respects. For the first fortnight the mother's breast was the sole nourishment. About this time, according to the mother he began to vomit, and thereafter he steadily lost ground. The vomitings were small in quantity and occurred shortly after the nursings. Thinking that the breast was not agreeing with him, it was abandoned, and a mixture of condensed milk and water substituted. This change was given a trial for a fortnight, and no benefit or progress being apparent, I was asked to see the child in consultation with the family physician, Dr. Dempsey. I visited the infant on August 29th, 1903, on which date he was four weeks old. The child was fairly nourished, but the mother said he was not as weighty as when he was born. The bowels acted about twice daily, and the motions were small, not constipated, and contained some curds. There was a rather copious eruption of thrush over the tongue and cheeks. No dilatation of the stomach was noted at this visit. A whey and cream mixture was recommended, and a powder consisting of hyd. c. cret. gr. $\frac{1}{2}$, and salol gr. j. was ordered to be given each night and morning. I was asked to see the baby again on September 20th. For a fortnight the whey and cream mixture agreed well and was retained better than anything previously tried. After this the child became much worse and the symptoms assumed a more definite character. The intervals between the vomitings became much longer and the quantities brought up much larger, indeed the description of the mother at this visit was most graphic as well as very suggestive, namely, "that the child drank well all day and threw it all off at night." Dr. Dempsey, who had seen the child at frequent intervals, was now of opinion that some obstruction existed to the onward passage of the food. On examination I found the child greatly wasted. The stomach was now much dilated and extended downwards to the umbilicus.

Peristaltic waves crossed the abdomen from left to right at short intervals. The pylorus was not palpable. The temperature was 97.4° F. in the rectum; the pulse was 130 and feeble. The motions were small in quantity, dark in colour, not constipated and were curdy-looking; two or three of these small motions were passed daily, but occasionally a day passed without any action of the bowels. The urine was very scanty and stained the diapers a brick-red colour. Stenosis of the pylorus was diagnosed, and operative measures recommended, but the parents were unwilling to consent to this. A nurse from the Children's Hospital was obtained, and under her skilled attention matters improved considerably, and the child gained one pound in weight. Eventually, however, the obstruction became more complete, and the operation of pyloroplasty was undertaken by Mr. Campbell under anything but encouraging conditions.

DESCRIPTION OF OPERATION BY MR. CAMPBELL.

As the child was in an extremely weak and emaciated condition, it was evident that no prolonged operation for the relief of the obstruction could be borne. I consequently determined to perform pyloroplasty, because I considered that it would relieve the obstruction more satisfactorily than dilatation, and would not be attended with the same immediate risks as gastro-enterostomy. When the abdomen was opened, a tumour the size of a walnut was at once seen at the gastro-duodenal junction, and the stomach was found to be greatly dilated and to have an abnormally thick wall. When the longitudinal incision was made through the pylorus, the mucous membrane was found to be loose and redundant, a very well-marked longitudinal fold being seen on the posterior wall. The incision was quickly closed transversely by three Halsted sutures covered by a continuous Lembert suture. The child bore the operation fairly well, but the vomiting continued as before, and it was noticed by the Sister in charge of the case that the vomiting was more frequent when the child was nursed on the right side. In the account of two other cases published by Mr. Clinton Dent, I had been struck by the fact that the vomiting only gradually ceased, and I came to the conclusion that this was probably due to the redundant mucous membrane. To obviate this I had determined to insert a bone hobbin to keep the canal patent, but was unfortunately unable to obtain one small enough. The vomiting continuing, the child gradually became weaker and died on the sixth day. At the necropsy the line of suture was found perfectly intact, and so covered in as to be only visible on close inspection. The peritoneum was quite normal. When the stomach was opened I found that the pylorus readily admitted a cedar pencil, but when the stomach was filled with water under the tap not a drop passed into the duodenum. This was found to be due to the redundant mucous membrane at the pyloric orifice falling together in folds and blocking the canal. The transverse suturing had also produced a slight bend in the canal, which possibly facilitated the obstruction by the mucous membrane.

