three months' treatment with chromic acid the growth again disappeared. Nine years later she died, but there had been no recurrence.

This case illustrates the importance of a form of treatment easily accessible. Had the patient resided near the centre where radium treatment was carried out, instead of three hundred miles away, the recurrence could have been dealt with at once. As it was, she could not afford a second journey. It may be argued that in widely scattered districts, where the patient lives ten or twenty miles from his doctor, this treatment is almost as inaccessible as radium. I had one such case.

A man, aged 60, came to me complaining of an ulcer which he had noticed three years previously and which he had endeavoured to cure by many and varied ointments of the proprietary type—and his ulcer slowly increased in size. It was situated at the angle formed by the lobe of the right ear with the skin extending from it towards the angle of the jaw and measured about three-quarters of an inch in diameter. As he informed me that it was quite impossible for him to attend daily for treatment I gave him a prescription and wrote down in detail the procedure to be followed, asking him to report weekly for observation and further guidance. I did not see him again for two months, and by that time the ulcer had almost healed. Eighteen months later he dropped in casually to tell me that his ulcer had completely healed a month after I had last seen him and had not again broken down.

The duration of the treatment where the soft tissues only are affected averages three and a half months. Where bone and cartilage are invaded the patients should be strongly urged to go where more effective treatment can be obtained. At the present day no patient suffering from rodent ulcer should be allowed to reach that stage.

Of the various local remedies that have been used successfully in the treatment of rodent ulcer, and whose action, like that of 10 per cent. chromic acid solution, is selective, salicylic acid, pyrogallol, and arsenious acid may be mentioned. Of these, arsenious acid, according to Dr. Norman Walker² of Edinburgh, has given most satisfactory results. In his *Introduction to Dermatology* he discusses very fully the treatment of rodent ulcer, and, in describing the use of drugs whose action is caustic and selective, he rightly emphasizes the necessity for care in the choice of the drug as well as in its application. Of the effect of the arsenious acid preparation favoured by him he says: "In twenty-four hours the part has swollen up and the pain experienced is very severe, so severe that it is often necessary to give the patient morphine." Farther on he says, "In many cases one course of this treatment is successful." I admit that, in comparison, the course of treatment by 10 per cent. chromic acid solution is long and even tedious, but it is less drastic in its action, the onset of pain is more gradual and need never be permitted to become unbearable. Its advantages discount both the length of time taken to effect a cure and the slight pain and discomfort experienced during its exhibition. The remedy is cheap, and it is easy to use. The destruction of tissue following its use is limited to diseased elements. The patient is spared the expense of a long railway journey and is able to continue at work throughout the treatment. The resulting scar, wherever situated, is soft and pliable, and there is no contraction with consequent disfigurement. And finally, should recurrence take place, the patient has the satisfaction of knowing that a simple and effective remedy is immediately available.

REFERENCES.

- ¹ Dawson Turner, *Radium*, 1910, p. 53. ² Norman Walker, *An Introduction to Dermatology*, seventh edition, p. 324.

PROPHYLACTIC RECTIFICATION AND VERSION AT THE ANTE-NATAL CLINIC.

BY

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Down to the close of 1921 the correction of malpositions (right occipito-posterior) and malpresentations (pelvic and transverse presentations) in the ante-natal department of the Edinburgh Royal Maternity Hospital had attained only a partial success. There were numerous cases, especially of malpositions (chiefly right occipito-posterior) in which neither one-handed nor two-handed palpation applied by the abdomen or the vagina or by both routes sufficed to bring the back of

the foetus round to the anterior aspect of the mother. Postural plans were also experimented with—for instance, a modified Trendelenburg position was used in some cases in the hope that the presenting part would slip out of the pelvic brim and become movable above it; but success was only occasional. Dr. F. J. Browne and I often talked over the subject, but without devising anything which was wholly satisfactory.

On November 12th, 1921, Dr. R. C. Buist of Dundee published in the *BRITISH MEDICAL JOURNAL* (p. 782) "A note on the early recognition and corrective treatment of occipito-posterior positions," in which he described the method of rectification by means of towel pads. There were some details in the procedure which were not clear to me, so I got into communication with Dr. Buist, who was kind enough to explain and illustrate the method by diagrams. From the beginning of the present year (1922) the method by pads has been employed in the ante-natal department for the correction of occipito-posterior positions of the head. The results for the six months from April 1st to September 30th, 1922, have been most satisfactory. During this period 509 expectant mothers attended the ante-natal clinic as new cases. Amongst these there were 26 instances of right occipito-posterior position of the foetal head, and of these 24 were rectified by pads into anterior positions, whilst 2 remained posterior, notwithstanding the treatment. In most of the cases the rectification was into the right occipito-anterior position, but in some the rotation was continued until the head was found to lie in the left occipito-anterior position. In one case which has occurred since the end of September the original position was diagnosed as left occipito-posterior and pads were applied, the rolled one on the left side and the flat one on the right; on the following day it was found that the presentation was a breech, and external version was then performed, producing a right occipito-anterior position. This was the only occasion on which the application of the pads in posterior vertex positions was followed by the production of a pelvic presentation.

