point to which I wish specially to draw attention, is that the large majority of the cases were exceedingly mild, the patients perhaps feeling ill for a day or two, often scarcely complaining of sore throat at all, and in many instances refusing even to keep at home. I have sometimes seen, on the first day of illness being felt, a small patch of membrane on the tonsil, while on the following day there would be present only a shallow exfoliation where the membrane had existed, and on the next day again even this had disappeared, and the surface appeared smooth and even. Usually, however, a considerable part of the tonsil would be affected, and the membrane would adhere longer; while, in one severe case, patches were still present, after three weeks' illness. In nearly all, the membrane was confined to the tonsils, but in a few the discharge of clear or blood-stained fluid from the nose showed that the nasal cavities were affected, and in one a patch of membrane was seen on the margin of the anterior nasal orifice. In two or three severe cases the soft palate and pharynx were thickly coated, and in the three fatal cases mentioned above, the larynx became involved.

Often in the convalescent stage the tonsils remained enlarged (as Dr. Gresswell has remarked), and in the crypts would lurk remnants of membrane, giving an aspect closely resembling follicular tonsillitis. Indeed, in some cases I do not think it is possible to make a distinguishing diagnosis between the two diseases, when the throats are seen for the first time at this stage. Another error easily made in such patients, is to overlook the presence of the membrane altogether, for the swollen tonsil may completely hide the fragments of membrane in the crypts, when the throat is viewed in the ordinary manner; but if the spoon-handle be passed into the fauces, and the action of retching induced, the tonsil seems to start forward and open out as it were, disclosing the patches of membrane still lurking in its recesses.

The disease was chiefly found in the young; and, in the fatal cases, the age varied from 2 to 5 years. It appeared in the better-class cottages, as well as in the miserably dirty ones; in isolated houses as well as in those grouped together. Generally, no history of contagion could be obtained; but, in some cases, it could be clearly traced. In three families, every child was attacked, only excepting the baby in each.

As regards recurrence, one of the fatal cases had had a well marked attack five months before, and, in another decided case, there had been an equally well marked attack six months previously.

The household, of which the last mentioned case was a member, figures largely in my note-book; for, out of its eleven people, no fewer than eight have had "sore-throat" during the past two years; in some, when examined, membrane was present, in others not. Again, one of the eight has been under treatment four times, though no membrane was visible at any time when I examined her. These instances become of great interest when considered with reference to Dr. Gresswell's paper mentioned above.

With regard to albuminuria, in the few instances of slight attacks in which I tested the urine, I failed to find albumen, but, in the severe cases, it was usually present.

The sequelæ noticed were very few, for in only two cases was there paralysis of the soft palate (accompanied by oculo-motor paralysis), and in one or two other cases prolonged general weakness.

The district was a country one, though well populated, and the subsoil a heavy clay. No particular relation to weather or season could be detected.

I may add that, at times, there occurred numerous cases of ulceration of the mouth in children, the mucous-membrane of the cheeks opposite the basis of the tooth-crowns being the part usually affected. Once or twice I have seen a similar ulceration of the vulva. I was unable to establish any direct relation between these cases and those described as diphtheria, but they occurred sometimes in houses afterwards affected by diphtheria, and in some cases, at all events, appeared to be contagious, and to give rise to a similar attack in others.

PURE TEREbene IN WINTER-COUGH.

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For some months past, I have been using pure terebene in the treatment of winter-cough and bronchitis. I have before me notes of fifty-one cases so treated, and the conclusions at which I have arrived from my experience of the drug are as follows.

In cases where the trouble has not been of long standing, and the symptoms are slight cough, more especially at night; expectoration moderate in quantity and easily voided; no feeling of rawness in the chest, and little or no disturbance of the general health, I consider that pure terebene is almost to be ranked as a specific, so quickly is a cure effected.

In cases where there is emphysema, and the ailment has been present for some time, it may be for some years, with the following symptoms: cough very troublesome, and sometimes even violent; expectoration tough and adhesive, or it may be easy and copious; great shortness of breath and rawness of chest; sleep broken, and general health much disturbed, the beneficial effects of the medicine do not manifest themselves for some little time, and not unfrequently the dose has to be increased to ten, or even fifteen, drops. If, however, the drug be persevered with faithfully and regularly, the cases are few in which I have to record a failure. Altogether, I consider pure terebene one of the most valuable remedies at our command in the above class of cases.

In six cases of phthisis in which I prescribed the drug, the patients, in every instance but one, remarked that they were not in any way benefited, and requested the medicine to be changed. In catarrh, also, the results were not satisfactory.