smooth and pliable by Rankin and Mackay, while Poynton says it is usually soft and natural to the touch although it may be redundant over the extremities. In my case the skin of the trunk and head was normal, but over the limbs, especially at the wrists and ankles, it was unusually soft and doughy to the touch, and the same feature characterized the hands of her two relatives.

The pelvis of my patient was contracted, the conjugate diameter at the brim was estimated by external examination at 6.5 cm., and there was a sharp angle between the lumbar and sacral vertebra which gave at first the impression that one had to deal with a spondylolisthetic pelvis, but this I do not think was the case. The uterus was situated in the right half of the pelvis. Presumably the pelvis of her sister was similarly contracted, as she had undergone Caesarean section.

Lordosis is described as one of the characteristics of achondroplasia; this is probably only apparent, the acetabula being displaced backwards from shortening of the ilio-pectineal lines, so that the femora are attached in a plane posterior to that of the normal individual (Poynton). My observation certainly accords with this view of the matter.

REFERENCES.

¹ Clifford Allbutt's *System of Medicine*, vol. iii. ²G. Rankin and E. C. Mackay, *BRITISH MEDICAL JOURNAL*, June 30th, 1906. ³Ibid. ⁴*Encycl. and Dict. of Med. and Surg.*, J. Thomson, article Achondroplasia.

A CASE OF GENERAL SUPPURATIVE PERITONITIS: RECOVERY.

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The infrequency of recovery from general suppurative peritonitis prompts me to record this case.

Ethel H., aged 8 years, was admitted into the Tolworth Isolation Hospital on November 9th, 1909, on suspicion of suffering from enteric fever.

She was rather a frail little girl, and looked ill; the cheeks were flushed, the orbits sunken, and the lips dry and scaly. Temperature, 100.8°; pulse, 128; respirations, 36. The tongue was furred; the fauces were noted as normal. The abdomen was somewhat distended, and did not move freely with respiration; there was considerable resistance on palpation all over the abdomen, and some complaint of tenderness on the right side, though not directly over the iliac fossa. The spleen was not palpable, and no "spots" were present. Rectal examination revealed no swelling or distension. The heart and lungs were normal. The urine was acid, clear, specific gravity 1024, and free from albumen and sugar.

During the next ten days there was continued fever, with persistence of the abdominal signs; vomiting occurred once on the day following her admission, and once again on November 15th. Some indefinite pulmonary signs in the form of coarse râles and rhonchi, suggestive of enteric bronchitis, also developed, and on the fourth day after her admission a general scarlatiniform rash was noted, though unaccompanied by any other signs of scarlet fever.

On November 21st there were signs of free fluid in the peritoneal cavity, and on November 27th, as this had increased very considerably, a Southey's tube was passed into the abdomen with a view of relieving what was thought to be an ascitic collection. Instead of serous fluid, however, pus welled out from the tube.

On the following day, under an anaesthetic, the abdomen was opened over the right iliac fossa, and several pints of thick creamy pus were evacuated. The peritoneal cavity was then flushed with a large quantity of sterile normal saline solution at 105° F., the rubber flushing tube being freely passed from the diaphragm to the pelvis and from one loin to the other. This huge collection of pus had in fact occupied the entire peritoneal cavity in exactly the same manner as ascitic fluid. Both visceral and parietal layers of peritoneum were represented by continuous sheets of pyogenic membrane, so that the individual coils of intestine were not visible nor consequently was the appendix. Two large drainage tubes were inserted. I regret that I did not on this occasion collect a specimen of the pus, which was thick, creamy white, and inodorous, for bacteriological examination. A specimen taken subsequently from the discharging wound, however, showed the presence of pneumococcus.

From this date the child gradually improved. One incident remains to be recorded. On January 4th, when all seemed to be going on well, she had an attack of haematuria, and the daily excretion of urine was much diminished. This was not accompanied by any other appearance of illness either objective or subjective; there was no elevation of temperature or alteration of pulse, and by January 15th no blood or albumen could be detected, and the kidneys were acting well.

On January 20th the wound was closed, and on January 31st the child was discharged from the hospital.

I would call attention to three points of interest in this case.

First, as to the diagnosis: This seemed at first to lie between enteric fever and appendicitis. The general appearance of the child suggested enteric; the abdominal signs were consistent with that view, and the advent of bronchitis supported it; moreover, the child did not become worse. On the other hand, the abdominal signs were the predominant feature of the attack, and the immobility of the abdomen was greater than is usually seen in enteric fever; moreover, there was no enlargement of spleen and no "spots"; the first Widal reaction was negative, but that was on the seventh day of illness and too early to be conclusive; when the second Widal was also negative signs of fluid had already appeared in the abdomen. At this stage tuberculous peritonitis seemed to be the diagnosis. It was only when the Southey's tube revealed the presence of pus that the diagnosis of general suppurative peritonitis was established.

The second great point of interest is that a general suppurative peritonitis should recover at all, especially at so late a stage, and this in itself suggested a pneumococcal infection, which was found to be the case.

Thirdly, a puzzling feature was the rash which appeared four days after the child's admission. This rash had the exact distribution and character of a scarlet fever exanthem, but there were no confirmatory signs in tongue or throat, nor was there any desquamation more than the powdery state of the skin so often present in patients who have been some time in bed. I looked upon the rash as a septic one. The occurrence of haematuria, however, during convalescence, which I could not otherwise account for, and which in its abrupt onset, its mild course, and rapid termination was so suggestive of a slight scarlatinal nephritis, again raised the possibility of that explanation of it. If this was so, the child had scarlet fever concurrently with her peritonitis.

Memoranda:

MEDICAL. SURGICAL. OBSTETRICAL.

CARCINOMA OF THE MALE BREAST.

IN connexion with Dr. Bingham's case of carcinoma in the male breast (February 19th, 1910), I think it may be of interest to record the fact that I have seen two such cases during the present year. Both were natives of Travancore, S. India. One of the cases, which presented all the naked-eye appearances of scirrhous of the breast, did not submit to operation, and I have, temporarily at any rate, lost sight of him.

The other I operated upon. He was a native, aged 65, and said that he had first noticed a small lump near the left nipple four years ago. This gradually increased in size until about a year ago, when he received an injury to the growth. Soon afterwards the skin over the tumour began to give way, and on admission to hospital there was a typical cancerous ulcer (about 3½ in. long by 1½ in. broad) with very hard raised edges (as shown in photograph).

The usual radical operation of removing pectorals and fascia and clearing out the axilla was performed. Some of the glands in the latter region were very hard, though