CASE OF REMARKABLE STRIAE ATROPHICAE
DUE TO CACHEXIA.

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A boy, aged 16 years, died in St. George's Hospital on December 11th, 1907, under my care, in a state of extreme emaciation from widespread malignant disease of the peritoneum and both pleurae. The growth appeared to be colloid carcinoma primary in the splenic flexure of the colon, but, like the case recorded by Kanthack and Furnivall² in a boy aged 16, the appearances closely simulated those of a myxosarcoma. In spite of every care in nursing and the use of a water-pillow, a bed sore formed on the left side of the sacrum (see photograph). About ten days before his death it was noticed that lineae atrophicae were appearing on the back. They continued to appear, until on December 9th the back presented a remarkable appearance, comparable to the markings of a zebra. There were numerous furrows or striae more or less at right angles to the spine, fourteen on the right and twenty-two on the left side of the spine in the dorsal, lumbar, and sacral regions. When recent the striae were depressed below the surface of the more normal skin and appeared of a livid colour; when older they were paler and almost flush with the surface of the surrounding skin. There were no similar striae on the front of the body. There was no subcutaneous oedema or ascites, but there was a bilateral pleural effusion.

REMARKS.

The appearances shown in the accompanying figure are so remarkable that they seem to be worth putting on record. The rupture of the underlying dermis was not due to distension, as is so commonly seen in the lineae albicantes on the abdomen of women who have been pregnant or suffered from ascites, abdominal tumours, and so forth. It appears probable that there were two

factors concerned in their production: (1) Malnutrition, due to cachexia which disposed the dermis to rupture on slight provocation; and (2) an immediate mechanical cause—namely, traction exerted on the dermis in the process of turning the patient in bed. It is possible that withdrawal of fluid from the skin, brought about by the pleural effusions and by the diarrhoea from which the patient suffered, may have helped to diminish the nutrition of the skin. It is also conceivable

that the numerous growths on the peritoneum and some behind the peritoneum (among which was one in one suprarenal gland) may have played some part in the production of these striae by implicating the sympathetic nerve fibres.

Lineae albicantes have been divided by Osler³ into three groups: (1) Those due to distension—the ordinary lineae gravidarum; (2) the post-febrile, especially those following enteric and scarlet fever; and (3) the idiopathic form, met with as frequently in men as in women. Abraham mentions¹ "lineae atrophicae traumaticae" following injuries from without. It would appear that there is a fifth form—cachectic striae atrophicae—as exemplified by the present case, and also by a case under my care some years ago of fatal pulmonary tuberculosis in a boy, in whom lineae albicantes appeared over the shoulders. In an interesting paper on striae patellares, Parkes Weber⁴ refers to their appearance after appendicitis, and explains them as due to stretching of the skin by flexion of the knees at a time when the patient was growing rapidly and his general nutrition was greatly affected by the appendicitis. The present case appears to be one in which cachexia was the important factor, in that it altered the dermis so that slight traction led to extensive rupture.

I am much indebted to Mr. W. R. Harris for the accompanying photograph of the patient.

REFERENCES.

- ¹ P. S. Abraham, *Albutt's System of Medicine*, 1899, viii, 697. ² Kanthack and Furnivall, *Trans. Path. Soc. Lond.*, 1897, xlviii, 99. ³ W. Osler, *Montreal Med. Journ.*, 1897, xxv, p. 795. ⁴ F. Parkes Weber, *Med. Press and Circular*, London, 1905, cxxx, 261.

Photograph showing acute striae atrophicae.

ON THE
PRODUCTION OF PSEUDO-ARTHRITIS
OF THE HIP WITHOUT DISARTICULATION
OF THE HEAD.

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SURGEONS have for nearly a hundred years endeavoured to bring about the formation of movable in the place of fixed joints. We are told, on the authority of Murphy, that Barton of Philadelphia first endeavoured to overcome flexion of the hip by means of osteotomy, and tried to avoid union of the fragments by passive movements. Similar efforts were made in the case of the temporomaxillary joint by division or removal of bone and the

interposition of foreign bodies. Gluck of Berlin, over twenty years ago, with great ingenuity introduced various ivory joints after removal of diseased ones, and some patients retained these foreign bodies for many months. Ultimately, however, they suffered extrusion.

I have in over sixty times, with varying success, endeavoured to bring about movement in ankylosed hips, mainly by removal of the head and neck and trochanter, by the interposition of foreign bodies between severed fragments, and lately by a method I am about to describe.

In 1895 and following years I interposed gold-foil between fragments, and later fortified this by the interposition of any available soft structures. I found during these years that my best results followed the free removal of bone, and that while I had most gratifying movements in many cases, in some the limb remained too flail-like to supply the necessary support during walking. By the later operations of the removal of small portions of bone