After an examination of the photographs a diagnosis of pancreatic calculi was made. I lost trace of the patient after that, but have since heard from Dr. Narunsky that, after having consulted several other doctors, the patient returned to him on May 22nd. He was then severely jaundiced and very emaciated, and died the same day. Unfortunately no consent could be obtained for a post-mortem examination.

Comment.

Certain points of interest emerge from a consideration of this case.

1. The pain was not typical of any particular gastric condition. It seemed to come on soon after food, but was not relieved by anything. Later, the pain was practically continuous.

2. The patient had no attacks of colic.

3. There was no glycosuria.

4. There were no fatty stools.

5. Jaundice was late, and was probably due to a pancreatic stone blocking the common bile duct.

6. The very probable diagnosis of pancreatic calculi from the x-ray examination, as the head, body, and tail of the pancreas are so definitely outlined by the shadows. Also the site of the abdominal tenderness coincides with the shadows seen.

ON A CASE OF BONY PLAQUES DEVELOPING IN THE SKIN.

BY

I. H. LLOYD-WILLIAMS, M.C., M.B., B.S.,
HONORARY MEDICAL OFFICER, HAYWARDS HEATH HOSPITAL.

(With Special Plate.)

The occurrence of calcification in tissues is well recognized. The presence of calcified deposits in the skin either as milia or in scars is described by Malcolm Morris and others. The existence of actual bony plaques in a cutaneous scar seems to me of sufficient rarity to be worth recording.

The patient is an elderly woman who, in 1894, got her right sleeve caught in the flame of a spirit lamp. The burn was a severe one, extending to the outer side from about two inches below the elbow to about six inches above, and in one part, just above the elbow, almost encircling the arm. Healing took about seven months, and skin grafting was resorted to. There was no trouble until about five years ago, when a plaque was extruded through the skin by a process of slow ulceration, taking about eight months for the ulcer to heal.

About a year ago last April "a little spot" started on the outer side of the arm, just above the elbow, which gradually grew larger. A calcareous plaque was observed in the process of extrusion. There was very little inflammatory reaction in spite of the presence of a little pus on the dressings. Solution of the plaque by lactic acid dressing to hasten the removal was tried without avail. The plaque was finally extruded and the residual ulcer healed in about three weeks. The plaque was sent to the Clinical Research Association, and they reported as follows:

"This specimen is found to be a piece of exceedingly hard, sclerosed bone in which an excess of calcium salts has been deposited; it is also covered on one side by a hard deposit of calcium and magnesium phosphates. We regret the exceptionally long time taken in the analysis, but the specimen was so exceptionally hard that special means of softening and decalcifying had to be adopted."

The specimen was about one inch long by about half an inch wide and perhaps a sixteenth of an inch thick.

At the time of writing another plaque is commencing to come away and several others can be felt lying in the skin and movable over the underlying tissues. The x-ray photograph shows the calcareous deposits in the skin. I had this taken with a view to determining the state of the underlying bone; this is obviously healthy.

The chief interest in the case lies in the fact of actual osseous tissue developing in an unusual position. So far as the history of the original injury and the present x-ray findings are concerned, the possibility of transference of osteoblasts from the humerus to the skin seems very unlikely. The most probable explanation is the conversion of connective tissue cells, either mature or in the early stage thereof in granulation tissue, into osteoblasts. This would bring the lesion into line with the ossification that occurs in callus and myositis ossificans.

I am indebted to Miss Ivatt, radiographer, Haywards Heath Hospital, for the radiograph, and to Dr. H. T. Cubbon, radiologist, for the following report:

"Lying in the soft tissues, posterior to the lower two-thirds of the humerus, there is a collection of opacities, which appear to be in the nature of plaques of bony tissue. Surrounding the plaque with a cavity in it, there is a collection of small granular opacities. The shaft of the humerus appears to be perfectly healthy, and although the bony opacities are very like sequestra, their origin could not be found. The appearances do not conform with a typical myositis ossificans."

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

LARGE LUNG ABSCESS WITH GANGRENE.

(With Special Plate.)

THE following case is thought to be of sufficient interest to be worth reporting.

A man, aged 63, was sent to the out-patient department of King's College Hospital by Dr. J. Shaw about June 1st, for haemoptysis of three weeks' duration.