The small intestine was so small and collapsed that its lumen was almost obliterated. It would therefore have been absolutely impossible to have performed a satisfactory gastro-enterostomy, which in such cases has been attended by a prohibitive mortality. Dilatation also appears to be accompanied by considerable risk from laceration of the bowel. Notwithstanding the unfavourable termination of this case, I should be inclined to try pyloroplasty again, endeavouring to obviate the danger of blocking by free resection of the redundant mucous membrane and the insertion of a small bone hobbin.

DONATIONS TO HOSPITAL.—The Tunbridge Wells Hospital has received donations of £1,000 each from Miss Stanley Puckle and Mr. Stanley Puckle, of Tunbridge Wells.

ACUTE DERMATITIS PRODUCED BY SATIN-WOOD IRRITATION.

By H. E. JONES, M.B., C.M. GLASG.,
Ibros.

IN 1898 an outbreak of acute dermatitis occurred amongst a number of joiners and cabinet makers employed in the joiner's shop of a Govan shipbuilding yard. At that time I saw several of the patients and made a careful study of the cases.

The first of the patients who consulted me at that time was a cabinet maker about 35 years of age. He called to see me regarding the condition of his face and neck, hands and wrists, which were all in a state of acute inflammation and much resembled that of erysipelas, so much so that I called the following day at his house to satisfy myself on that point. His face, neck, and ears were very red and swollen; his eyes were almost closed, his skin was hot, yet he was not fevered. He had no pain and no sickness. He said that for five weeks his skin had been, on and off, in a condition such as when I saw him, and in consequence he had to cease working from time to time. He had on several occasions during that period been well or almost so, but whenever he commenced his work the inflammation almost immediately reappeared in all the exposed parts—face, neck, ears, hands, and wrists, and soon again compelled him to leave off work. The inflamed area became moist, and this was followed by desquamation.

He told me that several of his fellow-workers were similarly affected. I saw a number of them and found exactly the same state of matters. In each case improvement followed cessation from work, and in each case the illness reappeared when work was resumed.

The history of the illness was sufficient to satisfy me that the cause was some irritant in the dust arising from foreign wood with which the men were working at the time—East Indian satin wood.

I consulted an eminent professor interested in diseases of the skin, and he corroborated my previously-expressed opinion that the cause was due to something connected with the wood, and suggested that the men should paint the exposed parts with a preparation of gelatine. Some of the men preferred going idle; one or two went to work elsewhere and got along without any further trouble.

Within the last few weeks another outbreak, almost identical with the foregoing, has come under my notice. It occurred in another Govan joiner's shop where five of the men working with satin wood have been affected. Three of these have had to cease work; the other two, not being so bad, are still at business.

As in the first outbreak, so with this, the exposed parts are those affected. The men state that they first experience a feeling of irritation on the skin, that later on the parts become hot and red, and subsequently become swollen and uncomfortable, and although not painful, sufficient to keep them off their sleep. This is followed by moisture and complete desquamation of the skin over the affected parts.

The first attack is rather slow in its onset, but relapses come on with great rapidity.

One of the men, a joiner of about 40 years of age, tells me that he was handling satin wood for about six weeks before he had to discontinue his work. Having remained off work for some time he made a fair recovery and again made a start, but was only able to remain at work for three days. He kept off work for eleven days more, and then made another attempt, but was only able to continue on duty for two days. After another interval of ten days' idleness he again resumed his work, but had to discontinue in two days. For ten days more he went about idle, then entered the shop once more, but had to cease work after three and a-half days. Since then he has remained idle.

Another joiner, 50 years of age, stated that he commenced to feel uncomfortable one month ago, but was able to continue at work for two weeks; after remaining off duty for nine days he made a start, but was compelled to cease in seven hours, and has not since tried to resume his work.

Assuming that the satin-wood dust be the cause of the dermatitis, the question may be asked: Why are not all the men who work with it similarly affected? My answer is, that some skins are more easily irritated than others, and that probably those affected were of that type. This is practically borne out by the fact that three of the sufferers who came under my notice showed slight traces of eczema.

