its usual support of tympanic membrane; pus seen in the tympanum.

May 28th. Large perforation seen in the posterior superior wall of the meatus $\frac{1}{2}$ in. from the orifice, debris presenting. Complete post-aural operation performed on left side, debris found in tympanum, cavity packed and wound closed.

May 29th. Patient looks well, paralysis not so marked.

June 1st. Wound healing well; can now close left eye, and slept during the previous night with eye closed.

June 4th. Paralysis fast resolving; can close eye, lift the lips, and smile now; wound healing, sutures removed.

June 11th. Wound quite healed; paralysis cleared up considerably; still deaf, having to be spoken to loudly.

June 17th. Paralysis almost cleared up, hearing much improved; can hear ordinary voice now, whereas had to be spoken to in a loud voice previously.

June 22nd. Paralysis cleared up; can elevate lips on this side better than on the right side, but left palpebral fissure still a trifle more open than right; can screw up both eyes easily.

It must be somewhat unusual to meet a case presenting similar features on each side of the face at an interval of almost exactly twelve months. It is instructive, too, in comparing the different periods of time which the two nerves required to return to their normal function, the right taking quite five months, though probably less would have sufficed had she attended regularly for galvanism which was ordered, as the actual duration of the paralysis prior to operation was uncertain, and with the view to remedy the soft and atonic state of the facial muscles, but unfortunately, owing to her irregularity of attendance, no true deduction can be made as to the effect of this treatment. On this side the paralysis had existed certainly for a fortnight, and probably for longer, whereas on the left side it had only shown itself two days prior to advice being sought, and cleared up entirely in less than a month after operation.

The rapidity with which the paralysis cleared up on the left side as compared with that on the right at once suggests the advisability of early surgical interference in cases of this sort, in order to save the nerve alone from permanent injury, and further to save the patient from a serious osseous lesion in the temporal bone, of which the facial paralysis is an outward and visible sign.

REFERENCES.

¹ R. Lake, *Diseases of the Ear*, p. 103. ² Politzer, *Diseases of the Ear*, p. 477.

A CASE OF MULTIPLE PLEXIFORM NEUROMA ASSOCIATED WITH BROWN PIGMENTATION OF THE OVERLYING SKIN.

By CECIL E. REYNOLDS, M.R.C.S., L.R.C.P.,

ASSISTANT MEDICAL INSPECTOR SCHOOL CHILDREN,
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AFTER reading Mr. Lenthal Cheate's interesting paper in the *JOURNAL* of June 12th, it occurred to me that the notes of the following case might have some bearing upon the question of neurotrophic influence in pigmentation.

A female child, aged 5 years and 4 months, came under my observation in April last during the routine inspection of the Berkshire schools. There was a swelling of the left side of the neck behind, extending from the left superior curved line of the occiput above, down over the complexus as far as the level of the first dorsal spine below, and extending round in front as far as the anterior border of the left sterno-mastoid muscle at the middle of its length. Posteriorly it was limited to the left side of the neck by the ligamentum nuchae. Soft and semisolid to the touch over the occipital bone, the tumour below was found to consist of firm masses, feeling like glands, ranging in size from a hazel nut to a pea, and more or less bound together by adhesions. The growth was thickest between the posterior border and the upper third of the sterno-mastoid and the outer border of the complexus. The skin over the whole of the tumour, with the exception of the occipital part, was stained brown. This stain was most marked over the prominent belly of the complexus, but extended as far as the middle line of the neck in front and also lower than the tumour below, becoming fainter and mottled at the edges. The opposite side of the neck was very faintly pigmented. The photograph (which unfortunately had to be taken in the country) is intended to show most of this pigmentation as well as the scar of the operation. The history is as follows:

The pigmentation was first definitely noticed at the age of 2 years. (The mother is quite clear on this point, as her friends used to remark that she had omitted to wash the child's neck.) It began at what is now the upper part of the stain behind, and extended slowly downwards and forwards. It was not until more than a year later that a swelling was noticed to commence beneath the upper part of the pigmented skin. There was no pain, but slight tenderness, which had of late increased, neither had the child suffered in general health. The child had enlarged tonsils when seen by me, but no other physical signs to aid or complicate diagnosis. The family history was negative.

As I was at a loss for a positive diagnosis, and the practitioner in attendance was equally anxious to settle any doubts as to the nature of the swelling, we removed the child to University College Hospital, where it was seen by Mr. Wilfred Trotter, who made the diagnosis of plexiform neuroma. We had the opportunity of witnessing the removal of the tumour by Mr. Trotter later in the day, when it was seen to consist of lobulated masses of fibrous tissue held together by strands, and almost inextricably mixed up with the muscle fibres in the neighbourhood, which latter fact rendered removal most difficult. After the greater part had been removed, it was decided to leave the rest for a second operation.

