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

occupying the renal area; no trace of the kidney or ureter could be found, but a large track led from this cavity downwards into the pelvis.

On opening the abdomen a remarkable appearance was presented; the peritoneal cavity was quite normal, the peritoneum being glistening and unchanged. Between the abdominal cavity and the pelvis a thick roof of peritoneum, shiny on its upper and black on its under surface, was seen. This was the peritoneal covering of the bladder stripped upwards. The pelvis was occupied by several pints of fetid pus. No trace of the bladder could be discovered—merely a black-walled cavity bounded by the pelvic bones remaining. The urethra opened directly into this cavity. The rectum could be seen apparently uninjured. The horizontal ramus of the pubis on the right side was fractured about its middle, the ununited ends projecting into the cavity. The left ureter and kidney could not be found, but in their place an abscess cavity with black walls, and a long track joining the two cavities.

I found two handfuls of blackened slough lying at the bottom of the pelvic cavity, apparently the remnants of the bladder walls. The inflammation, after destroying the bladder, had tracked up the left ureter and destroyed the left kidney.

ON DOUBLE LOOP HERNIA (W HERNIA). WITH REPORT OF A CASE.

BY

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WHILE a case of strangulated umbilical hernia containing two loops of bowel was reported by Benno Schmidt in 1880, the credit belongs to Lauenstein, of Hamburg, of drawing general attention to the subject of double loop herniae by reporting a case of strangulated inguinal hernia containing two loops in 1894,¹ of reporting a first series of cases in 1905,² and a further series in 1909,³ while he has also performed many experiments on animals with a view to elucidating some of the difficulties met with in explaining the formation of such herniae.

Although during the last few years a number of such W herniae cases have been reported (over 30 in all), the condition is not apparently a common one, even when allowance is made for some cases which, as I am aware, have occurred, but have not been published. So far as I have been able to ascertain, all the cases reported have occurred in the inguinal region, with the exception of the umbilical case already referred to and 5 cases which occurred in the right crural region, and, further, both loops of bowel have always been strangulated. The case which came under my care, on the other hand, was one of left femoral hernia and only one loop was strangulated, and both on account of the rarity of the condition and the possibility of its peculiarities throwing light upon some of the theories regarding the formation of such herniae, I consider it worthy of record.

D. B., a man aged 66, a miner, was admitted to the Royal Infirmary, Glasgow, under my care, when acting for Mr. Paterson, on December 14th. The patient was suffering from symptoms which pointed to intestinal obstruction. Five days prior to admission the patient had a sudden attack of pain, which he referred to the umbilicus and which lasted for several hours, and on the day following he had a similar attack. During the next three days, and prior to admission, the pain was almost constant and severe. The bowels moved fairly well with enemata, but no flatus was passed, while he suffered from severe eructations of wind from the stomach. The bowels again moved at 4 a.m. on the day of admission, but still no flatus was passed, and he became sick and vomited faecal matter.

Condition on Admission.

The patient was in a generally unsatisfactory condition and distinctly shaky; the pulse was 100 and the temperature normal. The abdomen presented no distension, rigidity, or tenderness. A large tumour, however, about the size of an ostrich egg, was found projecting from the left groin, and extending from the pubes to within an inch of the anterior superior iliac spine. He seemed to attach little importance to this swelling, and did not refer his present condition to it. When questioned regarding it, he said that the tumour had been present for a very long time, probably from childhood, and that, while it had been slowly increasing in size for some years, it had become markedly larger during the last few months. The tumour was hard to the touch, immovable, not tender, and gave no impulse on coughing. It became, therefore, a question whether this tumour was a very large femoral hernia, containing strangulated bowel, or whether it was, as the history seemed to suggest, a tumour which might or might not

be connected with the symptoms of strangulation. As the tumour mass was slightly tympanitic at one point, hernia appeared the more probable diagnosis, and it was decided to operate.

Operation.

A vertical incision was made over the mass through the skin and cellular tissue, exposing first one and then within it a second glistening sac. These sacs were perfectly free from one another, and, when the second was opened, a quantity of dark, blood-stained fluid poured out, while a dark solid mass presented, which still suggested the possibility of tumour. On opening up the sacs more widely, however, a loop of dark, bluish-purple, congested, and considerably distended small bowel about 1 ft. in length was exposed, and easily brought out through the wound. The portions of this strangulated loop which had been opposite the neck of the sac, together with a short portion above the constriction on either side, were found not to have suffered greatly from pressure, and then the loop, which apparently consisted of ileum, was with little difficulty returned to the abdomen. The remaining mass was still very large, and, on careful unravelling, was found to consist of two distinct portions. First, there was a large coiled mass of congested livery omentum, which, when ultimately disentangled and spread out, was found to be some 10 in. long, 6 in. broad, and fully $\frac{1}{2}$ in. thick. When in position it practically enveloped the second portion of the remaining mass, and to a less extent concealed the loop of bowel already referred to. The neck of this mass was both thin and narrow, rendering its ligature and removal very easy. Probably the size and thickness of the omental mass is accounted for by long presence in the hernial sac, with slight constant pressure at the neck causing venous congestion, and hence hypertrophy, just as is seen in the case of the mesentery of a herniated appendix of some standing.

The second portion of the mass now remained alone in the large cavity, and on introducing the finger and hooking it forward, it was seen to consist of bowel, into which the finger appeared at first sight to have penetrated. On closer inspection, however, it was found that the finger had gone into a little pocket and not into the lumen, and that the mass which now presented, and which was of the size of a large orange, was composed of bowel. The pocket into which the finger had gone was one of many with which the surface was covered, and which apparently represented positions where the original coils of which the mass was composed had not fused as they had done elsewhere. Save for these pockets, the surface was smooth and glistening, as in normal bowel, but here and there, particularly in the neighbourhood of the pockets, traces could be made out of fibrous adhesions running from one loop to another (see diagram).

Diagram of the bowel mass which had been long present in the hernial sac, was covered by omentum, and was not strangulated.

An attempt was made to determine the portion of intestine to which this mass belonged, but proved abortive, as neither limb of the loop could be drawn through the ring sufficiently for careful inspection. Both limbs were composed of perfectly healthy but thick-walled bowel, and it was thought that an imperfect longitudinal band could be recognized running along the front of the anterior limb into the bowel mass, but the point could not be definitely decided.

As this mass was perfectly normal in colour and there was no constriction whatever at its neck, the intestinal obstruction was obviously entirely due to the first, strangulated, loop, and as the patient had never experienced trouble from the condition, it was determined to try to reduce it in mass. This proved a comparatively easy proceeding, owing to the very large size of the crural opening, which extended out from Gimbernat's ligament, over the femoral vessels, for a distance of fully $2\frac{1}{2}$ in. The peritoneal sac was next freed from adhesions to within the crural ring, threaded in the ordinary manner, and drawn up behind Poupart's ligament, while the large outer sac, composed presumably of transversalis and iliac fasciae of the crural canal, but enormously enlarged and thickened, was similarly coiled and drawn up in front of the opening beneath Poupart's ligament. The wound was then stitched up.