The speedy recurrence of subsequent attacks is accounted for by the fact that the skin having desquamated, the new skin would be more easily irritated than its predecessor. And as this occurred again and again the parts would be more easily irritated with each subsequent attack.

As regards treatment, it has been suggested that the men should remain off duty till the epidermis is fairly strong, and that then vaseline or some oily substance should be smeared over hands and face, and allowed to remain there while the men were at work in the joiner's shop.

As an alternative, the men might seek a job in the open air or else in another establishment.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

INTRAUTERINE INFECTION OF THE FETUS IN SMALL-POX.

It is stated that children born of mothers suffering from small-pox usually show signs of the disease at birth or so soon after birth as to warrant the conclusion that they received the infection while still *in utero*. Of the former none have come under our observation; of the latter we have seen the following three cases:

No. 1.—The child was born on December 24th (evening), 1902, and the eruption of small-pox appeared on the morning of January 3rd, 1903. The attack was confluent, and the child died on January 13th. It was unvaccinated. The mother had an overlooked attack of small-pox, having sickened on December 20th, and the eruption having appeared on December 24th.

No. 2.—The child was born on June 26th, 1903, and was vaccinated the same day. The mother had sickened with a discrete attack of small-pox on June 25th, date of rash being June 26th. The child's vaccination took well, but on July 3rd the rash of severe discrete small-pox appeared, and the child died on July 15th.

No. 3.—The child was born on April 14th, 1904. The mother sickened on April 12th and died on April 16th, the dark purpuric rash of *purpura variolosa* having appeared on April 14th. The child was vaccinated on April 16th, but although this was successful the rash of discrete small-pox appeared on April 21st.

Taking the interval between infection and the appearance of the rash as the usual one of fourteen days, it follows that in the first case the child must have been infected on or about the date of onset of the mother's illness and three or four days before birth; in the second case six days before the onset in the mother and seven days before birth; and in the third case five days before the mother sickened and seven days before birth. These children were all born about full time.

Two other cases are of interest in this connexion. One was that of a woman in the seventh month of pregnancy who developed a discrete attack of small-pox. She was discharged from hospital about a month after admission. The child was born about a month after discharge, and showed no signs of having had small-pox, and in addition it was successfully vaccinated. Thus there was no immunity conferred on the child by the mother's attack. The other, a 5-months fetus born in the fourth week of the mother's illness, showed no signs of small-pox.

The five cases mentioned above include all the cases of which we know, in which variola attacked pregnant females. They seem to bear out McCombie's statement that the liability of the fetus to small-pox appears to increase directly with its age.

JAMES M. COWIE, M.D., D.P.H.,

DUNCAN FORBES, M.D., B.Sc.,

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EMPHYSEMA IN A CHILD.

On February 2nd, 1904, I was called to see D. E. F., a child aged 1 year 10 months, which had been ill for three days with sickness, rapid breathing, and occasional cough.

No food had been retained, but the bowels had acted once or twice since the commencement of vomiting, and the stools were normal. The first glance at the patient gave the impression that she was suffering from pneumonia with a failing heart, and death appeared to be imminent. Temperature was subnormal; respirations about 40 per minute; the pulse 160 per minute; there was little or no movement of the ribs, though the diaphragm was moving freely, and there was marked epigastric pulsation. The face and lips were pale and cyanosed, the expression anxious, and the eyes dim. On examining the chest I found to my surprise that the lungs were everywhere fully resonant, and the cardiac dullness imperceptible over the ordinary area. Some fine