A, Scar of operation; B, maximum pigmentation of skin.

I am informed by Mr. H. M. Davies, surgical registrar to the hospital, who examined microscopical sections, that bundles can be seen which resemble normal nerve bundles, but that it is doubtful whether they contain nerve fibres, the contents in the main consisting of short curling strands of fibrous tissue with well-marked nuclei. The wound healed by first intention, but the scar is now (a month later) becoming keloid.

I am indebted to Dr. D. G. Kennard, under whose care the child is, for permission to publish this case.

A CASE OF SO-CALLED DELAYED CHLOROFORM POISONING.

By CONRAD DE L. CAREY, M.B., B.C. CANTAB.,
GUERNSEY.

THE following case seems to me to be typical of the condition described by Dr. Guthrie as "delayed chloroform poisoning" in a child the subject of chronic suppuration in the form of a caseating abdominal gland. The rapidity of death and low range of temperature are against any form of sepsis introduced at the time of operation.

I was sent for recently to see a boy, J. H., aged 3 years 2 months, who had been "out of sorts" for the week previous to my visit, suffering from diarrhoea. The temperature was

100°, and there was a certain amount of general abdominal tenderness, but no rigidity or tender spot. The motions were green and extremely offensive. Next morning the temperature was still 100°, and there was distinct tenderness over the appendix area, but there was little abdominal rigidity; there had been no vomiting. I saw the child again that evening, when the mother told me that he had had a good deal of pain throughout the day. The temperature was then 102.5°. Pulse 120, abdomen slightly distended and acutely tender over the appendix, with rigidity of the muscles. My partner, Dr. E. L. Robinson, agreed in the diagnosis of acute appendicitis.

Next morning I operated. The patient was given chloroform throughout the operation. He took the anaesthetic well, kept a good colour, and gave no anxiety. I made an incision 1 in. in length over the usual spot, and on passing in my finger felt what at first I took to be the tip of a much enlarged appendix. On drawing this out of the abdomen I found it to be a gland, about the size of a large pea, and acutely inflamed. After removing this I found the appendix. There was one old adhesion, and it was thickened. After removing the appendix I inserted my finger into the abdomen again and felt a mass apparently behind the caecum, from which extended what I took to be a chain of glands towards the liver. I then closed the abdomen and put the child back to bed about 1 p.m., the operation having taken just under one hour.

I again saw the patient at 4.30 p.m., when the nurse reported that he had not vomited, had dozed as much as three-quarters of an hour at a time, and was fairly comfortable. The pulse was 120, and the child had a good colour and facies. He vomited at 6 p.m. and 8 p.m., each time after having sips of hot water. At 9.30 p.m. his pulse was still 120, and he was somewhat restless, but otherwise seemed doing well; temperature 99°. At 7 a.m. I received a telephone message, and on arrival at the hospital I found him unconscious, tossing about, grinding his teeth, and making faces. The nurse said that he had had a good night up till 5 a.m., when he awoke from a sleep, vomited some mucus stained with "coffee grounds," and then commenced grimacing and gradually lapsed into unconsciousness. His pupils were equal, reacted to light, and were slightly dilated. The extremities were rather cold; pulse 130 and soft. I ordered him a hot saline enema, and gave a hypodermic injection of 2 minims of liquor strychninae. The child died without a struggle at 10 a.m., exactly twenty-two hours after the operation.

On inquiry from the mother, I found that five months previously the child had been ill for three weeks with a "bilious attack" and abdominal pain.

I obtained permission to make an examination of the abdomen. The site of the operation was normal, the appendix stump was buried, and there was no sign of leakage nor of general peritonitis. On examining the mass I had felt at the operation, it proved to be a caseating gland, the size of a walnut. This I removed for examination. The liver was extremely pale, and on section was canary colour, with here and there streaks of purple. I drew off some urine with a catheter, and found that it reduced Fehling's solution.

I sent the gland removed at the operation, the appendix, the caseating gland, and a piece of the liver to the Clinical Research Association, and received the following reports:

"This appendix shows chronic inflammatory changes in the mucous membrane and proliferation of the lymphoid tissue. It presents no evidence of tubercle. The gland, on the other hand, is typically tuberculous. It contains giant cell systems, some of which are undergoing caseation.