History.—He had always been healthy and had never suffered from cough. In the beginning of May of this year he noticed a bad taste in the mouth, generalized pain, and slight malaise; this was put down to a septic tooth, which was removed under a local anaesthetic about May 7th; the tooth was removed whole and there was no choking at the time. A week later he commenced to cough up foul sputum, which became blood-stained, and later seemed to be pure blood, about an ounce at a time. At the end of May there was severe paroxysmal cough, often lasting an hour at a time, with pain in the right upper chest.

Physical Examination.—When seen, in the beginning of June, he was of the plethoric type, with a thick neck and slight cyanosis of the face and ears. The breath was very offensive; teeth extremely septic; no finger clubbing. Temperature 101°, respirations 20, pulse rate 84. In the right lung there was impaired movement and percussion note above the third rib; air entry was feeble, and there were numerous fine non-consonating crepitations; vocal resonance was increased. The heart was slightly enlarged to the left, without displacement, and there were no signs of aneurysm. Blood pressure 150/96. The liver was about three fingerbreadths down. On screening with the x rays a large opacity, the size of a grape-fruit, was seen in the right upper chest, with a fluid level; the amount of fluid did not decrease when the patient put the head low and coughed. (See radiogram in special plate.)

The diagnosis lay between lung abscess and interlobar empyema, causing acute congestion of the lung.

The patient was admitted to hospital early in June. The temperature was remittent between 99° and 102°, respirations 30, and pulse rate about 90. The sputum varied between 3 and 8 ounces daily; it was fetid, and consisted of brownish or bright red blood with pus. Microscopically it contained no broken-down lung tissue, but was teeming with bacteria of different types.

The physical signs altered very little, except that the air entry at the right upper lobe was very slight; on two occasions amphoric breathing was heard over the dull area; there was no whispering pectoriloquy or coin sound.

The diagnosis of pulmonary abscess with gangrene was made, but we were unable to account for the fact that the cavity did not empty materially on adopting a suitable posture; the large amount of fresh blood was also unusual. It was deemed inadvisable to try to tap the abscess by means of a trocar and cannula for fear of causing empyema.

The patient gradually became more toxic, and died suddenly after a fit of coughing on June 11th, after ten days in hospital.

Post-mortem Examination.—The teeth were very septic; oedema of the tissues of the right upper chest, neck, and mediastinum; serous fluid (35 ounces) in the right pleural cavity; the trachea was full of blood; old dense adhesions at the right apex and recent fibrinous adhesions over the right upper lobe in the axilla. The right upper lobe was converted into a huge gangrenous cavity with a mere shell of lung remaining; this was filled with blood-clot (at least 10 ounces) and broken-down lung tissue. The bronchus to the right upper lobe was occluded by gangrene and swelling, and was sticking into the cavity in such a way that it bent over at an angle; it would thus act as a valve, allowing air to enter but preventing the free expulsion of pus and blood (see photograph, Fig. 3). No foreign body was found.

There was acute congestion and early pneumonia in the lower lobes of both lungs. There was early pericarditis on the right side, with cloudy swellings and congestion of the various organs.

There seems little doubt that the origin of the condition was the inhalation of septic blood-clot following the extraction of the tooth five weeks before death; this set up an abscess, the bronchus became obstructed, preventing free drainage, and gangrene ensued.

J. L. LIVINGSTONE, M.D., M.R.C.P.,
Junior Physician, King's College Hospital.

J. L. LIVINGSTONE: LARGE LUNG ABSCESS
WITH GANGRENE.

FIG. 1.—Antero-posterior view, showing large cavity in right upper lobe. X indicates the fluid level.

FIG. 2.—Oblique view, showing cavity extending to the back of chest. X indicates the fluid level.

FIG. 3.—Post-mortem specimen of right lung.

I. H. LLOYD-WILLIAMS: BONY PLAQUES DEVELOP-
ING IN THE SKIN.

X-ray photograph of the case reported. Note the normal appearance of the bone and the superficial position of the plaques.

J. CLAY: BIMANUAL METHOD OF LOCATING
A STONE IN THE URETER.

X-ray photograph showing stone in lower end of right ureter.

B. T. HALLIWELL: FRACTURE OF RIBS CAUSED
BY COUGHING.