The method adopted was that recommended and described by Dr. Buist as follows:

"A binder is laid under the patient and two towel pads are prepared. The first is rolled to about the thickness of a forearm, the second is folded to a flat pad 6 or 7 inches square. The rolled pad is pinned to the binder in such a position that when the binder is firmly secured the pad will lie close in front of the anterior superior iliac spine behind and parallel to the trunk. The flat pad is pinned so as to lie on the limbs, pressing them backwards. It is sometimes useful to roll the patient to the side opposite the trunk and by hand bring the trunk as far as may be over to that side. The binder is then pulled firmly home."

In the Edinburgh clinic it has rarely been found necessary to take the patient into hospital for the rectification. The malposition is detected at the clinic; the patient is asked to return the next morning and to bring with her a binder, two towels, and safety pins; the pad and binder are then applied and the patient is allowed, after a short rest, to go to her home; she returns the next morning, when it is usually found that the position is anterior. Occasionally the pads have to be reapplied, rectification not having occurred at once. As has been said, the procedure only failed twice. Such failures are to be ascribed to the late date in pregnancy which has been reached, and the low level of the foetal head in the mother's pelvis. Very rarely was the posterior position reassumed after rectification.

It is difficult to find a completely satisfactory explanation for the corrective effect of the pads. Probably the rolled pad simply makes the existing position an uncomfortable one for the foetus; he will be mobilized, and, using the flat square pad to press his limbs against, will move into the position in which he is able to lie at rest, the right or the left anterior. I hardly believe it can be claimed that the rolled pad gets in behind the foetal back in the right occipito-posterior position and pushes it forward. The cases in which the position is found to be the left anterior are probably those in which the pads have produced a marked reaction by the foetus, and the back has thus been carried right across the abdomen. It is unnecessary to emphasize the great advantage this method of dealing with occipito-posterior positions possesses over the difficult and often uncertain plans of rectification applicable in labour; personal experience enables me to say with assurance that it is also much better than any method of manual replacement in pregnancy.

In the series of 509 pregnancy cases in the six months referred to 56 pelvic presentations were detected. In

11 of these cases no attempt at version was made as the pregnancy had only attained the sixth or seventh month, and it was thought that they might safely be left for a little longer. In 14 cephalic version was performed by external manipulation, sometimes by one and on other occasions by two operators. There were 7 cases in which version was found to be so difficult that chloroform had to be administered, with the result that success was obtained in 6. In 3 other cases attempts were abandoned owing to small amount of liquor amnii and close apposition of the uterus to the foetus. In 19 cases spontaneous version occurred. In 2 the patient did not return to the clinic. In this way the 56 cases were accounted for. There were 3 cases of transverse presentation in the 509 patients. Cephalic version was carried out in them all by external manipulation. Towel pads may be used in difficult breech and transverse presentations.

A CASE OF CONVERSION NEUROSIS.

BY

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WHILE doing the duties of staff surgeon in Ambala, India, I was called out early one morning to see a lady, aged 34, said to be acutely ill. On arrival I gathered that she had been having a series of fits which appeared superficially to resemble epileptic seizures.

When first I saw her she was just coming round from a second fit, and had gained a drowsy consciousness. She had incontinence of urine, rigid muscular contractions, and cyanosis. The temperature was 100° F., pulse full in volume. I learned that the day before, at about 11 a.m., she had gone into the bazaar wearing a very flimsy hat, and had come back with a severe headache which persisted throughout the day and night. A "touch of the sun" naturally suggested itself, particularly as that summer was an exceptionally hot one (about 108° F. early April, shade temperature at noon). I had the room darkened and cooled and a cold pack put to her head. The temperature and her general state did not seem to call for any other treatment. I eliminated malaria by film examinations. She had no more fits, and passed out of my care on departing to a hill station for the rest of the summer.

