has subsided, the pulse and temperature are normal, and beyond some feeling of debility there is nothing to note. Sometimes the throat is very much inflamed and the tonsils ulcerate, so that one can easily understand why such cases are notified as "diphtheria."

In looking over a copy of Cullen's *First Lines of the Practice of Physic*, a work which in style and lucidity has not been surpassed in medical literature, I find numerous notes made by Dr. Robert Lee, my father, when a student, in 1813, at the University of Edinburgh, and when, I think, Dr. Gregory was Professor of Medicine. The copy is interleaved, and the notes being chiefly in shorthand have been difficult to decipher.

It is quite clear, from Cullen's *Lines*, published five years before 1813, that there was very great interest felt by the profession in the question whether cynanche maligna was scarlatina or not. The description given by Cullen of cynanche maligna accords with that which would be given of the malady I am dealing with. "I am still of opinion," said Cullen, "that there is a scarlet fever which is a disease specifically different from the cynanche maligna"; and again (paragr. 655, vol. i), "From these considerations, though it may appear that there is some affinity between the cynanche maligna and scarlatina anginosa, it will still remain probable that the two diseases are specifically different. I have been at some pains to establish this opinion. . . ."

From Dr. Lee's notes one can appreciate the extent to which Cullen's views had gained ground between 1808 and 1813. It looks as if the malady we now call diphtheria to some extent took the place of cynanche maligna, and scarlatina became specifically recognised.

In dealing with the nature of the malady we are discussing, it is surely very important to observe that those who have had scarlatina already are quite as liable to be attacked with this malady as those who have not had it. Why Cullen makes no allusion to this point seems strange, for it would have been the strongest proof that cynanche maligna and scarlatina were different.

There is another point of interest which is one difficult to deal with: it is, that the skin effloresces and then scales off in very small fine particles, and does not peel off as in scarlatina.

This is exactly what occurred in the cases I described. The eruption seemed to me to be of a rather fainter or pinker hue than we see in scarlatina, and it looked as if the very small blood vessels or capillaries of the surface were more congested and the superficial cells subsequently detached, while in scarlatina there must be effusion in deeper layers of the skin leading to the peeling that follows.

The whole subject of the pathology of eruptions is one, however, which requires more investigation than it has yet received, and certainly deserves it, to aid us in diagnosis. Why eruptions should vary as they do is strange. When we compare typhus and typhoid, English and German measles, chicken-pox and variola, each with the other, are we not at a loss to explain why they differ as they do? As there is no name now for this malady, which seems to be the same as cynanche maligna, shall we go back to the old, or shall we call it by some other name? We had the impression in Fulham that it was due to the inhalation of sewer air; but as sewer air must vary much, we must not expect a specific malady from its inhalation. By some it is thought that the dust from the wood paving produces sore throat and fever. This, of course, is possible. The chief point, however, to which we ought to give attention is to be careful not to mistake this malady for either diphtheria or scarlatina, as is very liable to be done.

A CASE OF SUPPURATIVE PERITONITIS TREATED BY LAPAROTOMY.

By H. GOODWYN, L.R.C.P. and S. EDIN.,
Bovey Tracey.

E. W., aged 7, was first seen on September 18th, 1896. She had been ill for about a week previously with pain over the epigastrium, nausea, and diarrhoea. The temperature was 102° F. Two days later she complained of acute pain over the abdomen, most severe about the region of the umbilicus, which was very tender on pressure. She lay on her back

with the knees drawn up. The diarrhoea still continued. Respiration was accelerated, and the temperature was 104° F.

On September 22nd the morning temperature was 103°, the evening 104°. There was dullness at the bases of both lungs. The respiration was 50, but there was no cough. Tenderness over the abdomen and diarrhoea persisted. The case then followed the course of an ordinary pneumonia. The abdominal symptoms were not marked. There was tenderness and slight dullness below the level of the umbilicus, extending into both flanks, not affected by position. The diarrhoea continued throughout, the pneumonia gradually decreasing at the end of the lung affection.

At the end of about eight days dullness over the abdomen became more marked below the level of the umbilicus, and fluctuation could be elicited on percussion of the flanks. The temperature ranged from 99° in the morning to 101.4° in the evening for several days. After a few days a globular swelling appeared, extending as high as the umbilicus from the pubes, and laterally about 3 inches on each side of the middle line.

