NOTE.—Since this article has been in the press several replies have been received from patients in various parts of the world, all of which show the operation to have been successful up to date. To the stated period since operation five months must be added in every case.

ACUTE NECROSIS OF SKIN.

By CAREY COOMBS, M.D. LOND.,
CASTLE CARY.

IN the following remarkable case the persistence of high temperature, the appearance and progress of the sore, and the fact that the first nurse had to leave because her hands became infected suggest a bacterial cause. Syphilis may be dismissed, and tuberculosis is improbable, as the patient and her children had never shown any tendency of the kind.

History of the Case.

A stout lady of yellowish complexion began to suffer from remittent fever on April 10th, 1907. There was much pain in the course of both sciatic nerves, followed after a few days by the appearance of three or four bullae, like those of ecthyma, about $\frac{3}{4}$ in. in diameter, near the tuber ischii. These bullae formed sores which healed in three months. On the inside of the right knee one bulla appeared about May 11th, $\frac{1}{2}$ in. in diameter; nine days later it was $\frac{3}{4}$ in. in diameter. Its margin was purplish-red, raised $\frac{1}{2}$ in. above the surface of the sore, which consisted of healthy granulations. In two months the whole thickness of the true skin had gone from the right leg; the limits in the front of the foot were the bases of the toes, on the sides of the foot the points of the malleoli, the upper edge being on the level of the patella. The tendon of the extensor of the toes was exposed on the dorsum of the foot. On some days more than a square inch of skin died. The process usually began by serum appearing under the epidermis at the growing point of the necrotic area; the cutis vera died in a few hours; when it was cut off, granulations were found growing beneath.

The necrosis ceased at the end of July—that is, in the tenth week—and the whole surface had skinned over in November, 1908, eighteen months after the disease started.

As a rule, the edge of the wound was well defined, purplish-red; the surface generally was clean, and islands of new skin appeared from time to time. Skin-grafts generally grew readily. But in March, 1909, the skin began to die again on the inner side of the calf, and in six weeks the surface of the sore was $\frac{3}{4}$ in. in diameter. The patient's temperature was above 99° at night for twenty-five weeks, the highest point being 104° . The discharge from the sore was not examined until the recurrence took place in 1909.

There can be no doubt that the patient's excellent appetite helped her recovery. The recurrence has followed four months of lack of nourishment, as her food began to return daily soon after she started a laryngeal cough. Her veins were weakened by her pregnancies, and venous bleeding has three times followed lowering the leg to the floor. Bier's bandage had the result that great pain and large blebs of blood appeared in two minutes after it was applied. The whole limb became oedematous, just as the sore was nearly healed.

Treatment.

Quinine and iron were taken throughout the illness. Opium was given at night, and was added to the ointment used for about a year—namely, lanoline containing tincture of benzoin and opium, suggested by Dr. Milner Moore. At first boric acid was used in carbolic lotion, $2\frac{1}{2}$ per cent. Then, by the advice of Dr. Firth, of Bristol, iodoform was added to the lotion, and the edges of the wound were painted with hydrogen peroxide. These methods were continued during the time of rapid sloughing—ten weeks. When the skin began to die again, in March, 1909, I ionized the sore by placing the positive electrode of a Leclanché battery over layers of lint soaked in 2 per cent. zinc sulphate solution on the sore; 10 to 12 milliamperes of current were used for ten minutes every two or three days. The result was to make the surface look silvery white, as though mild silver nitrate had been applied. But the use of hydrogen peroxide and iodoform lotion had a better effect, and at the end of six weeks the recurring ulceration is arrested. One ulcer, $2\frac{1}{2}$ in. in diameter, is closing, and seven, which are about half an inch across, are stationary.

THE Edinburgh Post-Graduate Course, which commences on August 30th and extends for four weeks from that date, promises, judging from the number of entries, to be at least as popular as its predecessors. The full number of applications for the Special Surgical Course, the attendance on which is limited to twenty-five, were indeed received almost a month prior to the date of its commencement, and some of the limited classes of the General Course, which is, as in former years, divided into two quite independent fortnights, are filling up rapidly. Among those who have entered are several who have taken out the Course in previous years.

Three Demonstrations

ON

CONGENITAL MALFORMATIONS OF PALATE, FACE, AND NECK.

GIVEN AT THE ROYAL COLLEGE OF SURGEONS, ENGLAND.

BY

PROFESSOR ARTHUR KEITH, M.D., F.R.C.S. ENG.,
CONSERVATOR OF THE MUSEUM.

II.—CONGENITAL FISTULAE OF THE LOWER LIP.

A BILATERAL cleft in the upper lip is frequently associated with a curious malformation of the lower lip, in which two fistulae or recesses open on the lower labial surface opposite the clefts in the upper lip. The orifice of each recess may be raised into a nipple-like process, which, when the mouth is shut, fits into the corresponding upper cleft. This was the condition in a specimen submitted to me by Mr. Woolcombe,¹ which was excised from the lip of a boy, aged 3 months. The orifice of the recess was situated at the apex of the papilla; its fundus, about the size of a rice-grain, lay within the substance of the lip, and was surrounded by mucous glands which opened into it. A layer of striated muscle surrounded the pocket, which in nature was clearly a localized invagination of the mucous membrane and glands of the lip. In three cases reported recently by Mr. R. C. Dunn,² there was one in which the recesses opened on nipple-like processes; another in which the orifices were wide and flush with the surface of the lip; while in the third the two recesses were confluent—thus forming a transverse depression on the surface of the lower lip. The condition has been described by Mr. Bland-Sutton, Mr. Arbuthnot Lane, Mr. Clutton, and Dr. Ballantyne. There is no example of this malformation in London museums. An appeal to comparative anatomy does not afford a satisfactory explanation. Seeing that the malformation is so closely associated with bilateral harelip and cleft palate, a condition which occurs normally in certain fishes, it is clearly in this vertebrate class that an explanation of the condition is to be sought. On each side of the middle line of the lower lip of sharks, and exactly in the position where these recesses are found, open a group of mucous canals which are connected with nerve endings found in fishes. It is possible that these labial recesses have some relationship with these two mucous labial organs found in selachians, but the matter requires further investigation.

TABLE II.

	A.	B.	C.*	Total.
Recesses and papillae on the lower lip ...	—	—	—	—
Median clefts on the lower lip and mandible	—	1	3	4
Naso-maxillary cleft	—	4	—	4
Lateral nasal clefts... ..	3	1	—	4
Mesial nasal clefts	—	—	5	5
Lateral nasal proboscis	—	—	—	—
Recess on nasal septum	—	—	—	—
Congenital perforation of nasal septum ...	1	—	—	1
Occlusion of anterior nares	2	—	—	2
Occlusion of posterior nares	—	—	—	—

* For explanation see Table III.

Median Cleft of the Lower Lip and Mandible.

Among the 250 specimens of malformation examined, only 4 showed this condition—a full-time child in the museum of St. George's Hospital and three specimens in the museum of this college, one from an ass, another from a cockatoo, and a third from a sparrow. Seeing that the lower lip and mandible arise by the fusion of right and