HYDRONEPHROSIS DISTENDING THE ABDOMEN; SPONTANEOUS EVACUATION, AND RECOVERY.

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ON February 6th, 1894, at the annual meeting of the Glasgow Branch of the British Medical Association, I reported a case of hydronephrosis simulating an ovarian cyst, abdominal section, and recovery. The details of that case I published in the *Glasgow Medical Journal* for March, 1894. The operation was performed on April 25th, 1893. The patient called at the Western Infirmary some months ago, where I saw her, and the other day she reported herself as still quite well.

Shortly after the foregoing case, a young man was admitted to my ward, in the Western Infirmary, with a fluctuating swelling of the abdomen. The clinical history and diagnostic signs were very similar to those of the case above referred to, which, before operation, had been assumed to be a parovarian cyst.

G. G., aged 20,¹ was admitted to the Western Infirmary on January 2nd, 1894, complaining of pain in the region of the left kidney. About five years ago he had pain in the same situation, which lasted only one day; since that time he has had similar attacks at intervals of about six months.

Present illness: About three weeks ago he had an attack like the former. A few days after the onset of the pain he noticed the abdomen getting swollen in the left lower lumbar region. There was a round globular swelling, which increased in size till it assumed its present aspect. It is fully as large as a man's head, is resistant and tense but fluctuant. It extends from the left lumbar region across the abdomen to midway between the umbilicus and the right flank. Circumference of body at umbilicus 30 inches. As the patient is subject to constipation, and there is some flatulent distension of the intestine round the tumour, he was ordered to have some soap and water enemata every two or three days, which always relieved him; but the tumour was not reduced in size—indeed, it seemed gradually to increase. The urine was more scanty than normal but varied occasionally. Judging from the history of the illness and from my experience of the former case I diagnosed it as a case of hydronephrosis, probably proceeding from a calculus impacted in the ureter, but there was no tender spot to indicate where it was located, and there never had been the acute local pain or any hæmorrhage which usually accompanies that condition. In the alternate days from the enemata I caused his abdomen to be kneaded and rubbed downwards, especially in the left lumbar region, in the hope of dislodging a calculus, if there, or undoing any twist or kink of the ureter.

January 20th. The bowels acted without enemata, but the swelling was rather increased in size.

January 29th. Aspiration was performed and 40 ounces of a clear amber-coloured liquid were drawn off. Examination of the liquid after standing: Deposit of a pinkish precipitate, consisting chiefly of altered blood corpuscles, granular and fatty, mainly non-nucleated cells. Reaction neutral, specific gravity 1005. Albumen and urea were detected. The character of the liquid was that of altered urine.

January 30th. Tumour completely gone.

February 6th. The patient was shown at the meeting of the Glasgow Branch of the British Medical Association.

February 10th. The tumour returned to almost its former size. There was no alteration in the character of the urine and no sudden acute pain to indicate the presence of a calculus.

February 19th. The swelling suddenly disappeared, 120 ounces of urine having been passed during the night.

March 6th. The patient was kept in hospital until this day, but as there was no sign of any return and he was otherwise quite well; he was dismissed—to return if the swelling reappeared.

January 17th, 1895. The patient returned to report that there had been no return, that he had been quite well, and that he had been at work ever since he left the hospital. He asserted that he had carefully observed every time he passed

urine and that he had not passed any calculus. There was no trace of the former tumour nor any symptoms of disorder of kidney or ureter.

A CASE ILLUSTRATING INFECTION IN SKIN DISEASES.

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A PROPER apprehension of the mode in which certain diseases of the skin originate and spread is of essential importance, not only in forming a correct opinion as to the pathology of the condition, but as often giving a valuable clue to the principle upon which successful treatment may be founded. It is a fact well recognised by all practitioners that many superficial diseases of the skin, which in themselves appear to be trivial, become of serious moment to the patient owing to the frequency with which they, as it is commonly said, relapse. In many cases these so-called relapses are in fact examples of reinfection. The patient, temporarily incapacitated by an acute attack of his disorder, relinquishes his work or changes his habits, thus removing himself from the source of infection, and submits to treatment. With amelioration of his disease he returns to his former occupations, is reinfected, and soon in a condition as bad as before, to which the term relapse is improperly applied. If I am right in the interpretation of the case which I am about to narrate, my patient, on resuming his usual occupation with the absence of certain necessary precautions, would almost surely have become again infected, and the disease would have appeared to present an inveterate character which in reality it does not possess.

