After microscopical examination it was considered to be a retroperitoneal pelvic multilocular cystoma, quite unconnected with the uterus, ovaries, or tubes, the cysts being lined with a single layer of cylindrical epithelium, with isolated muscle fibres and glands occurring in the wall, such as might arise from remains of the Wolffian body.

Cystoma (Papilliferous) (Winternitz⁵).

Winternitz removed a retroperitoneal pelvic growth, which proved to be a papillary cystoma, presenting the appearance of an ovarian cyst, although no ova or follicles could be found in its walls. He considered it as originating from some aberrant cells or ova, as there was no reason to infer the presence of a third ovary.

Sarcoma (Winternitz⁵).

Winternitz also mentions a retroperitoneal pelvic tumour which he removed, which was sarcomatous in nature. It recurred shortly after.

Of these cases, one could be definitely assigned to a bony origin, and another was considered as arising from aberrant glandular cells. The remainder, including the present case, were sarcomatous in character. They all contained a considerable amount of fibrous tissue, and were more or less encapsulated. None of them, so far as can be ascertained, were metastatic at the time of operation or death, although metastases occur in about 33 per cent. of retroperitoneal tumours as a whole. The case we now report differs from those previously recorded in its tendency to haemorrhages and in its location in a region which did not easily permit pressure on and subsequent distension of the urinary tract.

PROGNOSIS AND TREATMENT.

Judging from retroperitoneal sarcomata as a whole, the prognosis is unfavourable; but Williams, in the *American Journal of Medical Science* for 1903, collecting the results of operation on these tumours, mentions that Burgoin of Paris had 14 recoveries in 29 cases of extirpation of solid retroperitoneal tumours, 4 of which were sarcoma, 2 of these being among the recoveries; that McCann successfully removed a retroperitoneal sarcoma with several inches of gut; and that Heurteaux of Wartes successfully operated on a man of 60. Other so-called successful cases are reported, but the period of immunity from recurrence is not mentioned. Death usually occurs from exhaustion unless the tumour is surgically treated. In 3 cases intraperitoneal haemorrhage was the cause of death. The presence of a capsule in these growths suggests that, were it possible to accurately and early diagnose the existence of a tumour mass in the retrovaginal tissues, its removal via the perineum offers considerable chances of success. An attempt at extirpation is therefore certainly justifiable.

ETIOLOGY.

Retroperitoneal sarcoma may arise from lymph glands—perhaps their most common origin—and from the periosteum of the vertebral and pelvic bones. A certain proportion originate from normal or inflammatory connective tissue and from the sheaths of vessels and nerves. There are also a number of cases of retroperitoneal growths recorded in which the structure of the tumours suggested an origin from Wolffian bodies or ducts, or from the Müllerian ducts. The latter group of cases may be ruled out of court in the present instance, on account of the structure of the growth.

In view of the tendency of many recent writers to trace the origin of sarcomata to some traumatic influences, it may be remarked that the location of the tumour in this case is consistent with the hypothesis of trauma, since the region here involved must be more or less injured in all primiparae. It is impossible, however, to cite this case in support of the phrase "ohne trauma, ohne sarcoma," for this location is one of the rarest seats of sarcoma, and yet one which is perhaps, of all tissues, the most exposed to injury.

It is a great pleasure to express our thanks to Dr James Swain for his courtesy in permitting the publication of this case.

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ACUTE PELVIC ABSCESS FOLLOWED BY ACUTE OBSTRUCTION.

By ERNEST LEACH, M.B., B.Ch. OXON.,
WITHERIDGE, NORTH DEVON.

THE interest of the following case appears to lie chiefly in the patient's condition before operation with regard to the diagnosis as to the cause of the original trouble. The pelvic abscess suggested appendix or ovary as its origin.

On August 14th, 1906, I was summoned to see Mrs. G., aged 53, the wife of the rector of a neighbouring village. She had complained of constipation for the last four months with attacks of pain of a darting character situated in the left flank, usually noticed in the early hours of the morning when in bed. Previously she had always enjoyed good health, except for one or two attacks of bronchitis. The bowels had always acted regularly up to the last few months. For the last two years she had noticed the pain after standing on damp grass; during the last year this had been more marked. The menopause had occurred three years previously. There was no history of any loss of flesh.

The patient was stout and healthy-looking; the tongue was clean, the heart and lungs normal. The abdomen moved well with respiration; there was no tenderness on palpation nor was any abnormal swelling felt. On rectal examination nothing was detected. The pulse and temperature were normal; the urine was normal. There was no history of any mucus with the motions. A mixture containing bismuth salicylate was given.

On August 18th she was feeling better and the pain was relieved.

