CASE OF REMARKABLE STRIAE ATROPHICAE
DUE TO CACHEXIA.

By H. D. ROLLESTON, M.D., F.R.C.P.,

SENIOR PHYSICIAN TO ST. GEORGE'S HOSPITAL; PHYSICIAN TO THE
VICTORIA HOSPITAL FOR CHILDREN.

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.

By ROBERT JONES,

SURGEON TO THE ROYAL SOUTHERN HOSPITAL AND TO THE
LIVERPOOL COUNTRY HOSPITAL FOR CHILDREN;
LECTURER ON CLINICAL SURGERY,
LIVERPOOL UNIVERSITY.

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

and the interposition of muscle as described by Nélaton, my results are on the whole more reliable.

There are, however, a large class of cases in which it is inexpedient to disarticulate the head even when a certain amount of disease is present there or in the acetabulum. For many years I have been in the habit of excising the head of the femur in the type of osteo-arthritis which we sometimes name *malum coxae senilis*. For present purposes it will not be necessary to describe this affection beyond stating that it is characterized by considerable pain and by flexion deformity. It is a progressive trouble ultimately completely depriving its victim of any comfort. Taken early, I have noticed that by rigid confinement in bed and in a splint not only is deformity corrected and pain removed, but that many patients make a good recovery with a stiff joint. From this one learns that the disease is only progressive because of friction induced by motion and body weight. The misfortune is that many patients cannot stand the strain inseparable from the endeavour to correct flexion. In some it induces persistent vomiting if the deformity is great; in others, collapse following abdominal pain. Such are the cases in which I have several times removed the head of the femur, and have recognized the great shock that accompanies the act of disarticulation, and I finally determined in the future to bring about a movable joint, leaving the head of the femur *in situ*. I was justified in this conclusion from my clinical knowledge that if the head of the bone escaped body weight and friction it would cease to trouble.

In spite of the suggestive paper by Murphy, I also apply this procedure in many cases of bony ankylosis following tubercle or sepsis.

DESCRIPTION OF OPERATION.

The operation consists in removing a slice of the great trochanter, chiselling through the neck and screwing the separated portion of the trochanter to the proximal end of the neck in order to avoid union of the fragments (Figs. 5 and 6). The neck may be chiselled close to the head or at a little distance, or the neck may be completely removed (Figs. 1 and 3), or where there has been destruction from disease, additional bone may be removed (Figs. 2 and 4).

Fig. 1.

Fig. 3.

Fig. 2.

Fig. 4.

The operation, which is not admissible in the case of children, is performed as follows:

A longitudinal incision is made about 6 in. in length with the upper border of the trochanter in its centre.

An incision is made across the base of the trochanter just below the insertion of the gluteal muscles.

A slice of the trochanter from this point to its junction with the neck above is sawn or separated by a very wide osteotome and retracted upwards. The capsule is now

opened and the head separated from the neck with an osteotome (Fig. 1).

Extension is next put on the femur, and the trochanter with its muscles attached is screwed on to the head of the femur, which remains in the acetabulum (Figs. 3 and 6).

Deep and superficial sutures complete the operation.

Fig. 5.

Fig. 6.

In the case of a tender joint, to avoid impinging, it may be necessary to remove a portion of the neck (Fig. 1). In the case of an ankylosed sound joint following sepsis, it may be advisable, instead of dividing the neck near the acetabulum, to divide it near the trochanter (Fig. 5).

I commend this operation as very suitable to those advancing in years. It saves the shock of disarticulation, an all-important consideration.

In bony ankylosis, where disarticulation has to be made with a chisel, the time saved is great, and the result is more reliable than where a flap of tissue intervenes, unless the piece of bone removed is considerable, while the removal of much bone involves the sacrifice of muscle and some control of movement. The femur remaining is well supplied with muscles for useful movement, and no stitching of capsule is needed for the prevention of displacement upwards.

SCARLATINA ASSOCIATED WITH PYREXIA IN APPARENTLY HEALTHY CONTACT CASES.

By BERTRAM THORNTON,

SENIOR SURGEON, ROYAL SEA-BATHING HOSPITAL, AND MEDICAL OFFICER OF HEALTH, MARGATE.

In the BRITISH MEDICAL JOURNAL of June 18th, 1904, a paper of mine appeared recording some observations on an epidemic of scarlatina in a school under my charge. The outbreak occurred in 1902 in a boarding school of about 300 children, and was chiefly characterized by the mildness or absence of the usual symptoms. Out of 96 cases, only 31 showed typical symptoms of rash, sore throat, and pyrexia; 19 had no observable rash, very slight sore throat, and pyrexia of one or two degrees; 46 cases, although they had been carefully examined every day, showed no signs of any rash or indispotion, but these and all the others peeled more or less freely. The epidemic smouldered on for about seven months, and was a source of much trouble and expense.

The experience of this outbreak caused me to be doubly anxious when, on August 23rd, 1906, nine days after the children returned to school after the summer holiday, two girls were shown to me who presented typical symptoms of scarlatina, and were immediately sent to the Isle of Thanet Isolation Hospital. Judging from the time they had been at school, and the fact that they had not been exposed to any outside source of infection, it seemed probable that these two children had contracted the disease from some child in the institution who was suffering from a mild form of scarlatina, or was a simple carrier of the germs. I might here mention that, for precautionary purposes and to promote oral asepais, the whole of the children had had their throats sprayed daily since they returned to school with a 1 in 2,000 solution of mercury perchloride.

On the discovery of these two cases the whole of the children were stripped and examined, with the result that with the exception of two or three children all appeared to be in perfect health, and these two or three children