ACHONDROPLASIA OCCURRING IN A CHINAMAN.

By GORDON MOIR, SURGEON, R.N.

THE following notes, and the photographs by which they are illustrated, were obtained with some difficulty in Shanghai, where the man resides. The family history was very meagre, but he stated that

his father and mother (natives of Hankow, 500 miles up the Yang-tse-Kiang) were of normal size; both of them are now dead. He is married, and has a son and a daughter, but neither could be observed.

The man himself is 58 years of age, quite intelligent, bright and alert. He earns his living (chiefly on account of his small size) by dancing, buffoonery, etc. He talks English to a slight extent.

The physical conditions are entirely due to achondroplasia, there being no signs of

rickets. The head is large and globular, the occipital bones being well developed. The bridge of the nose is depressed, the lips and eyelids are not thickened; the teeth are nearly all gone; the vault of the palate is

normal in appearance. The lower limbs are short, but remarkably well-developed muscularly. He is somewhat flat-footed; the legs are well formed; there is bowing, and no nodosity present.

The umbilicus is altered from the normal position of $\frac{42.75}{19}$ to $\frac{2.35}{1}$. Hair, especially pubic, is very scanty, but this is common among the Chinese. The ribs are normal, no beading being present. The arms are very short; when they are hanging down the side, fully extended, they only reach the crest of the ilium, instead of halfway down the thigh, as in the normal individual. The radius has no enlargement on its lower end;

the shortness of the radius ($2\frac{3}{4}$ in.) gives a great increase to the normal radial curve.

The following measurements were obtained:

1. Height, $42\frac{3}{4}$ in.
2. Umbilicus from ground, 19 in.
3. Circumference of head, $22\frac{1}{2}$ in.
4. Clavicle, $2\frac{3}{4}$ in.
5. Tip of mastoid to tip of mastoid, 7 in.
6. Radius, $2\frac{3}{4}$ in.
7. Olecranon to ulnar spine, 5 in.
8. Anterior superior spine of ilium to internal condyle, $9\frac{1}{2}$ in.
9. Internal condyle to internal malleolus, 8 in.
10. Chest expanded, 27 in.

A CASE OF "DERCUM'S DISEASE."

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THE following case appears to me to be of sufficient interest, if only as a clinical curiosity, to warrant its publication, presenting, as it does, almost all the characteristic symptoms of *adiposis dolorosa*, as described by Dr. Dercum in 1892 at the Neurological Society of New York.

History.

Elizabeth N., aged 61, married, with ten children (height, 5 ft. 6 in.; weight, about 12 st.), enjoyed good health until five years ago, when she commenced to suffer from numbness of the hands and arms, followed later by pain of an aching character, and subsequently by symmetrical fatty deposits in both upper arms. The condition led her to consult a medical man, who told her they were fatty tumours, and not to worry, and this I have since confirmed, being informed by another practitioner that he had seen the case four years ago, and at that time one arm, at least, presented a circumscribed fatty tumour on its upper and outer aspect.

These deposits in course of time attained considerable dimensions, the pain and numbness being also increased to such an extent that she was unable to undertake even the lightest household duties, and was obliged once more to seek medical advice.

With the aggravation of the symptoms referred to the arms, pain and numbness were experienced across the back and chest, and lately in the thighs just above the knees. There is nothing noteworthy in the family history.

Previous Illnesses.

Two years before I saw her the patient had severe haematemesis on several occasions and nine months ago uncontrollable haemorrhage following upon the extraction of a tooth; save for these haemorrhages and the present condition with which they are probably associated, patient has always enjoyed good health. Her habits are satisfactory at present. She has probably consumed more than an average amount of alcohol in the past.

Present Condition.

She is pale and sallow, and evidently suffers from debility and some anaemia. The conjunctivae and mucous membrane of the mouth and gums is paler than normal, and the latter seem spongy. The skin is dry and harsh, perspiration being very deficient. The temperature is 98° F., and the pulse 76. On inspection the observer is struck by the large diffuse deposits of fat, pendulous and flabby in consistence, which involve both upper arms, and to a lesser extent the upper portions of the forearms on both their extensor and flexor aspects.

Measurements.

Upper right arm, $2\frac{1}{2}$ in. at thickest portion.	
Upper left arm, $22\frac{1}{2}$ in.	"
Right forearm, $11\frac{1}{2}$ in.	"
Left forearm, 11 in.	"

Furthermore, there is a pad of fat over the manubrium sterni extending for a few inches across the second and third costal cartilages at either side. The back also shows symmetrical fatty deposits over either scapular region and extending as low as the tenth or eleventh rib.

Below the waist the patient shows no pathological increase of fatty tissue, her legs being more slender than one would expect in such a large woman. The hands and feet are normal. There are no fatty deposits about the neck.

The patient complains of numbness and tingling, with aching pains at times, principally in the upper limbs, but also across the chest and between the shoulder blades behind. To a lesser extent these symptoms occur in the thighs, just

above the knees to the inner side. The pain is very much aggravated by using the limbs.

