found lying one in either iliac fossa near the pelvic brim; they were normal in appearance, and showed evidence of the formation of Graafian follicles. There was no trace of a uterus or of any tissue representing it.

The technique of the Baldwin operation was followed. A loop of small intestine about 7 inches long and about 12 inches from the ileo-caecal valve was selected. It was isolated, together with its mesentery, and the cut ends of the bowel in the loop were permanently closed by purse-string sutures of catgut. The continuity of the intestinal canal was restored by an end-to-end anastomosis. The apex of the U-shaped isolated loop was easily pressed to the bottom of the pelvis, where it was grasped by the forceps previously introduced from the vulva, and drawn to the surface. The isolated loop of bowel was now sutured to the pelvic peritoneum, but this did not exclude it entirely from the peritoneal cavity, as the mesentery passed through the pelvic floor. This concluded the intra-abdominal part of the operation, and the abdomen was closed without drainage.

The patient was again placed in the lithotomy position. The loop of bowel was of normal colour, and there appeared to be no undue tension on its mesentery. The convexity of the loop was incised and the cut edges sutured to the skin edges within the labia minora. This concluded the operation. The patient made a straightforward recovery.

It was thought advisable to wait a few months before proceeding with the division of the septum between the tubes of the transplanted bowel. At the end of three months the septum had retracted to such an extent that this procedure was unnecessary. At first there was a constant discharge of mucus from the vagina, but this rapidly diminished in amount.

Two years after the operation the patient was examined. Her general condition, mentally and physically, had improved. She expressed herself as well satisfied with the result of the operation, and there is every reason to believe that coitus can be carried out satisfactorily. There is no contraction of the orifice of the vagina, which admits two fingers with ease.

A collective review of the literature on the formation of an artificial vagina, by Frank A. Pemberton, is to be found in the *American Journal of Obstetrics and Gynecology* for August, 1925.

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A NOTE ON TREATMENT OF IMPETIGO

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Of all the skin diseases that fall within the province of the school medical service, impetigo must be given pride of place, alike for its commonness and for its effects. It is the cause of an enormous amount of loss of education, its treatment involves considerable expense, and it produces immeasurable results in the way of impairment of health. For these reasons any improvement in existing methods is to be welcomed. The following notes describe what I believe to be an improvement by means of the already well-recognized principle of the occlusive dressing.

The subjects of the treatments recorded below were elementary school children treated at the Southampton municipal clinics. Three different lines of treatment were adopted.

Group I: Treatment by the Occlusive Dressing

This consisted simply in the application of a piece of "elastoplast" bandage to the lesion—whatever its stage of development. The lesion was not touched in any other way. Crusts, if present, were left *in situ*; superficial pustules were not pricked; and the adjacent skin was not cleaned. Some selection of patients had to be employed. There are situations, such as the lip edge, on which a dressing cannot con-

veniently be stuck, and there were children who, by reason of their irresponsible nature, could not be trusted to leave their dressings alone. No other method of selection was invoked. On the first visit the dressing was applied and the patient was told not to pull it off or to wash it. Unfortunately—and even surprisingly in respect of the second injunction—these instructions were often ignored, and the result has been a considerable diminution of the material available for statistical purposes. These failures were sometimes due to the misguided efforts of the parents, who would much rather use sulphur ointment than be parties to a revolution. More frequently they were due to the natural restlessness of childhood, for in point of fact the "elastoplast," if not interfered with, will stand a good deal of immersion in hot water. Fifty children have been treated from first to last with "elastoplast." They were excluded from school at their first visit and not allowed to go back till healing was complete. I believe there is very little risk of the infection spreading to others through the dressing, but the children were kept from school partly owing to the possibility of fresh lesions developing, and partly in order to make sure that they did not vanish from observation. The total time lost from school by these fifty children was 486 days, giving an average of 9.7 days per child. The longest period of exclusion was nineteen days, the shortest five days.

