of the bougie, and it will probably be found that the shadow is really not exactly in the line of the ureter, as can be shown by taking a skiagram with a fine metal stylet within the bougie.

In one of these cases there was very marked thickening of the ureter for an inch below the point at which the stone was impacted. This is rather remarkable. One would not be surprised at hypertrophy and dilatation of the tube above, together with a certain amount of inflammatory thickening at the seat of impaction; but why the ureter should be so thickened below does not seem clear. It is possible that at first the stone had a range of movement somewhat further down the ureter than was found at the operation, and that chronic inflammatory thickening set up by the irritation eventually narrowed the lumen both above and below, so as to fix the stone in the centre of the markedly indurated area.

I now propose to say a few words about the operative treatment of these cases. In all the cases the kidney was explored at the same time that the stone was removed from the ureter, in three cases by an incision through the cortex, and in one by sounding the interior through an opening in the ureter. It seems to me that this should always be done. If a stone has passed down into the ureter, it is quite likely there may be another in the kidney. So far as the symptoms can guide us, as I have already pointed out, we cannot say that they are due to stone in the kidney or ureter, and therefore it is as necessary to explore the kidney, even if the seat of pain is over the ureter, as it is to explore the ureter if the seat of pain is over the kidney. I think if a skiagram showed a stone in the ureter, and failed to show one in the kidney, it is very unlikely one would be found there, but I should explore.

My four cases seem to me to show that we cannot expect to be able to push the stone into the upper part of the ureter, though we should always try, and we must be prepared to cut down on it near the lower end of the ureter, where it is certainly very difficult to reach it, even though we carry our incision as far forwards as the outer border of the rectus. I think when the stone is very low down, near the bladder, the Trendelenburg position might help us, as it would be easier to draw the peritoneum aside if the pelvis were emptied of small intestine, but it would be difficult to turn a patient from the loin position which we employ for the renal part of the operation, into the Trendelenburg one in the middle of an operation, with aseptic towels covering the area of operation.

In three of the cases—in all in which I could—I sutured the ureter, using very fine catgut (as fine as fine silk, and kept in alcohol) for the mucous membrane, or, when it was not possible to define the mucous membrane, for the inner part of the tube, and very fine (intestinal) silk for the outer layer. It is interesting to note that in the one case in which I did not suture the ureter it healed at once, and urine ceased to flow through the drainage tube at the end of twenty-four hours. This is encouraging when we cannot suture the ureter, but the good result in this case should not make us abstain from suture when we can use it. It is most important not to contract the ureteral lumen when we suture. If there is a considerable risk of this—if we cannot see the interior of the ureter clearly—I think it would be better not to suture at all. We should pass a bougie down the ureter whilst we are inserting the stitches, and withdraw it before tying the upper one or two, so as to make sure we do not take up too much of the ureteral wall in the suture and in this way encroach on the lumen.

I think after these operations for removal of stone from the ureter, in which the stone is low down in the pelvis and a very long incision may be required, it is very necessary to suture the divided muscles very thoroughly, and with some substance which will last for at least a fortnight, and I always supply such patients with a well-fitting belt, which is likely to adequately support the long line of scar. Even with these precautions a hernia may form in the scar, as it did in one of my cases.

I have considered very carefully the best position for drainage in these cases. This is very important, as, even if the ureter is sutured, some urine may escape. I think the best position is on the side of the operation, with the pelvis tilted up on pillows. This will not suffice to drain the pelvic portion of the ureter, the true pelvis is such a deep cup-like space, the drainage tube dips over the pelvic

brim into it, and cannot drain it by gravity. But the pressure of the intraperitoneal contents will probably press any fluid in the true pelvis along the drainage tube, and the moderate tilting of the pelvis will help in its escape.

