much difficulty. He sways much on standing and feels giddy, but does not fall even with his eyes shut. There is no rigidity of any muscle.

There is no nystagmus; the pupil reactions and ophthalmoscopic appearances are normal. The fields of vision are nearly normal, but there is a certain amount of limitation, equal in all directions, on the left side. There is slight ptosis on each side. Speech is somewhat explosive and at the same time scanning. It was this defect in speech more than anything else that made him give up his work. There is no affection of sensation in any part.

The knee-jerks are exaggerated. There is no ankle clonus. The plantar reflex is flexor. There is no affection of the sphincters, but some frequency of micturition—about twelve times in the twenty-four hours, including once or twice at night, when he is compelled to get up for that purpose. The quantity of urine in the twenty-four hours is only about 60 oz., and it appears to be normal.

C. B. P., the eldest brother of the family, was also examined. He showed a more advanced stage of the same disease. He first noticed signs of it nine years ago at the age of 43. He is now almost bedridden. In his previous history there is nothing of note. His first symptom was pain in the legs on walking, soon followed by coarse tremors of his hands, which at the end of a year prevented him from following his occupation as a clerk. He also suffered from a prolonged fever of unknown nature and was left much worse at the end of it. Since then his disease has steadily progressed, and now he cannot move about without support on each side. He complained much of vertigo; when at rest he felt all right, but on sitting up or after any movement everything appeared to be going round.

On examination the nervous and urinary systems alone appeared affected. The signs were like those of his younger brother described above, but much more marked. The hand-grasps were strong and the limbs muscular. Inco-ordination was extreme; he took two hands to a glass of water and then spilt half of it. He could, however, button up his shirt. There was no spasticity. There was no nystagmus, nor anything abnormal about the eye, except that the pupillary reaction to light was slow. Speech was very explosive and indistinct, and it was difficult to understand him. When he attempted to stand his general ataxia combined with his explosive speech gave him very much the appearance of a drunken man. There was no affection of sensation. The knee-jerks were present, somewhat exaggerated on the left side. There was no ankle clonus and plantar reflex was extensor on both sides. The mental condition was normal. There was much polyuria; he micturated every twenty minutes during the day and every hour or so at night. He appeared to have a little difficulty in starting the act. Each time he voided about 8 oz., and the total was nearly 300 oz. in the twenty-four hours. The urine (sp. gr. 1002) was clear and of very pale colour, neutral in reaction, and contained neither albumin nor sugar. Thirst was correspondingly great, and he always had a glass of water by him.

The children of C. B. P., of E. S. P., and of T. W. P. were seen and are apparently healthy, but as they are all under the age of puberty it is impossible to say yet whether they may not be affected later. So far the disease has shown the phenomenon of "anticipation"—that is to say, whereas the father, G. P., did not show signs of it until the age of 50, his eldest son, C. B. P., began to show signs at 43, and the daughter at 40; the next son, E. S. P., at 32; and the next son affected at 28. It remains to be seen whether the next generation will develop the defect earlier, if at all. If so the stock will thus naturally be eliminated.

Similar families have been previously reported, notably by Sanger Brown; that family showed no fewer than 21 cases in four generations. In those and other cases where *post-mortem* examinations have been obtained the cerebellar structure appeared normal, but there was degeneration of the dorsal and spino-cerebellar tracts of the spinal cord. Cases described by other authors, however, have shown either the existence of a small cerebellum or of degeneration of that organ.

Marie described a series of cases under the name "hereditary cerebellar ataxia"; but critical examination of his cases since has shown a lack of unity in their symptoms

and pathology. Without a *post-mortem* examination on one of the affected of the family now reported, it is impossible to state the limitation of the lesion.

The symptoms produced so strongly resemble those we associate with experimental cerebellar lesions that we are justified in thinking that the cerebellum or the spino-cerebellar tracts, or both, must be at fault.

I am indebted to my clinical clerk, Mr. V. D. Saksena, for notes on the history and genealogy of these cases.

A CASE OF WOODY PHLEGMON OF THE NECK (PHLEGMON LIGNEUX).

By GEORGE PARKER, M.D. CANTAB.,

PHYSICIAN TO THE BRISTOL GENERAL HOSPITAL.

THIS condition is worth noting because of its remarkable resemblance to a malignant or tuberculous growth and its exceedingly slow progress, ending generally in a complete recovery. Such a case might easily be mistaken for a cancerous one, and if treated with "Mr. Polypody's pills" or some elixir or other, the results would be considered most convincing.