On October 13th the abdomen was aspirated midway between umbilicus and pubes in the middle line, and about half an ounce of blood-stained serum with flakes of pus was obtained. The character of the swelling did not materially alter for some days, the temperature varying between 99° and 101°. The diarrhoea ceased, and the tongue was fairly clean and moist. The patient had lost much flesh, and it was decided to open the abdomen.

On October 18th an incision 3 inches long was made in the middle line, and on opening the peritoneum sanguineous pus came freely through the wound. There were no important adhesions, and the cavity was irrigated with sterilised water, and a large drainage tube communicating freely with the abscess cavity was stitched into the wound; the rest of the wound was closed with deep interrupted sutures, and dressed with cyanide gauze and carbolised wool. The patient rallied well from the operation, and the evening temperature was 99°.

The subsequent history of the case was uneventful. The temperature never rose above normal, the bowels moved naturally on the fourth day after the operation. The cavity was washed out with sterilised water every day, and on the fifth day the tube was shortened, there being very little discharge. On the tenth day the tube was removed, and on the thirteenth day the patient was sent home with the wound practically healed. The child gained flesh after the first few days, and there was no pain.

A CASE OF GENERAL PERITONITIS DUE TO PERFORATIVE APPENDICITIS: OPERATION: RECOVERY.

BY
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I. T., aged 16 years, an errand boy, was admitted into St. Thomas's Hospital, on July 30th, 1896, with the following history. He had always enjoyed good health until seven days prior to admission, when he was seized with sudden and severe pain in the right iliac fossa, accompanied by diarrhoea. There was no vomiting, but he was feverish and felt ill. Except for a little extension of the pain across the lower part of the abdomen he remained in much the same condition for the following two days, and continued to follow his occupation; but he was compelled to take to his bed at the end of that time, and remained there for a further period of two days, when he felt better and got up. The same evening, however, all his symptoms underwent aggravation; the abdominal pain became general, and he vomited for the first time. A medical man later advised his removal to hospital.

On examination, he was lying on his back with knees drawn up, cheeks flushed, and a somewhat anxious expression. His pulse was 88, of fair strength, and regular; respirations shallow, 30; temperature 99.4°. The abdomen was slightly distended all over; it scarcely moved at all on respiration, and was the subject of general tenderness. There was shifting

dulness in either flank, as well as a fixed area of dulness in the right iliac fossa which ran obliquely across the lower part of the abdomen, to terminate at the middle of Poupart's ligament on the opposite side.

There was a good deal of pain on micturition. Thoracic viscera healthy. No impairment of liver dulness. The whole aspect of the case strongly suggested peritonitis, secondary to perforation of the vermiform appendix, but the general condition was sufficiently good as to deem it inadvisable to operate at once. The next day, however, there was no material improvement, so exploration was decided upon.

He was anæsthetised, and an incision made in the middle line, immediately below the umbilicus. The peritoneal cavity being opened, it was observed that the underlying intestine was deeply injected and covered with exudation. No fluid escaped. The hand was then carefully introduced, when it was found that everywhere the coils of bowel were feebly adherent the one to the other, and more or less buried in plastic lymph. The hepatic region was not so thoroughly explored, but elsewhere the signs of general peritonitis were unmistakable. A second incision was then made in the right iliac fossa. The same condition of matting as existed in the middle line manifested itself here also, and it was not till the finger was gently passed down over the pelvic brim that an abscess cavity of considerable size was evacuated of much thick and offensive pus. No irrigation was employed, but a glass tube was introduced from the mid-line incision into the pelvic region, and another from that in the right iliac fossa. He was then put back to bed.

During the next fourteen days he remained in much the same condition. The wounds continued to drain well, and in a week's time rubber tubes were substituted, and shortened as occasion demanded. The pulse remained about 88, and there was no material rise of temperature. He was, however, a little sick from time to time, and diarrhoea was an occasional complication. A trial was made immediately after operation of antistreptococcic serum in doses of 10 c.cm. twice daily, but as no benefit appeared to accrue to this it was discontinued after six or seven days.

At the end of this fortnight the temperature rose to 100.2°, and for the first time a tender point was noticed about two inches to the left of the median incision. It was thought that a loculus of pus existed in this situation. Accordingly, an incision was made, and fully a pint of offensive pus let free, a drainage tube being inserted. In due course both this wound and the median incision closed, but on two subsequent occasions that existing in the right iliac fossa broke down, and discharged a varying amount of purulent material. The boy left the hospital, well, on October 7th.