I do not propose in this lecture to discuss the question as to what route should be employed to reach the ureter. In three out of these four cases the stone, though found in the ureter, might, from the symptoms, have been in the kidney, and therefore the transperitoneal route could not have been considered. In the case in which we found evidence of ureteral stone by the skiagram the stone certainly might have been removed by the intraperitoneal route and with less difficulty; but although it has been shown by the published records of a few cases that the stone may be removed through the peritoneal cavity without any disaster, yet, I must say, without any special difficulty as to reaching the stone by an extraperitoneal method—whether the one I adopted or the sacral operation—I should hesitate to employ it, for it seems to me there must be some risk of infecting the peritoneum either at the time of operation or from leakage after. Because we safely evacuate offensive pus through the peritoneum seems to me no reason why we should deliberately cut into the ureter by this route. The pus is already there, and there is no other way of evacuating it. Even in cases in which we have to implant a ureter divided in some intra-abdominal operation into the bladder, we have no choice in the matter. If we had to plan such an implantation, we should, I think, prefer to do it, if it were possible, by an extraperitoneal route. Because the peritoneum is more tolerant than it was thought to be in the past, we must not be rash in exposing it to infection. We cannot be at all sure the urine which may escape when the ureter is incised, or leaks into the peritoneal cavity afterwards, is aseptic. With a block in the ureter it is very likely not to be so.

I have discussed this question of the advisability of operating by the intraperitoneal route because, although condemned by Sir Henry Morris and other surgeons, it has lately been advocated as the operation of choice.

An Address

ON

SOME IDIOPATHIC DISEASES OF THE SKIN WHICH MAY SIMULATE SYPHILIS.*

BY

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THE early syphilographers of the fifteenth and sixteenth centuries, when the great epidemic of syphilis spread over Europe, seem to have been well acquainted with the fact that the eruptions of that disease often resemble those of other maladies. Special attention was called to the matter by the Italian writers John of Vigo and Massa (1536), and again, two centuries later (1735), by Astruc. This tendency of syphilitic cutaneous manifestations to simulate idiopathic dermatoses has always been, and indeed still is, a source of some confusion—not infrequently, even at the present time, leading to error in diagnosis. Our great authority, Sir Jonathan Hutchinson, has observed that “there is in fact no single skin disease of constitutional origin which may not be imitated very closely by an eruption which is due to syphilis”; but, as he goes on to say, “the imitation is rarely absolutely correct . . . there is very frequently a mixing of the types of two or more in one.”

In point of fact, the practised eye, as Bateman long ago said, can usually recognize a difference between the ordinary diseases of the skin and syphilis; and by carefully noting the form, colour, situation, course, etc., of the eruption, the skilled observer will, in the large majority of instances, very soon feel sure whether he has to do with a case of syphilis or not; and he will often be able to form a definite opinion, even without reference to the other

* Delivered before the Ealing Division of the British Medical Association.

symptoms of the disease, and however much the patient may be ignorant of, or protest against, possible infection.

Cases, however, sometimes present themselves which, from an examination of the skin lesions alone, are not so readily placed in their proper position; and even with the help of all the objective and subjective information that we can get, the most experienced specialists are occasionally baffled, as the diverse opinions expressed about a case from time to time at the various dermatological or other medical societies will abundantly show. Doubt, in reference to the diagnosis of a case, is sometimes, indeed, quite excusable.

It is true that many cases simply, as it were, "shout" at you: the diagnosis can be made in a second: the form, colour, situation, etc., of the skin lesions may be so typical that your mind is made up at once. It is not always wise, however, to "rush" a diagnosis in this fashion, for upon going more thoroughly into the case, you may have to withdraw your hurried impression, even though at first sight there seemed to be no possibility of a second opinion. In considering, indeed, the true nature of a cutaneous affection—in determining whether it be really a syphilide—a great many points have generally to be investigated before coming to an absolutely sure conclusion.

I propose to refer to certain diseases of the skin which occasionally may give one the impression of being syphilitic, and to describe shortly a few cases in illustration, which have been under my care.

A great many other dermatoses—seborrhoeic eczema, lupus, leprosy, bromide eruptions, variola, and a host more—might be included in the list as being sometimes mistaken for syphilis; but I shall now only speak of certain cases of psoriasis, pityriasis rosea, impetigo, ecthyma, rodent ulcer, mycosis fungoides, pemphigus vegetans and dermatitis herpetiformis.

PSORIASIS.

