left iliac fossa, but this was not so severe nor did it radiate elsewhere. She had had two miscarriages. On examination (by Dr. Tenison Collins) the uterus was found to be anteverted, the right tube was very much thickened and extremely tender on palpation, and there was shortening of the right broad ligament. The left tube was thickened, but not to such a degree, nor was it so tender.

Case 3.—A married woman, aged 40, suffered from abdominal pain for nineteen years. A week before admission to hospital she complained of very severe pain which started in the right iliac fossa and passed down the right thigh to the knee. She was tender over the whole of the lower abdomen. At operation (by Professor Ewen Maclean) free purulent fluid was found. The right tube was thickened and distended with pus. There was a condition of general inflammation in the pelvis, involving the appendix and the left tube, which was secondary to the right tube.

Case 4.—A married woman, aged 45, multipara, had her last menstrual period six weeks previous to admission. Two weeks before admission to hospital, for one day, she passed blood, pale in colour, per vaginam. Four days after this, while at stool, she complained of a sudden agonizing pain in the left iliac fossa, and a little way down the left thigh. Below this point, down to the knee, she felt a sense of numbness. On the following day she passed blood and clots from the vagina. At operation (by Dr. Tenison Collins) a ruptured left tubal gestation was found.

Case 5.—A female patient, aged 50, admitted to hospital as an emergency case, complained of severe pain in the hypogastrium, in both iliac fossae, and down the anterior surface of both thighs, the pain being most severe in the left iliac fossa. At operation (by Mr. H. Geary Grant) a bilateral salpingitis and diverticulitis was found. The left tube was the more inflamed, and had given rise to the diverticulitis (sigmoiditis).

Case 6.—A married woman, aged 26, complained of dysmenorrhoea, metrorrhagia, and leucorrhoea for the last three months. Nine days before admission to hospital she felt a sudden pain low down in the right iliac fossa, passing down the right thigh on the anterior and outer side of the limb to the knee. She complained of a burning pain on micturition since the onset of the pain; she vomited for the first time five days after the onset of the attack. On examination, a tender fluctuating lump was felt in Douglas's pouch on the right side. At operation (by Dr. Tenison Collins) a right pyosalpinx was found, much pus escaping; the left tube was inflamed.

In spite of the difference in character of the lesions—namely, acute salpingitis, pyosalpinx, and ruptured tubal gestation—the pain complained of in these cases had as a common feature its origin in the iliac fossa and radiation down the anterior aspect of the thigh to the knee. The uniformity of this distribution is against the hypothesis of an "overflow" of the stimulus from the tube through the last dorsal and first lumbar spinal segments to the lower lumbar segments; it suggests rather that the Fallopian tube is represented in the spinal cord by the eleventh and twelfth dorsal and first, second, and third lumbar segments, the first three lumbar posterior roots innervating the area of the skin from the groin to the knee, on the anterior aspect of the thigh.

Summary.

Lesions of the Fallopian tube cause pain which, arising in the iliac fossa, is referred down the front of the thigh to the knee. This distribution of pain is significant of an involvement of the tube, and appears to be of diagnostic value. It suggests, further, that the tube is represented in the spinal cord by the eleventh and twelfth dorsal and the first three lumbar segments.

In a note contributed to the *Lancet*² the above observations were used to establish a differential diagnosis between appendicitis and inflammation of the right tube, the difference being that the pain of appendicitis starts usually round the umbilicus, and, felt later in the right iliac fossa, does not pass below the groin.

I wish to thank Dr. Tenison Collins, Professor Ewen Maclean, and Mr. H. Geary Grant for permission to publish their cases, and Dr. Alexander Hastings for allowing me to make use of some of his notes.

REFERENCES.

¹Head, H.: *Brain*, 1893, vol. 16, Part 1, pp. 89, 101. ²Marcus, M.: *Lancet*, 1922, ii, p. 813.

THE nineteenth Dutch Congress of Natural Science and Medicine will be held at Maastricht from April 5th to 7th, under the presidency of Professor C. H. H. Spronck.

THE United States Census Bureau announces that in 1921 about 15,000 deaths from diabetes mellitus were recorded in the registration area. This area comprises 82 per cent. of the population of the United States. The death rate from diabetes was 16.8 per hundred thousand of the population in 1921, as compared with 16.1 in 1920.