The arms are tender wherever the fatty tissue is present, and even slight injuries cause bruising and discoloration. There are marked hyperaesthetic areas over both arms, principally on the outer and posterior aspect of the limb, but no areas of anaesthesia can be demonstrated.

The patient is fairly bright and intelligent, but complains of some loss of memory. There is, however, nothing about the case to suggest myxoedema.

The following characteristics of adiposa dolorosa are, however, present: The history of numbness and pain, followed by diffuse symmetrical fatty deposits; the associated haemorrhages; the presence of hyperaesthetic areas; and the general debility and harsh, dry skin of the patient.

With regard to treatment: I have followed the recommendations of Dercum and others, and have been giving the patient thyroïdin, grains v, t.i.d., and thus far, a period of scarcely two weeks, the result has been very satisfactory. The pains have almost disappeared, the numbness and tingling have been very much alleviated, and there is a distinct reduction in the size of the right arm of almost $\frac{1}{2}$ in. She herself states that she feels very much better, and can sleep and do a little work much better than she could for several months previously.

THE latest addition to the many societies in Paris connected with medicine has given notice of its intention to organize next November an exhibition of painting, sculpture, and engraving. This society, l'Esculape by name, is devoted to a combination of art and medicine, and to meet its purposes it proposes to hold literary, dramatic, and musical conferences. Among its council are Richelot, Widai, Gilbert, Gariel, and Labbé, all professors in the medical faculty of the University of Paris. The president is M. Bezançon, another officer of the society being Dr. Cabanès, editor of *La Chronique Médicale*.

INHALATIONS of oxygen have been used with good results in thirty severe cases of whooping-cough by Weill and Mouriquand (*Lyons Médical*, cxiii, p. 309). The severity but not the number of the kinks was diminished, yet the relief was so great that some of the children learnt to ask for the inhalation when they felt that a kink was coming on. The authors believe also that the risk of bronchopneumonia is lessened and its severity diminished if the oxygen is given every hour so soon as symptoms of the complication are suspected. Otherwise the gas is given at or, if possible, just before the beginning of the kink, as much as 10 or 20 litres being administered on each occasion through a funnel.

SEVENTY-SEVENTH ANNUAL MEETING

OF THE

British Medical Association.

Held at Belfast on July 23rd, 24th, 26th, 27th, 28th, 29th, and 30th.

PROCEEDINGS OF SECTIONS.

SECTION OF HYGIENE AND PUBLIC HEALTH.

LOUIS COLTMAN PARKES, M.D.Lond., President.

DISCUSSION ON LATENT INFECTIONS BY THE DIPHTHERIA BACILLUS.

OPENING PAPERS.

I.—PATRICK WATSON WILLIAMS, M.D.Lond.,

Lecturer on Diseases of the Nose and Throat, University of Bristol; Laryngologist, Bristol Royal Infirmary.

THE CLINICAL SIDE OF THE QUESTION.

SINCE my share in the introduction of this discussion is limited to consideration of the question from the clinical standpoint, I propose merely to direct attention to various clinical phases of latent diphtheritic infections, giving concrete examples when required.

If diphtheria may be defined as any pathological condition, local or general, due to infection by specific diphtheria organisms, then diphtheria is "latent" when such pathological conditions are unaccompanied by obvious illness or by symptoms sufficiently characteristic to be recognizable as those of diphtheria. With regard to the classification of such cases I cannot do better than retain that which I made in introducing a similar discussion at Leicester at the annual meeting in 1905, more especially as my grouping has been accepted in the main by Nuttall and Graham Smith in their recent monograph.

From the clinical standpoint cases of latent diphtheria may be grouped under three heads:

A.—Patients who afford none of the usual clinical indications of diphtheria, are not definitely ill, and yet are found to be anaemic, or have increased pulse frequency, or are simply poorly in association with nasal catarrh, membranous rhinitis, faucial redness or slight subacute tonsillitis, otorrhoea, sores, etc., which on bacteriological examination prove to be diphtheritic.

Of such cases I present two examples:

CASE I.

G. B., aged 2 days, prematurely born (about seven and a half months' gestation), was admitted with her mother to the Bristol Royal Infirmary October 11th, 1908, weight 4½ lb., yellow and wizened.

About December 24th it was noticed she had some nasal discharge, and as it did not clear up I saw her on January of this year and took it to be simple rhinitis. On February 6th cultures were made from the nasal discharge, that is, after it had persisted for six weeks, more as a matter of interest than because it was thought to suggest diphtheria, which, however, it proved to be.

The child died very shortly after. It was a good example of latent diphtheria, for no symptom pointed to the true nature of the case. There was no evidence of any sore throat, and, as the child was only 4 months old, I confess my inspection of the nasal passages was not satisfactory. A case of primary nasal diphtheria is reported by Kuhn¹ in a baby aged 2 weeks, probably contracted from the maternal genitals in parturition.

CASE II.

Mrs. V. O., a lady whom I had been attending a long time for asthma and accessory sinus suppuration, mentioned on March 29th, 1909, that her throat was uncomfortable. On the left tonsil was a small pocket with some exudation from one or two crypts, and the area of tonsil around was a little reddened. She

¹ *Journal of Laryngology*, February, 1909.