As a student I was taught that when scaly patches occurred on the extensor surfaces of the limbs the affection was "simple psoriasis," and that when they occurred on the flexor surfaces, it was "syphilitic psoriasis"; but when I subsequently began the serious study of diseases of the skin I soon had to give up that idea. Although the term "syphilitic psoriasis" is still loosely used for the scaly macules and papules of the common early syphilitic exanthem, and also for the scaly syphilide of the palmar and plantar surfaces, in point of fact there are in my experience very few syphilitic cutaneous manifestations which are really closely like, or easily mistaken for true psoriasis. I admit that an error in diagnosis is excusable in certain cases of the palmar and plantar syphilide, and even occasionally in the case of a scaly nodular syphilide on the elbows and knees; but on the limbs and body I have seen comparatively few in which the similitude was so great as to lead to any doubt as to the diagnosis.

In recently looking over some notes of a series of 829 hospital cases of early and late syphilis at the West London and Blackfriars Hospitals, I have not found more than about half a dozen in which the eruption is described as essentially resembling true psoriasis.

One of the West London cases, a woman aged 33, exhibited psoriatic patches on the elbows and knees, and extensively on the backs of the hands. There were typical lesions of syphilis elsewhere, and under small doses of potassium iodide, the psoriatic, as well as the other manifestations, soon disappeared.

I have perhaps more frequently seen a psoriatic syphilide appearing late in life, especially on the legs, in patients who must have been syphilized many years previously. There are usually a very few large patches, of livid tint and serpiginous outline, and with less hypertrophy of the horny layers than in the true psoriasis. These cases, too, are more amenable to treatment with potassium iodide than true psoriasis.

PITYRIASIS ROSEA.

Although attention was called to this disease fifty years ago by Gilbert in Paris, it has only been recognized in this country since 1884, when Dr. Colcott Fox wrote a paper on the subject. Although not very common, it is sufficiently frequent to have been seen probably by every medical practitioner. In one of my statistical series at the Blackfriars Hospital it occurred twenty times in

2,175 skin cases, but I believe that I see a proportionately larger number at the West London Hospital, and still more, perhaps, in private. In my experience no idiopathic disease of the skin is more frequently mistaken for an early syphilitic rash. The slightly pigmented spots with fine or furfuraceous desquamation—often exhibiting a roseate bordering ring, rapidly making their appearance on the chest, neck, shoulders, trunk, and limbs, generally spreading from above downwards and sometimes accompanied with but little subjective sensations—are often at first sight very suggestive of syphilis in the early "secondary" stage. But there is no accompanying adenitis, and no throat trouble, or other signs of syphilis, although the patient may have been otherwise "out of sorts," or have had some digestive "upset." There is usually, too, a history of one large macule having made its appearance some considerable time before the outburst of the others. It is really of importance for a practitioner to recognize this affection, for if he mistakes it for syphilis disagreeable complications may ensue. The following case is, in this regard, instructive. A particular friend of mine in large practice in the West of London called me in consultation over the case of a lady in the theatrical profession whom he had been treating with mercury for a rash which certainly had a very strong resemblance to an early specific exanthem. The husband, who knew a little about medicine, discovered what his wife was taking for her eruption, and was greatly perturbed. It required considerable diplomacy on my part to calm down the indignant spouse, and convince him on the one hand that his wife had nothing very serious or anything infectious the matter with her, and at the same time to exonerate my friend the doctor.

IMPETIGO.

It may seem rather far-fetched to suggest that the common and well-known impetigo or impetiginous eczema could be easily confounded with syphilis, but I cannot forget a case which once took me in. A young woman came to the hospital with a rapidly developing and copious yellowish crusted eruption upon the scalp, ears, forehead, and neck, together with swollen glands about the neck, as was only to be expected. After a few days the usual treatment for impetigo had had no effect, the eruption had increased, one of the glands had become enormously enlarged, and there was a rise of temperature. She was so ill that I took her, as an in-patient, into the West London Hospital for operation. Until then I never suspected syphilis, but after a few days in the hospital a typical maculo-papular eruption made its appearance with other phenomena of syphilis. We could never get a definite history, but she had evidently acquired a big dose of the disease, for in spite of the usual treatment, gummatous and other late lesions were developed within a very few months.

ECTHYMA.

I have had several cases of a staphylococcal infection causing deep-seated inflammation and ulceration of the skin. These ulcers may be mere erosions, or they may be sharply cut and punched out, coalescing and spreading in a serpiginous manner. They are, indeed, extremely like syphilitic ulcers. A case of the kind is now attending my out-patient department at the West London Hospital—a little girl of 18 months with a number of punched out ulcers in both groins and about the vulva.