On my arrival, in answer to an urgent telegram, on August 21st, I found that during the previous night she had been seized with violent abdominal pain accompanied by frequent vomiting. The pain, which was situated all over the lower half of the abdomen, was so severe that she could not lie still in bed. The face was flushed, the temperature was 102.6°, and the pulse 104. The abdomen was excessively tender, more especially over the left lower half, and moved badly with respiration; micturition was painful. On vaginal examination the mucous membrane was very hot and tender; the uterus was not fixed. By the rectum nothing was felt. She was given a saline fever mixture by the mouth, and two doses, containing 20 minims of liq. morphinae to allay the pain, also hot vaginal douches and hot fomentations over a square of lint spread with glycerine of belladonna.

During the following week the pain gradually diminished. The temperature ranging between 100.8° and 102.6°. The abdominal tenderness was less marked, but always more noticeable on the left side. A definite band of thickening could be felt lying just above and parallel to Poupart's ligament on that side. The uterus became fixed, and posteriorly a well-marked swelling could be felt occupying Douglas's pouch. On August 29th during defaecation about a pint of very offensive pus was passed from the rectum, and on five occasions during the following twenty-four hours in smaller quantities. After this the temperature came down to normal, and the patient felt very much more comfortable. The band of thickening above Poupart's ligament slowly disappeared, and the mass felt in Douglas's pouch was very much smaller in size.

On September 6th I asked Dr. Harper of Barnstaple to see her, with me in consultation, as the temperature had been steadily rising for the last four days. It was decided that no operative interference was needed, and a mixture containing potassium iodide and liq. hydrarg. perchlor. was prescribed, also salol gr. x in cachets twice a day. Five days later the temperature reached the normal again, there having been no fresh discharge of pus. On September 11th the uterus moved much more freely, and an indefinite band of thickening could be felt high up in Douglas's pouch extending towards the left.

On September 23rd the patient came downstairs and had made arrangements to go away the following week. All this time the bowels were acting naturally, and all seemed to be going well. On September 25th, after breakfast, the patient was sick once or twice, and the bowels were open naturally; a dose of calomel to be followed by salts was ordered and a stomachic mixture prescribed. The following day she felt better, the sickness had ceased. She complained of one or two twinges of pain on the left side, but not severe. The abdomen was not distended, the pulse and temperature were normal. As the bowels had not moved, a simple enema was given with a small result. She passed a good night, and on the following day, as the bowels had not acted, a simple enema followed by an olive oil enema was administered, the result from both being practically nil, otherwise her condition was unchanged.

At 2 a.m. on the morning of September 28th she was seized with violent abdominal pain accompanied by frequent vomiting. When I saw her she was in great pain, the face was flushed and anxious, the abdomen was distended, the temperature was 97°, the pulse was bad and 136 per minute. The vomiting continued and frequent hiccough. The patient was clearly suffering from acute obstruction, probably due to adhesions from the previous attack of peritonitis. I wired at once for Dr. Harper as an urgent operation was needed. He very

kindly came and performed abdominal section under chloroform. A hard growth (? carcinoma) was found springing from the left ovary, to which the bowel was bound down by numerous dense adhesions, giving rise to the obstruction. The patient's condition was so bad that it was impossible to do more than bring up a loop of bowel into the wound, which was accordingly done. She gradually sank and died the following afternoon.

NOTE ON THE PECULIARITIES OF THE TONGUE IN MONGOLISM AND ON TONGUE-SUCKING IN THEIR CAUSATION.

By JOHN THOMSON, M.D.,

PHYSICIAN TO THE ROYAL HOSPITAL FOR SICK CHILDREN, EDINBURGH.

NEARLY all the peculiarities which distinguish the so-called "Mongol" baby from other children, and make him look like the young of a different species of man, are obviously developmental in origin and are recognizable from the day of his birth.

The condition of the tongue, however, forms a notable exception to this rule. Its apparent largeness may, indeed, often be noticed soon after birth; but this appearance is probably attributable rather to an abnormal shortness of the mouth than to any real longness of the tongue. The well known characteristics of the mucous membrane—its coarse, raw, sodden appearance, from swollen papillae, and the numerous deep fissures in it—are entirely absent at birth and for long after. They only develop slowly as the child grows. The enlargement of the papillae sometimes begins during the second month, oftenest in my experience between the third and ninth months; and, rarely, not till late in the second year. The fissuring generally begins to appear in the course of the third or fourth year. It may be present in a slight form, however, during the second, and it may not be noticeable till as late as the sixth year.

The slow development of these changes on the tongue's surface may be explained in two ways. On the one hand, it may be supposed that, though the organ looks normal at birth, it is really so abnormally vulnerable as to be unable to carry on for long the common work of an ordinary tongue with impunity. On the other hand, it may be suggested that the various abnormalities of the mucous membrane might be accounted for if it could be shown that the child used the organ in an abnormal way. Neither of these explanations seems quite adequate without the other. It is probable, however, that though the lingual mucous membrane in these children is, like their skin, not quite normally resistant, yet what chiefly determines its swelling and cracking is the way in which it is used.