REMARKS.—We are obliged to Dr. Ord for permission to publish the notes of the case, which we think well worthy of putting on record, since we had the opportunity of assuring ourselves that the peritonitis which existed was very nearly, if not quite, general, and that recovery only took place with the formation of loculated abscesses. It will be noted that no irrigation whatsoever was employed at the primary operation, since the peritoneal cavity was practically obliterated by plastic peritonitis. His constitutional state, throughout, was good, and seemed altogether out of proportion to the abdominal condition. To this we must ascribe the successful issue of the case, and inasmuch as such are almost uniformly fatal, the present result is highly encouraging.

A CASE IN WHICH CHOLECYSTECTOMY WAS FOLLOWED BY RECOVERY.¹

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[With Notes by L. M. BRETON, M.R.C.S., L.R.C.P.]

In August last I saw the patient, in consultation with Mr. Breton, and agreed with him that the only chance of her living, or dying in any degree of comfort, lay in operation. Accordingly I performed cholecystectomy on August 13th.

The following history and notes of the case have been

written by Mr. Breton, who kindly assisted me at the operation.

Previous History.—For twenty years the patient, whose age is 52, has been subject to recurring attacks of abdominal pain, coming on suddenly, and generally accompanied by vomiting. The intervals, which at first were long—sometimes three or four years—became shorter, until within the eighteen months before the operation she had as many as six such attacks. During the eighteen months she had never been free from a constant dull aching pain in the situation of the gall bladder. She stated that she has never been jaundiced. When called in to see her on June 30th, 1896, I found her suffering from intense abdominal pain; she had vomited twice, her skin was cold and moist, and the pulse small and rapid. The acuteness of the pain passed off in a few hours, and on the following two days twelve or more gall stones were passed, varying in size from that of nearly a hazel nut to a split pea. After a few days the patient got about the house as before, but complained very much of constant aching pain, and expressed her willingness to undergo any treatment which could hold out prospect of permanent relief. Thinking that the mischief was most probably confined to the gall bladder or cystic duct (from the fact that the attacks had never been followed by jaundice), I thought the case was one favourable for the operation of cholecystectomy.

OPERATION.

The ordinary incision having been made and the peritoneal cavity opened, the gall bladder was found to be filled with what appeared to be one large stone. There was no fluid in the bladder, which was in close contact with its contents. Bearing in mind the excellent results of inguinal colotomy, where a glass rod is used, and only a couple of deep sutures instead of the old and more elaborate stitching, I determined on trying a somewhat similar mode of operation in this case. Accordingly, the pear-shaped tumour was drawn forward through the abdominal wound and used as a wedge. I then passed two deep sutures, including the peritoneum, through the abdominal wall, the one above the other below the apex of the "pear." A few more stitches completed the first stage of the operation.

On August 17th I removed the stone and adherent bladder. Its weight is 5 drachms, and it measures 2½ ins. in length and 1½ in. in width. Some small pieces were broken off in extraction, and on clearing these away and passing a probe into the duct no other stone could be felt. It appears to me that in any case where the gall bladder is fully and firmly distended, like this one, this operation is much to be preferred to the more complicated one, with its innumerable sutures in the gall bladder, which are always difficult to pass. Mr. Breton tells me that his patient is now in good health and spirits, and able to take short walks, though she had two drawbacks during convalescence—the one cystitis, the other phlebitis in the left leg; both, however, yielded to treatment, and she now expresses herself as absolutely free from the old intolerable pain.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

THE PATHOLOGY OF RODENT ULCER.

At the recent meeting of the Pathological Society of London, the question of the origin of rodent ulcer was again brought forward, and in the course of discussion Mr. S. G. Shattock alluded to the suggestion I made some two years ago at a previous meeting that the source of this growth was in abortive lachrymal glands upon parts of the face corresponding with the sites in which these glands exist in many of the higher mammalia, for example, antelopes, deer, sheep, goats, etc. He objected to this view on the ground of the wide distribution of the lesion, but suggested that the origin was in foetal residues of abortive glands. Now, the lachrymal glands or face glands I drew attention to are in structure highly differentiated glands of an acinous or tubular type. In one species both types may exist in the same gland, in another but one type may occur. Their position is most frequently at the inner canthus of the eye, infraorbital or supra-maxillary, but also supraorbital, inframaxillary, and post-audicular.

Almost without exception does rodent ulcer affect one of these positions. Cases are said to occur in other regions of the body, but, if we exclude the groin, these cases are so rare that one feels there may be some doubt about their being

¹Part of a paper on Calculi, read before the Southampton Medical Society, November 3rd, 1896.