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.