Tongue-sucking is, of course, a well-recognized characteristic of Mongolism. In studying recently the notes of 92 cases of Mongolism observed during the last twenty years, I have been greatly struck with the extreme frequency of this habit among them, and with the extraordinary energy and persistence with which it is practised by many of the children. In 69 cases in which its presence was inquired into, it was found certainly to exist, or to have existed, in 59. In the other 10 it was said never to have been observed, although at least 2 of them were given to sucking their fingers or hands. Two children who were noticed when in hospital to suck their tongues constantly were stated by their mothers, on admission, never to have practised the habit. Its presence is, indeed, so easy to overlook that it seems allowable to suppose that possibly all Mongols at some period of their childhood may have a period of tongue-sucking, although it may not always be recognized.

In all the cases of older children I remember to have seen, in which the tongue-sucking had been very prolonged and severe, the fissuring and the enlargement of the papillae were particularly marked. In a few in which a reliable history was given of the habit having lasted only for a short time, the surface of the tongue was comparatively little affected.

THE fourth French Congress on Public Assistance and Private Beneficence, which was to have been held this year at Rheims, has been postponed till the spring of 1908 on account of the death of M. Casimir-Perier, Ex-President of the French Republic and President of the National Committee.

THE ACCIDENTAL RASHES OF VARICELLA.

By J. D. ROLLESTON, M.A., M.D. Oxon.,

ASSISTANT MEDICAL OFFICER, GROVE FEVER HOSPITAL, METROPOLITAN ASYLUMS BOARD.

THE occurrence of accidental eruptions in varicella receives but scant notice in most of the English and American textbooks. Considerable attention, however, has been given them by French authors, especially during the last fifteen years. Gintrac is usually credited with having first noted a prodromal rash in varicella, but Willan* in 1801 and Bateman† in 1813 had already described such an eruption. Regarded at first as exceptional and prodromal only, they were later shown to be by no means rare, and to be likely to develop at any stage of the disease, being premonitory like the prodromal rashes of small-pox and measles, concurrent with the specific exanthem, post-eruptive, or a combination of two or more of these forms. Cerf, writing in 1900, had collected 45 cases of accidental rashes in varicella. A search through subsequent literature has enabled me to add 14 more, excluding the 6 personal cases recorded below which have come under my own observation at the Grove Hospital in the course of the last two years.

Though accidental rashes in varicella may develop at any stage of the disease, the prodromal and concomitant ones are much more common than the post-eruptive. Examples of the latter are recorded by Charmoy, Chauffard, Comby, Cerf, Galliard, Nissim, Clemmey, Daverède, and Gillet, and below in Cases II and III.

The varieties of the accidental rashes of varicella are in order of frequency—scarlatiniform, purpuric, morbilliform, and mixed. The scarlatiniform variety is the only one represented in the cases below. Purpuric eruptions have been recorded by Bérard and De Lavit, Baader, Andrew, Lannoise, Comby, and Rundle; morbilliform by Revilliod, Chauffard, Désandré, and Heubner; and mixed by Lannoise and Roger.

Urticaria, which, as I have shown elsewhere, not infrequently precedes the characteristic eruption of measles, is rarely met with in varicella. In MacCombie's case a bright erythema with numerous urticarial wheals preceded and accompanied the specific exanthem. Varicella being mainly a disease of childhood, it is obvious that most of the cases will be found in children. Cases in older patients, however, have been published by Almérás in a female of 16, by Lorrain in a male of 19, by Nissim in a female of 24, and by Metcalfe in a male of 39. The trunk is most frequently affected, but there is no site of predilection, like the abdomino-femoral region in the prodromal rashes of small-pox. Like the prodromal rashes of measles, the accidental rashes of varicella are usually of short duration, and are not accompanied by any cutaneous irritation nor followed by desquamation. These facts sufficiently explain how it is that the accidental rashes of these two diseases have not received a wide recognition in the profession. With the following exceptions there is nothing noteworthy in the previous history of the recorded cases. In a few there had been a recent pre-existent eruption. Thus one of Chauffard's patients had had measles a fortnight before. Oeconomon's case had recently had scarlet fever. One of Daverède's cases showed the eruption of hereditary syphilis. Four cases reported by Sabathé, Charmoy, Bourdineau, and Cruet respectively were convalescent from broncho-pneumonia; and two cases reported by Nissim and Lannoise respectively were suffering from pulmonary tuberculosis. Alezais's case was a weakly child prematurely weaned. One of Daverède's cases was delicate and rickety.

From a diagnostic standpoint varicella rashes are of considerable interest. The scarlatiniform variety is most likely to cause difficulty in diagnosis. Since 1899 a total of 94 cases, or an annual average of 15.6 cases, of varicella has been admitted to the Metropolitan Asylums Board hospitals, which had been certified to be suffering from scarlet fever, probably on account of the prodromal scarlatiniform rash.

With the important exception that the scarlatiniform

* "The varicella, or chicken-pox, has been very prevalent during the summer (1797). The eruption was generally preceded by a strong fever; and in three cases, by a vivid universal rash, similar to that which often attends the eruption of the small-pox." Loc. cit., p. 120.

† "The eruption is sometimes preceded, for a few hours, by a general erythematous rash." Loc. cit., p. 208.