There is nearly always in these cases evidence of impetigo elsewhere, and another indication that they are not syphilitic is the fact that they readily heal up with antiseptic lotions and ammoniated mercury ointment, without further specific treatment.

RODENT ULCER.

The patient I show exhibits an ulceration on the cheek and lower eyelid which might easily, even at this stage, remind one of the specific ulceration. A few weeks ago the likeness was even stronger, for the ulcer was then deep and cavernous, and the edge at one side sharply cut and of irregular outline. It is now healing under the influence of radium, which is being kindly used for her by Dr. Mackenzie Davidson. When she first came to the West London Hospital in 1905 she had a typical rodent ulcer, which had been slowly developing for nine years. Under x rays it disappeared satisfactorily, but after an interval of some months it again made its appearance.

This time it did not respond to the rays, and zinc ionization likewise proved futile. It was obviously increasing, and it became so large that I suggested wide excision and a subsequent plastic operation, with Thiersch grafting. My late lamented colleague, Mr. Keetley, however, thought it advisable to make another endeavour at cure without the knife. The result is, on the whole, encouraging.

The slow development, the hard consistence of the edge, the sites of predilection, and the absence of other specific signs in a large majority of cases sharply differentiate a typical rodent ulcer from the syphilide; but occasionally, it must be admitted, when the ulceration is extensive, a mistake in diagnosis is possible. It must be remembered, too, that a rodent ulcer may, though rarely, be developed on the site of a syphilitic scar.

MYCOSIS FUNGOIDES.

The ulcerating, fungating lesions of this terrible malady may strongly resemble the gummatous ulcers of syphilis, and if the patient happens to give a history, or show signs of former venereal disease, the diagnosis is by no means easy. A case of the kind is now at the West London Hospital. The man presented himself in November last with an extensive pruritic, inflamed, and scaly eruption all over the head, body, and limbs, with several rupia-like lesions, and large ulcers on the back, abdomen, legs, and other parts, and a very large swelling in one groin. There were several scars, apparently syphilitic, on the legs, and he gave a history of having had a sore on the penis and subsequent symptoms some twenty-two years ago, and a wart on his penis seven years ago. At first we thought it was syphilis, and he was put upon specific treatment. I have since come to the conclusion that we have to do with a very severe case of mycosis fungoides.

PEMPHIGUS VEGETANS.

I am indebted to Dr. Timmins for having the opportunity of seeing and of treating this patient, who has kindly come here for you to see. The dried-up, darkly-crustated lesions which she exhibits on her shoulders and back, arms, abdomen and legs, are very different from what they were; but, even in their present state, a passing idea of specific disease might be possible. Her lips and the mucous membrane of the tongue, mouth, and pharynx, and even the larynx, were, some weeks ago, profoundly affected, and she was really in a very serious condition. The blebs of pemphigus which arose on the inflamed areas soon broke, and granulations were developed in their place. Under arsenic she has improved immensely, and she was able to leave the hospital as an in-patient some weeks ago. Microscopic examination and cultivations failed to show micro-organisms in her case, and the Wassermann reaction also proved negative.

DERMATITIS HERPETIFORMIS.

Cases of this disease occasionally call to mind syphilis; and in a patient with severe dermatitis herpetiformis who has been under my observation for some years, I am not at all sure that a syphilitic taint is not at the bottom of it. I think it is rather an example of a syphilitic affection simulating another disease than the converse; and perhaps it hardly comes under the same category with the others to which I have alluded. The patient, a woman aged 30, was admitted to the West London Hospital in June, 1900, with a severe and extensive pustular eruption particularly well developed about the groins, inner part of the thighs, pubis and lower part of the abdomen, and in a less marked form in the right axilla, left side of neck, and the trunk generally. The pustules seemed to arise as small papules, soon becoming vesicular and then pustular, upon a red base. They rapidly became confluent and were very pruritic. From the fact that she had recently had an infant, and from the impetiginous appearance of the eruption in the neighbourhood of the groins and pubis, I was at first inclined to regard it as a case of the rare impetigo gestationis. She left the hospital in about five weeks, somewhat improved, and went to the infirmary for a few weeks. She got quite well and remained so for three years, when she again presented herself at the West London Hospital, with a still more extensive, but more bullous, eruption, which benefited little under treatment, and she left the hospital in about two months. It appears from her statement that the affection then left