crepitations could be heard at the bases of the lungs, but no rhonchi. Strychnine gr. $\frac{1}{16}$, with $\frac{1}{15}$ of brandy was at once injected hypodermically, and the child rallied somewhat, the pulse becoming fuller, while the pallor gave place to a cyanotic flush. Thinking there might be some bronchial obstruction, I then gave two teaspoonfuls of ipecacuanha wine and placed a mustard poultice over the cardiac area with a view to relieving pressure within the right ventricle. The child then coughed and vomited freely, but the respirations did not change in rate or character. The temperature was subnormal. The following treatment was ordered: Peptonized milk 1 oz. with brandy 1 drachm by rectum every two hours, and one teaspoonful of peptonized milk by the mouth every quarter of an hour unless the child slept. On the following day the condition appeared somewhat better; the pulse had improved, being only 140 per minute, but respiration continued as before and the physical signs were unchanged. The child had spoken one or twice, and nearly all the food had been retained, while she had slept a little at intervals. Food was now given more freely by the mouth, and the rectal feeding was ordered at four-hour intervals.

Necropsy.—On the following morning, February 4th, at about 7 a.m., the child died, and in the afternoon of the same day a necropsy was made. On removing the sternum the lungs bulged forward and were seen to be pale and typically emphysematous in appearance, a lobule of the left lung overlapping the upper part of the pericardium. Further examination showed that the emphysema involved the whole of both lungs except for a few patches of collapse. On pressure with the hand they were found to be soft, non-elastic, and slightly crepitant. There was no marked oedema at the bases, nor was there any pleuritic or pericardial effusion. The bronchi contained a little muco-purulent material, but there was no sign of tracheal obstruction, nor were the bronchial glands enlarged. The right auricle was distended and contained *ante-mortem* clot, but the ventricle was contracted and empty. The heart in all other respects appeared to be quite normal.

REMARKS.—So far as could be ascertained the sole cause of death appeared to be the extreme condition of emphysema from which the child was suffering, rendering impossible, as it did, any effective interchange of air in the pulmonary alveoli. There was no subcutaneous emphysema. I had attended the child on two previous occasions when it was suffering from bronchitis with blocked bronchial tubes, and on each occasion an emetic of vin. ipecac. had relieved the symptoms immediately, while during the interval the child had seemed strong and healthy. I have ventured to report this case, as it seemed a very uncommon one, and I do not remember seeing or reading of any other exactly similar. What should have caused so extreme a degree of emphysema is difficult to conjecture. The elasticity of the pulmonary tissue must doubtless have been below normal, but it can scarcely be supposed that the degree of dilatation found at death had existed for more than a few days. Idiopathic emphysema is a strange term, but there is certainly a temptation to apply it in this case.

Felixstowe.

G. J. CONFORD, B.A., M.D., B.Ch.Oxon.

ECTOPIC GESTATION: EARLY DIAGNOSIS: OPERATION: RECOVERY.

Mrs. A., aged 23, married early in August, 1903, was quite regular up to the middle of September. About the middle of October, at the usual time, she was unwell, but only for one day. I saw her first on October 30th, when she complained of flatulence and other symptoms of dyspepsia. On November 8th I was called to see her, because, while taking supper, she was seized with a sharp pain in the lower abdomen, and felt rather faint. I saw her half an hour after this; she was not faint at that time, but complained of a good deal of pain. The next day she said that she was unwell and had passed several clots of blood. I examined all that had passed, but could find nothing particular. I also made an examination of the patient, but as she was very sensitive I could not make out anything unusual—in fact, I could only just reach the os. She continued to pass blood for about five days. At the end of ten days she got up, feeling quite well.

On November 25th, that is to say, seventeen days after her first attack of pain, I was sent for to see her as she, whilst walking quietly with a friend, got a very sharp pain in the lower part of the belly and felt and looked very faint, and had to be driven home (less than half-a-mile). I arrived at the house before she did. On arrival she had quite got over the faintness, complained of pain, not acute, in the belly, and was able to walk upstairs and get into bed unaided. I examined her but could detect nothing, but urged that she should be examined under an anaesthetic.

The next day, November 26th, Dr. F. Carey having got her under chloroform, I was able to make a careful and thorough examination. The os was rather high up and the uterus pushed rather to the right side. A small round tumour about the size of a large walnut was felt to the left of the uterus, and quite distinct from it; it was quite movable. I diagnosed