"This liver shows fatty degeneration of the hepatic cells, but in addition there is a leucocytic infiltration around the vessels and bile ducts in Glisson's capsule. This suggests an infective or septic cholangitis, which we conclude must have existed before the operation. The gland contains definite caseating giant cell systems, which are certainly tuberculous. It is possible that delayed chloroform poisoning may have something to do with the fatty degeneration, but we cannot help thinking that it is more likely to be a septic condition."

I may add that no carbolic acid was used at the time of operation.

TREATMENT OF THE SMALL INTESTINE IN OPERATIONS FOR INTESTINAL OBSTRUCTION.*

By C. HAMILTON WHITEFORD, M.R.C.S., L.R.C.P.

GIVEN a case in which the intestine is completely obstructed, either in the region of the caecum, or higher up in the small bowel, what are the duties of the surgeon?

In a patient almost *in extremis* the actual obstructing cause has to be neglected, and an enterostomy—that is, opening and draining the first distended coil which presents through a small median abdominal incision—is all that is justifiable, and may give the patient a fighting chance.

* Read before the South-Western Branch of the British Medical Association.

To a patient who can stand a general anaesthetic the duties of the surgeon are two:

1. To evacuate completely from the distended bowel the quarts of liquid which are poisoning the patient and are paralysing and causing a succession of partial kinks in the intestinal walls.

2. To restore the patency of the intestinal tract by either (a) removal of the obstruction, or where this is impossible by (b) a short-circuiting operation.

A partial, as opposed to a complete, emptying of the distended bowel is not infrequently performed, simply because the surgeon finds that, without this partial evacuation, it is impossible to replace within the abdomen the whole of the distended intestines. The time occupied by the operation must always be an important factor in the prognosis of these cases. But, while the time-consuming process of making a series of incisions into the distended coils remained the only efficient method of emptying them, the surgeon has usually contented himself with emptying the bowels sufficiently to allow of their being replaced within the abdomen.

It is hardly surprising to find that in many cases the intestines, in their paralysed, kinked, and crowded condition, fail to empty themselves even after relief of the original obstruction, the patients dying, poisoned by the foul intestinal contents.

The plan devised by Moynihan, of emptying the intestines by threading them on a straight tube, has placed in the hands of the surgeon a means by which the distended bowels can be rapidly and completely emptied. The tube, made of either metal or glass, is 8 to 10 in. in length and $\frac{3}{4}$ in. in diameter. The end, which is inserted into the bowel, is cut obliquely with smooth edges. Two inches from the other end is a flange, and beyond the flange the tube terminates in a rubber tubing for conducting away the intestinal contents. In selecting a tube it is necessary to make certain that the oblique end of the tube is quite smooth and blunt. Some of the tubes on the market lack both these essentials, and are well calculated to injure, or even perforate, the engorged and softened intestine.

A loop of bowel, emptied preferably by a milking movement, is clamped by the fingers of an assistant, and is incised longitudinally on its convex border. The tube is inserted, and the bowel and tube, wrapped in gauze, held by an assistant so as to prevent leakage by the side of the tube. As each coil is emptied the collapsed bowel is threaded on to the tube by the surgeon. Each inch of the tube will carry a foot of collapsed intestine. The intestinal incision is best made in the centre of the distended bowel, so that the tube may be passed first upwards to empty the jejunum, and then through the same intestinal incision downwards to empty the ileum. If, when the tube has been completely loaded with collapsed intestine, there still remains unevacuated a short length of bowel, its contents can easily be removed by milking them down to the end of the tube. It is quite easy in fifteen to twenty minutes to empty the whole length of the small intestine.

The conclusions which this paper is intended to emphasize are:

1. Excluding those cases which are nearly moribund and in which an enterostomy is all that is justifiable, it is essential that the operation, in addition to relieving the obstruction, should empty the distended small intestines of their poisonous contents.

2. The most efficient and rapid method of emptying the small intestine is to adopt Moynihan's plan of threading them on a straight tube.

[The method of using the tube was demonstrated on a model. In replying to the discussion on the paper, it was pointed out that the method, the value of which the reader of the paper had personally proved, was not of very recent origin, being at least three years old.]

LEPROSY CONFERENCE.—The conference on leprosy recently held at Bergen unanimously passed the following resolutions: (1) It is necessary that in countries where leprosy exists means of segregating the sufferers should be provided. (2) It is desirable that the children of lepers should be separated from their parents as soon as possible and kept under observation. (3) Those who have lived with lepers should be examined from time to time by practitioners having special knowledge of the subject. The last resolution was based on the possibility of the transmission of the disease by means of sucking insects.