A CASE OF RITTER'S DISEASE.

BY

RONALD McD. CAIRNS, M.B., CH.B.,

SENIOR HOUSE-PHYSICIAN, ROYAL INFIRMARY, LEICESTER.

THE following case of an exceedingly rare disease seems of sufficient interest to warrant its being placed on record:

The mother, a primipara, had always enjoyed good health and presented no abnormality throughout her pregnancy. The child, a male, was born after a somewhat difficult labour, which demanded instrumental interference, but at birth the baby appeared perfectly normal and did not exhibit any cutaneous abrasions, and incidentally the skin, in general, was quite healthy.

The child thrived, but on the seventh day my attention was arrested by a flaccid bulla, about two inches in diameter, resembling the lesion in pemphigus foliaceus. It had arisen during the night, was situated in the left pectoral region, and but for the fact that the surrounding skin did not exhibit any local reaction it looked suspiciously like the blister from a scald, but no history of exposure to heat could be obtained. The temperature was normal and there were no constitutional symptoms.

On the following day the lesions had spread; they involved practically all the left pectoral area and extended over the left shoulder. The bulla had burst, exposing a hyperaemic dermis and large pieces of the affected epidermis were peeling off. Under the remaining raised edges of the skin there were small collections of serous effusion, showing a very slight degree of turbidity.

There was still further extension on the ninth day, the method of spread consisting of the actual increase in size of the existing affected areas and the formation of new bullae. The left upper arm, practically as far as the elbow, was now involved, but between the lesions patches of comparatively normal skin still showed. The child was irritable, crying almost continuously, refused both breast and artificial feeding, and was obviously wasting, but the temperature was still normal and the motions regular and normal.

On the tenth day hyperaemia of the skin over the nape of the neck and the occiput appeared, and by evening a bulla had appeared in this position. This formed a marked contrast to the primary blisters, which had shown no initial reddening, nor a reaction areola. The new bladder-like swelling contained seropurulent effusion and the fluid in the other lesions was assuming this character also. The right side of the chest and right upper arm became affected on this day. The elbows were practically clear, but the hands, particularly the dorsal aspects, and the wrists showed the typical bullae. There were, in addition, a few reddened patches on the cheeks and brow, one in the neighbourhood of the umbilicus, while below the knees the affected skin was being shed in large moist flakes. Almost all the surface of the back had desquamated, and in the arm in particular, but to a certain extent in all the larger lesions, the exposed dermis was acutely inflamed, yet exhibiting no signs of necrosis, being quite dry in the centre, with no appearance of any exudate.

On the following day, the eleventh, and the fourth day from the onset of the disease, the child died. The affected parts had still further progressed and the child was very much wasted, death evidently being due to marasmus. Even up to the end there was no fever, but on the last day the temperature was subnormal.

The bowels were regular throughout and no internal complication arose. Ung. hydrarg. ammon., carron oil, ung. sulph., arsenic, and soothing baths were all tried, but proved equally useless in attempts to arrest the progress of the disease. The mother made an uninterrupted recovery.

This disease has been variously described as Ritter's disease, dermatitis exfoliativa neonatorum, and pemphigus neonatorum, and Ritter von Rittershain, Elliot, and others have described this non-contagious affection. In founding institutions on the Continent it is comparatively common, nearly 300 cases occurring in the founding asylum at Prague during a period of ten years, but down to 1900 no cases had been recorded in this country. Recently, however, I believe, one or two isolated cases have been noted.

The etiology is most obscure. Some regard it as a form of pemphigus foliaceus, some consider it impetiginous, others attribute it to some abnormal condition of the maternal milk, while still others look upon it as an exaggeration of the natural exfoliation of the newly born. Sepsis has never been found to be responsible. It usually occurs between the first and third weeks of life, but occasionally the onset is delayed until a month or even five weeks after birth.

The condition presents such a typical and unusual picture that little difficulty is experienced in diagnosis. Treatment, beyond the protection of the blebs by powders and the prevention of secondary infection by suitable dressings and soothing baths, appears to be unavailing.

In Ritter von Rittershain's series the mortality was practically 50 per cent., but some place it at an even higher rate. The sporadic cases certainly appear to be more fatal.

I much regret my inability to obtain a *post-mortem* examination and a bacteriological report on the exudate aspirated from the unbroken bullae.