Group II: Treatment by Ung. Hyd. Ammon. Dil.

This comprised children who, by reason of the situation of the lesion, or by their probable or proved irresponsibility, were unsuitable for treatment in Group I. It also included those treated in the first part of 1932 before the "elastoplast" treatment had been started. The patient was given a box of dilute ammoniated mercury ointment and was told to keep the lesions well covered with it. Nothing was said about removal of crusts or any supplementary form of treatment. This group included sixty-five children, and they lost in all 1,208 school days, giving an average loss of 18.6 days per child. The longest period of exclusion from school was eighty-two days, the shortest five days.

Group III: Intensive Treatment

The fifty children in this group were treated on similar lines to Group II but on a more intensive scale. No attempt was made at any sort of selection. Crusts, if a prominent feature, were removed by means of a starch poultice applied either at the school clinic or at home, the materials in the latter case being provided and the method of use explained. The child then attended the clinic for "daily dressings," and the parent was given a box of ointment, as in the previous group, and told to apply it six times a day. These fifty children lost 1,127 school days, giving an average loss of 22.5 days per child. On an average they were dressed at the clinic six times each. The longest period of exclusion from school was eighty-one days, the shortest three days. The largest number of dressings in any individual was thirty-three, the smallest one.

Complications

One patient treated with "elastoplast" for three lesions on the left knee developed an abscess in the subcutaneous tissues of the middle of the left thigh. This was opened and recovery was uneventful. One patient in Group III—also with the primary focus on the knee—developed an abscess in one of the inguinal lymph glands. In this case, too, recovery was rapid after the abscess had been opened.

DISCUSSION

A comparison of these three groups, relatively small though they are, shows quite clearly the advantages of a policy of non-interference in the treatment of simple impetigo. Indeed, a study of the patients themselves brings home even more forcibly its benefits, for a comparison of the lesion which has been kept occluded with another on the same patient from which the dressing has been removed is most striking. Another feature, but one which it is difficult to express in statistical form, is the limitation of spread from one site to another in the individual patient. Nor does the occurrence of a subcutaneous abscess in the "elastoplast" group invalidate the claims

of the latter, for such a complication may arise in impetigo however treated. An increased incidence of such complications would have to be demonstrated in a very much longer series of cases before the very obvious advantages of the method could be seriously decried. But there is no need to stress the benefits of the occlusive dressing in superficial infections: they are already well enough known to all who have used them. An important aspect of impetigo is the administrative one. If the disease can be cured so readily with so little treatment the work of the school clinic can be enormously reduced. The amount of supervision needed from the medical officer will be lessened, and the school nurse, absolved from the necessity of doing daily dressings, can apply her energies in more useful spheres. Adhesive dressings no doubt cost more than ointment, but in the long run their use might well prove to be an economy. At any rate the cost is scarcely likely to outweigh their great advantages. Finally, the occlusion of the individual lesions is likely to have the effect of limiting the spread of the disease from one member of a household to another.

SUMMARY AND CONCLUSIONS

1. Three methods of treating simple impetigo are described—by means of the occlusive dressing, by means of ointment applied intensively, and by means of the same ointment applied in a more desultory way.

2. The evidence indicates that the advantage is strongly with the first method of treatment, the period of invalidism being almost halved. The worst results come from intensive methods.

3. This advantage to the patients may also be felt by the school medical service in the form of increased simplification of work. The occlusive treatment is likely to diminish the infectivity of the disease.

I should like to express my thanks to my colleague Mr. I. D. Dear for permission to use the records of his patients.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

FATAL CEREBRAL HAEMORRHAGE IN A YOUNG ADULT

There are several points of interest in the unusual case described below—the extreme difficulty of diagnosis in the first emergency, the occurrence of fatal cerebral haemorrhage in one so young, and the presence of glycosuria and albuminuria.