J. P., aged 25, a student of Oriental languages, consulted me recently for an acute impetiginous affection of the hands, or, more strictly speaking, of certain digits. The affection was similar in appearance to the superficial, suppurating, and exfoliating condition which is frequently seen on the fingers of those who nurse children suffering from impetigo. As shown in the illustrations, the disease occupied the dorsal aspect of the second finger of the right hand, having commenced over the last joint. On the left hand, the index and third finger were similarly affected, and had a similar history in every respect. The thumb of the left hand was also affected near its last joint, but on a different aspect, that is, at the junction of its dorsal and palmar surfaces on the radial side. All of the patches were extending with well-defined, inflamed borders; but the severity of the inflammation generally had been greatly lessened by boric acid and vaseline, which the patient had employed for a few days without medical advice.

I was at a loss at first to account for such a remarkable distribution of lesions. The patient's history stated, as I have already said, that he was a student of Oriental languages. He had been reading in the British Museum, and had copied and translated a good deal. I requested him, therefore, to assume his usual attitude when translating into Hebrew or copying from books, printed or in manuscript. He took up the position shown in the illustration, with one exception, namely, that the index finger of his left hand remained extended, though I observed that the second was his pointer. After writing for a few seconds he allowed the first finger of his left hand to bend in some degree. I then flexed it underneath as far as it would go, and asked him if that was not the usual position in which he worked. He replied that it was, and that probably he would have placed the said digit in that position had the skin not been at the time too stiff to allow free flexion without pain. After twenty-four hours' treatment the disease was so rapidly disappearing that I was obliged to colour the affected areas in order to obtain a satisfactory photograph. For this purpose I used tincture of iodine, which combines the advantages of a good remedy and a useful stain. The manner in which the pen is seen to be held is one which the patient says he frequently adopts, and finds the most convenient for writing Semitic languages, which of course read from right to left. He does not feel sure which digit was first

¹ From *Hospital Records*, by George Urnside Buchanan, B.A., M.B., C.M.

involved, but thinks it was the index finger of the left hand. The rest followed, probably on the same day. There was no history of any constitutional complaint or of local disease elsewhere. Whatever may have been the original source of the virus, there cannot, I think, be the least doubt that his books and papers formed the inoculating instruments, and that the portions of skin exposed to friction were vulnerable, with the exception of the pad of the second finger, which, being better protected by horny layer, consequently escaped infection. On the thumb side of the index finger can be seen a small promontory stretching out from the diseased patch; the disease has evidently spread in that direction

rather quickly. A glance at the patch on the thumb shows a similar condition and explains the cause. The digits have come together at these spots, caused friction, extra warmth, and moisture, and so supplied conditions favouring the extension of the disease. The little finger appears generally to remain flexed, and not in contact with the surface over which the hand is being passed; whereas the three joints corresponding to the foci of disease formed the three legs of a tripod, which is steady in itself, and so related to the second finger as to fix it also, and render it the best digit for pointing with. With respect to the infection of the right hand little explanation is required. The penholder, first taken hold of in the left hand, is placed between the first and second fingers of the right, and held only by the thumb and first finger rather low down near the pen. The second digit is flexed, and the back of its last joint allowed to rest upon the paper while the hand is writing and travelling from right to left.