Reclus first described it in 1893, and a number of instances have been observed on the Continent and in America, though I have not found any recorded in this country. It generally occurs in males over 50 who are in low health, but usually no kidney or constitutional troubles are present. A slowly growing swelling due to infiltration of the subcutaneous cellular tissues appears over the lower jaw, in the neck, or in the lower part of the scalp. Occasionally such a mass has occurred in the abdominal wall after an attack of appendicitis. The tissues become as hard as a board. The skin darkens, and may be cyanosed or violet coloured in places. The surface may be nodular or smooth, and after some weeks slight fluctuation is found at several points and a little pus is evacuated, more or less blood stained and granular. In many cases there is no pain, tenderness, or fever, and the indurated mass may remain unaltered by the discharge of pus. Fresh sinuses form, and the process goes on for months, but when final absorption does take place, it is remarkably perfect and very few scars remain. Lang and Smincke tried to show that the tumour was cancerous, but this view has found no support, and usually it disappears entirely. The inflammatory infiltration may be leucocytic or lymphocytic. Perhaps the most common organism found is a staphylococcus, but a streptococcus, a pneumococcus, a diphtheroid bacillus, and others have been noticed in different cases. Reclus thinks it may be caused by any organism of weak virulence acting in highly resistant tissues. There may be patches of oedema along the margin, due to obstruction of the lymph channels. One patient died from oedema of the glottis, but the majority get perfectly well. Operative treatment has had little effect. The incisions discharge for a time, then heal up and fresh sinuses form. Vaccines have not been much more successful, but in any case the hard infiltrated areas slowly diminish and pass away. The history of my case is as follows:

A gentleman, aged 74, of strong physique and leading a regular and abstemious life, with hardly any records of previous illness, suffered in March, 1912, from toothache, for which he consulted Mr. Perry, a dental surgeon. A swelling in the cheek appeared about April 14th, and a necrosed lower molar tooth was extracted on April 18th. Considerable swelling of the face and gum took place and went on increasing. The mouth became closed from infiltration of the masseter, and could not be opened for eight months. During this time the front teeth were so closed together that often a knife blade could hardly be inserted, but occasionally there would be a gap of a quarter of an inch. On May 2nd an incision was made in the gum down to the bone and a drainage tube inserted. The tissues over the jaw were thickened and hard. Hot fomentations were employed for months. A sinus in the neck began to discharge about May 22nd, and others followed from various nodules on the surface, but very little change took place in the dense mass which covered the greater part of the right side of the neck from about 2 in. above the clavicle to a little below the level of the

mouth, curving upwards in front of the ear and behind it to the mastoid process. There was some oedema of the cheek above the hard area.

An examination of the pus showed a growth of *Staphylococcus aureus* only. It also contained blood and granular matter. An autogenous vaccine was prepared and a course of injections was given, beginning on June 20th, rising gradually to a dose of 1,200 millions, but with practically no effect. There was considerable difficulty in feeding the patient for the eight months during which the jaws were closed, since there were hardly any gaps in the teeth; he had to be content with thick soups, grated kidney, farinaceous food, and milk. During November and December slight pain from a dental nerve or the ear was complained of; it was relieved by gelsemium and phenacetin.

Towards the beginning of 1913 the indurated and thickened area began to grow smaller, the secondary oedema diminished, and the sinuses were less active. The general health improved, and after the middle of February the mouth at times opened for half an inch, but fresh nodes appeared from time to time and discharged, causing the jaws to close for a while. It may be noticed that there was no pyrexia throughout and little or no odour from the pus.

By August nearly all the thickening deformity and scars had passed away and the skin was of nearly normal appearance, except for a very small patch of induration about the ramus of the lower jaw, and occasionally a trifling discharge from one or two minute sinuses. The mouth could generally be opened for an inch or more, and the patient gained weight and appeared in vigorous health. By November there were few traces of the phlegmon left. It had lasted about nineteen months, had caused practically no pain or constitutional disturbance, and, except for the absence of definite glandular enlargement, closely resembled some forms of malignant growth.

LITERATURE.

Reclus, Des phlegmons ligneux, *Gaz. d. Hôp.*, No. 88, 1893, p. 833.
Leonard Freeman, *Keen's System of Surgery*, vol. i, p. 262. (C. A. Powers *Journ. Amer. Med. Assoc.*, lvii, July 29th, 1911) gives a bibliography of the earlier cases.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

ANAPHYLAXIS.