I was recently called to attend a young lady of 25 who, while dancing, had suddenly sunk to the ground. On examination she was quite unconscious; all reflexes were absent, the pulse was very bad, but colour was good and there were no obvious signs of injury to the head. A stomach wash was done, nothing abnormal being found, and with oxygen the pulse revived a little. Soon after it was noticed that the pupils were becoming unequal, and there was some divergence of the left eye. The history was entirely negative. She had been at her work as a secretary during the day, and had been quite herself all the evening. For two days during the previous week she had been at home with a slight cold. She had had some septic infection of the face some three years before, but had never had a serious illness. After about two hours it was decided to remove her to a nursing home, where a catheter specimen showed a considerable quantity of sugar and some albumin. Blood pressure was 190. A few minutes later the left pupil, which had been smaller than the right, was seen to be dilating. The divergence increased, and the patient died four hours after being first taken ill. Post mortem the only abnormalities found prior to an examination of the skull contents were a few calcareous glands in the abdomen and a slight thickening of the mitral valve suggestive of old vegetations. On opening the head the dura mater was found to be rather adherent. There was a marked

effusion of blood in the subarachnoid space all over both sides of the brain. This was slightly more marked in the left fissure of Rolando and left Sylvian fissure than in the right. The pons, medulla, and the lower surface of the brain were all covered with effused blood. No ruptured aneurysm could be found, but there was so much disorganization that it was difficult to identify the vessels, which, incidentally, did not appear to be unduly thickened.

Cerebral haemorrhage in young persons is not so rare as might be expected. Allbutt¹ quotes the St. Bartholomew's figures of 3,790 necropsies with 134 cases of intracranial haemorrhage, of which 7, or 5.6 per cent., occurred between 21 and 30. In Dr. Cookson's interesting series of eight cases of subarachnoid haemorrhage recently published in the *Journal*,² only one—a boy of 17—was under 30. In the historic work of Charcot and Bichard in 1868 it was considered that haemorrhage came from military aneurysms, but according to Osler and Price this view was negated by Ellis and Pick,³ and it is now held that the cause is a rupture of a definite aneurysm, or of a weak arterial wall, following an infective embolus.^{4 5} In this case the history of a septic infection of the face and the suspicious mitral valve are suggestive, but there is no explanation of why the rupture took place when it did.

The occurrence of the glycosuria and albuminuria is of practical importance as bearing on the diagnosis of cases of sudden unconsciousness. My colleague Dr. Beare had removed the appendix some two years previously, when the urine was free from sugar and albumin. No history of polyuria or diabetic symptoms since then could be obtained, nor were there any naked-eye changes in the kidneys post mortem. Though the literature on this matter seems scanty, it is generally taught, and held by Munch-Peterson,⁶ that such an occurrence is due to interference with some special centre in the brain, probably in the medulla oblongata or corpus striatum. None of Dr. Cookson's eight cases showed any glycosuria, and in five out of six there was only slight albuminuria. It would appear that this centre must be very active, as in the present case urine in the bladder contained a large amount of sugar and albumin within three hours of the onset of the haemorrhage. The high blood pressure may have had some similar cause, but it may have been terminal, as it was not taken until just before death.

I am indebted to my partner, Dr. Max Davison, and to my colleague Dr. C. E. Beare for their assistance, and to the latter for permission to publish the case.

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Dorking.

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DRUG ERUPTIONS

The extended use of gold and bismuth salts has been followed in some instances by a rash. I propose to record here an example of an eruption due to solganol, which, so far as I know, has not been recorded in English literature as producing a characteristic rash.

Mrs. M., aged 46, was admitted under my care at St. Mary's Hospital on February 20th, 1933, when she gave the following history. She had suffered for some years, probably since early 1929, from an eruption diagnosed as erythema pernio by a dermatologist in charge of a department at a teaching hospital. This is described as a gyrate purple eruption on the backs of both legs, with a history of having had it at some time upon the face. The