At a meeting of the Dermatological Society of Great Britain and Ireland I have already called attention to infection of the legs, brought about by interchange of stockings from leg to leg, carrying with them diseased products, and causing the appearance of a false symmetry of eruptions on the legs or feet. In such cases lesions situated upon the backs and fronts of the legs present what may appear to be perfect symmetry, but the outside of the left leg becomes so infected as to correspond in appearance to the inside of the right, and *vice versa*. In this way a sore on the left little toe may infect the foot of a stocking; the stocking is laid aside during the night; the micro-organisms increase in the discharges as upon an artificial cultivating medium, and next morning the infected stocking is drawn upon the other leg, with the result that a corresponding portion of the skin of the previously healthy foot (the skin over the root of the great toe) becomes inoculated. In more than one case of this kind the infection has resulted in ulceration and the production of a slough, and thus the secondary infection may be more destructive than that of the original wound. This explains a false kind of symmetry which is not uncommon

upon the lower limbs, and one to which I have ventured to give the name of "stocking symmetry."

The case which I exhibited to illustrate this condition, was one which most of the dermatologists present diagnosed as a typical case of Bazin's disease. It would occupy too much space if I were to attempt to describe the case fully; suffice it therefore at present to say that the patient has remained perfectly cured to all appearance for nearly two years, and yet it is easy to discover where each lesion has been by means of the scars. A careful study of these scars alone, without any knowledge of the history of the case, would probably convince any unbiassed observer that my explanation of the distribution of the lesions was probably the correct one. The case came under my notice at the Children's Hospital, Shadwell, while I was acting as clinical assistant, and I have fortunately been able to watch its progress for some years. I am indebted to Dr. Dawson Williams for permission to show the case in the first instance, and I hope to have a further opportunity at the forthcoming International Dermatological Congress, which is to take place in London next year.

Another important instance of infection is one often seen upon the face. Commencing from the corner of the mouth or from a nostril may be observed a fan-shaped area of skin infected by discharges which have escaped from the mucous membrane and travelled over the skin. Such patches or groups of efflorescence generally possess a narrow angle at the mucous orifices from which they originate, and widen out as they pass along the cheek towards the ear. Such an eruption is sometimes unilateral, or at least most marked upon the side on which the patient sleeps, not "eats," as has elsewhere been reported, obviously by an oversight.

The important practical directions which such observations suggest are: that stockings should not be interchanged if discharge is upon them, but should be laid aside at night in such a manner that next morning each stocking may be returned to the leg from which it was removed, as by that means the infected parts of the stockings are prevented from further spreading disease until a fresh pair is available.

In the second instance the mouth, throat, nose or conjunctivæ should be carefully examined, and treated if necessary to prevent further infection of the skin of the face; and the common but objectionable habit of brushing the teeth over and expectorating into the washhand basin should be discontinued, especially if the patient possess a vulnerable skin.

Most practitioners will admit that impetiginous eczema is extremely liable to recur, especially in the case of infants in arms. Such recurrences or relapses, as they are generally termed, are, I believe, not infrequently instances of reinfection from an unsuspected source. When by appropriate treatment a baby's head has been apparently cured, it is not a rare occurrence for the disease to break out with great violence upon one side of the head over the most prominent portion of the parietal bone. In one case of such recurrence I have seen a considerable slough produced at this spot on the scalp, and it seems almost certain that in that case, as in many others of less severity which I have observed, the true explanation was to be found in reinfection from the nurse's dress. Not only may the dress be soiled by discharges containing active pathogenic germs, such as the staphylococcus aureus, which can survive many months of inactivity, but the multiplication of the germs is accelerated by the extra heat and moisture produced when the head of the child rests against the mother's or the nurse's breast. Friction of the child's skin against the dress has the further effect of making the inoculation more sure and extensive. Owing to the greater extent of disease on one side of the scalp than the other it is not difficult sometimes to guess upon which arm a nurse carries her child, and, when once the source of reinfection has been discovered, to adopt the necessary precautions for the prevention of another so-called relapse, which may prove disheartening to both nurse and medical attendant and a source of great suffering to the little patient.

Instances of infection and reinfection might be multiplied indefinitely, but the above will indicate the importance which the subject possesses from the practitioner's point of view.