I was called again to see her in the following September. During her stay at the hill station she had had three severe attacks of a similar nature to the first, each more alarming than the one before, with longer periods of unconsciousness. The present was the fourth in five months. I found her on this occasion practically unconscious, the eyes turned upwards, the lips blue, the teeth still set (tongue not bitten as means to stop this had been employed). She had had a succession of four fits during the night, and was clearly feeling the strain. I admitted her immediately into the family hospital of which I had charge and asked the sisters to watch her closely and to note anything peculiar regarding the attacks. She was kept screened and quiet and put on a strong triple bromide mixture. She had three further fits, each one less severe than its predecessor, and under the influence of the bromides quieted down by the following day. The fits certainly appeared practically identical with those seen during an epileptic seizure. There was no family history of epilepsy or fits of any kind. Another blood film examination proved negative to malaria, and showed nothing abnormal in the differential count. Specific disease was excluded. I examined the central nervous system with extreme care. Nothing could be found beyond a slight increase in the knee-jerks.

Closer examination into her domestic life brought out the fact that her fits always corresponded with periods of worry about her two children during the absence of her husband on tour. The fits came on when he came back or just prior to his return—that is, when the tension of solitude was relieved. My patient passed rather a secluded life and saw very few people, although she lived well inside the cantonment.

Treatment.

The case here assumed a new aspect. I talked with her for a long while in private and led her towards the solution of her problem, which she eventually solved to her own satisfaction. She would never live again without a companion while her husband was away. This was the first step. Next came the consideration of drugs. Bromides I put immediately out of court in view of the fact that the case did not call for depression but healthy stimulation. I therefore put her on a series of injections (twelve in all) of the glycerophosphate compound put up in ampoules by Parke, Davis, and Co. During the full course her husband remained at home. The result was excellent. She felt inwardly much fitter—"never better for years," as she described it—and ceased to worry over her domestic problem.

Her husband went on tour shortly afterwards and returned to find her quite well. A companion stayed with her during his absence. Only once while he was away (she had again elected to live alone on three successive occasions) did she have any signs of recurrence. I was called in and found that she had been alone for

nearly two weeks at a time when the political situation was causing us all some anxiety out here. She had three slight fits, not to be compared in severity with those seen previous to treatment. Again she settled down quickly and has not had any trouble since. I have now lost sight of her.

In a space of about nine months after the above treatment she had only one slight recurrence under great mental provocation.

This case I think is rather exceptional, (a) in virtue of the fact that the weakness caused through exposure to the sun should become by "conversion" the expression of a psychoneurosis and continue as such; (b) the vast improvement in the case after a strong tonic, backed up by the patient's own solution of her problem; (c) the complete lack of previous or family history pointing to any disorders of this nature.

NINETIETH ANNUAL MEETING

OF THE

British Medical Association.

Held at Glasgow, July, 1922.

PROCEEDINGS OF SECTIONS.

SECTION OF DISEASES OF CHILDREN.

Sir HERBERT F. WATERHOUSE, M.D., F.R.C.S., President.

DISCUSSION ON THE ETIOLOGY OF RICKETS.*

OPENING PAPERS.

I.—LEONARD FINDLAY, M.D., D.Sc.,

Visiting Physician, Royal Hospital for Sick Children, Glasgow.

It is an interesting coincidence that on the return of the British Medical Association to Glasgow after a lapse of thirty-four years rickets should again form the subject of discussion by the Section devoted to the study of diseases of children. One appreciates the appropriateness of the choice, since rickets is a disease specially prevalent under industrial conditions, and probably no city in the kingdom possesses these in a more marked degree than does Glasgow. For this very reason the disease has naturally always interested Glasgow's students of medicine. The name of our distinguished President, as you are all aware, is associated not only with one of the most characteristic manifestations of the disease (Macewen's tibial spine) but also with an operation for the rectification of the rachitic deformities. Two important investigations into its presence or absence in India, and the reasons therefor, have been carried out by Glasgow graduates (Huntly¹ and Hutchison²), and it is needless to remind you that within recent years the Glasgow school has earned for itself a certain notoriety on account of the interest which it has evinced in the malady.

Though the two meetings are alike in the choice of subject, the present debate differs from the one of thirty-four years ago in that it is a conjoint one between the physiologists and the pediatricists. This is of course in consequence of the great amount of experimental work which, during the intervening years, has been done to elucidate the pathology of the disease, and the lion's share of this stands to the credit of the physiologist.

Although there is nothing farther from my intention than to belittle animal experimentation, as I appreciate only too well the great benefits which have accrued to medicine in consequence, and indeed much of my own humble energies have been expended in this direction, yet the final battle regarding the etiology of rickets, at least human rickets, must be fought out in the clinical field. It is the admission of this fact, I take it, which is responsible for the onerous and at the same time honourable duty of opening the discussion falling upon me, a clinician.

Clinical Generalizations.

In the life history of human rickets there are several broad facts with which any theory of its origin must be reconciled before it would be justifiable to adopt it as the correct

* Joint Discussion with the Section of Physiology.