her for a considerable time, but reappeared badly in 1905, and she had to go several times into the infirmary. In March, 1908, until May she was in St. George's Hospital, and afterwards again in the infirmary and at a convalescent home. She came a third time to the West London Hospital in December, 1908, and I kept her in until August, 1909. The condition now was more typical of dermatitis herpetiformis; there was marked eosinophilia, and cultures showed pure staphylococci. From time to time she had been treated with mercury, iodide, thyroid, tonics, arsenic, soamin injections, and staphylococcal and polyvalent serums, which certainly did some good. Since leaving the hospital she went again to the infirmary, where I am told she was treated with mercury, and I hear that she is now free from the eruption.

While she was under my care last year I had an opportunity of seeing her little girl, aged 9, who was born just before her first attack. The child is a typical congenital syphilitic, with well marked Hutchinsonian teeth and interstitial keratitis. The patient had also had a miscarriage some time before her complaint made its appearance. I regret that the "Wassermann reaction" was not tried in her case, nor any attempt to find the spirochaete. With the assistance of these measures the diagnosis would no doubt be cleared in such a case as this and in other puzzling ones of the kind.

In my opinion, no more important and useful advance in scientific medicine in recent times has been made than the serum reaction for syphilis. Unfortunately it is a process which takes time, and can only be carried out in a pathological laboratory by an expert. The same may be said of the recognition of the *Spirochaeta pallida*, which we are all now agreed is the pathogenic organism of syphilis.

RUPTURE OF THE BLADDER FOLLOWED BY GANGRENE OF THE BLADDER WALLS.

By P. CLENNELL FENWICK, M.D.,
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THE following case is, I think, interesting as a proof of the resistant power of the peritoneum and from the fact that the patient lived so long—thirty-three days—after such a severe accident.

On April 17th, 1909, a man aged 39 was run over by a light cart when intoxicated. He was assisted to his home and sent for a doctor, who passed a catheter and drew off a large quantity of clear urine. The patient complained of his back and legs, but had no other symptoms. Next morning the catheter withdrew bloody urine, and he was sent into hospital.

On admission the temperature was 99.2° F., pulse 80, and the patient then localized his pain in the right hip and right leg. A catheter was passed with some difficulty, and bloody urine was withdrawn. He remained in hospital thirty-six hours, during which time the catheter was passed at intervals, the urine being always bloody. He then entered a private hospital.

On April 26th—eight days after the accident—he was seen by Dr. Brittin. He was passing exceedingly foul urine. Dr. Brittin advised immediate operation, as the diagnosis of fracture of the pelvis and urinary extravasation was clear.

On May 2nd—fifteen days after the accident—I saw the case in consultation. The temperature was 102° F., pulse 120; the face was sunken and anxious; the abdomen presented the exact appearance of a five months pregnancy, a firm ovoid mass rising from the pelvis as high as the umbilicus. The mass was dull on percussion, tender, and very well defined. The abdomen above this was soft and resonant and quite painless. Jarring of the right foot caused great pain, which was referred to the right hip and right groin. I washed out the bladder after withdrawing a quantity of extraordinarily foul urine loaded with pus. We advised operation, but this was refused.

The patient's condition became worse, and on May 7th a fluctuating mass appeared in each groin, and he consented to operation. I opened the mass in the right groin and liberated several pints of fetid pus. On passing the finger down into the cavity I felt the horizontal ramus of the pubis fractured and projected nearly at right angles into the cavity. On incising the left side a very large quantity of pus escaped, and the finger passed into a large cavity, of which the boundaries appeared to be the pelvic bones.

The temperature fell to normal, and the patient's condition improved, but he passed all the urine through the left wound; only twice were a few drops of pus and blood passed by the urethra. He died on May 20th.

A post-mortem examination was made a few hours after death by Dr. Inglis and myself. The right kidney was exposed by the usual oblique incision, and was quite normal. On making the similar incision on the left side a large abscess cavity was found