IN the JOURNAL of November 22nd, 1913, Dr. E. W. Goodall says that he is not sure that any article of diet except mussels, crabs, strawberries, or raspberries is capable of producing anaphylaxis. Recently I had a case remarkably like anaphylaxis produced by dried milk in the form of powder. The patient, a widow aged 76, had never been able to take cow's milk in any form without feeling ill, and in her early days had been brought up on goat's milk, which suited her quite well. I suggested she might try milk in the form of a dry powder. About 9 p.m. she took two tablespoonfuls in a glass of water. In a few seconds she had intense flushing of the face and a most severe headache, and also strong colicky pains in the stomach; at the same time breathing became difficult, and she felt very ill. The gastric pains lasted three hours, the headache one hour severely, but less intense all night. At 11 a.m. next day patches of congestion were still visible on the face. Surely this was a case of anaphylaxis; the symptoms came on too rapidly for the powder to have acted as an irritant poison, besides which there was no vomiting and no diarrhoea.

London, N.

R. BROADBENT, M.D.

AN UNUSUAL CONDITION OF THE APPENDICES
EPILOICAE OF THE PELVIC COLON.

A WOMAN aged 68 was admitted to the Royal Infirmary, Derby, with symptoms of intestinal obstruction. She had been treated for an attack of gall-stone colic and obstructive jaundice by Dr. Moon, who suggested that the intestinal obstruction was due to a gall stone impacted in the ileo-caecal valve.

An exploratory laparotomy proved this diagnosis to be entirely correct, a large single unfaceted gall stone being found in the ileum just above the ileo-caecal valve. It was evident that the stone had travelled down to the valve, but was unable to pass through on account of its

size. It was interesting to note that the stone evidently moved backwards and forwards in the ileum for a distance of about 4 in. from the valve. The stone was removed by a linear incision, and the intestine closed.

Whilst exploring the rest of the abdomen for any more possible gall stones, I found two hard nodules in the pelvic colon. This was brought to the surface for examination, when it was seen that the two nodules were attached to the side of the pelvic colon away from its mesentery in line with the appendices epiploicae, which were particularly well marked. The nodules were very hard, were beneath the serous coat, and blackish in colour. The exposed portion of the bowel was carefully packed off from the rest of the abdomen by means of sterile gauze, and the peritoneum over the nodule incised. A hard faecal concretion of the size of a large pea was obtained, but no communication with the bowel could be made out. The incision was, however, carefully sutured. The other nodule proved to be exactly similar.

I have not come across the same condition before, nor have I seen any description of such a formation. My explanation of the presence of these nodules is as follows: Appendices epiploicae are practically small subserous lipomata, and it is conceivable that in an atonic intestine a small hernial protrusion of the mucous membrane lining the intestine might project between the fibres of the muscular coat. Faecal matter could find its way into such a hernial protrusion, and becoming desiccated would form a concretion. Owing to the peristaltic movements of the intestine and the presence of the concretion, the narrow neck of the hernial protrusion might tend to become a pedicle, and ultimately get completely shut off from the lumen of the intestine.

The patient made an uninterrupted recovery. She volunteers the statement that before operation she had been unable to lie on her left side for some years, owing to pain in the left iliac fossa, but that now she could do so without discomfort. It is possible that the traction of the nodules may have had something to do with this symptom.

FRANCIS L. A. GREAVES, F.R.C.S.,
Surgeon to the Derbyshire Royal Infirmary.

SURGICAL EMPHYSEMA FOLLOWING OPERATION
IN THE TRENDLENBURG POSITION.

MRS. X. was admitted to the Florence Nightingale Hospital suffering from chronic inflammation of the right ovary and tube. She was operated upon, and the ovary, tube, and appendix were removed, as well as two small subserous myomata of the uterus.

The operation was performed in the usual Trendelenburg position, the wound being sutured before the table was lowered. After the operation she suffered from rather severe post-anaesthetic vomiting, but made a good recovery. On the sixth day after the operation the patient called attention to a movable swelling in the right thigh, which was found to be due to surgical emphysema, following the course of the femoral vessels and reaching down to the middle of the thigh. On removing the dressings on the eighth day in order to take out the stitches it was evident that there was emphysema all over the abdomen. The condition cleared up in about a week.

What had apparently happened was that air had been left inside the peritoneal cavity, and, the peritoneum not being sufficiently closely sutured, had escaped during the vomiting efforts into the cellular spaces deep to the transversalis fascia, and thence had forced its way down into the thigh through the femoral sheath. The condition is not unimportant, as it might have led to strangulated hernia or other mischief.

The lesson to be learnt is that in operations in the Trendelenburg position the table should be lowered before the peritoneum is sewn up, so that air may be displaced out of the peritoneal cavity and the omentum may be rearranged in its proper position, precautions which I think are usually neglected. Correspondingly, at the commencement of the operation, it is of advantage to have the patient in the Trendelenburg position before the abdomen is opened, as otherwise air gets access to the subdiaphragmatic region and the intestines do not retract properly into the upper abdomen. This precaution is, however, more generally adopted.

KENNETH A. LEES, M.B., B.C. Cantab.,
F.R.C.S. Eng.
London, W.