there are other factors in the production of the latter is apparent from its rarity compared with the frequency of toxaemias.

Failed splenectomies have been recorded not only in the apparently acquired type of acholuric jaundice but also in the hereditary congenital type (Freund, 1932), and there seem to be no data available to show whether failure is commoner in one type or the other. It is doubtful at present, therefore, whether splenectomy should be regarded with greater favour in the familial congenital type.

Summary and Conclusions

A case of acholuric jaundice with a haemolytic crisis is recorded, in which splenectomy failed to cure the haemolysis.

Recovery followed the subsequent removal of an ovarian teratoma.

From a consideration of this case and others from the literature it is apparent that splenectomy does not always cure or prevent haemolytic crises in acholuric jaundice, and where radical treatment is necessary splenectomy is not invariably the method of choice.

Evidence suggesting that toxaemia may act as one of the precipitating factors in producing a haemolytic crisis, and that the latter may be cured by removal of the toxaemia, is discussed.

We are indebted to Mr. P. McEwan in regard to the surgical procedures mentioned.

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F. Hamburger (*Dtsch. Tuber.-bl.*, March, 1938, p. 53) points out that almost every tuberculous patient has tuberculous bronchial glands; there is, however, a narrower and more definite clinical entity occurring chiefly in infants under 2 years old. The general symptoms include a subfebrile daily temperature with a slight rise at night, lassitude, night sweats, and anorexia. Local symptoms are due to compression of the bronchi or trachea, and give rise to a high-pitched metallic cough and expiratory stridor. Similar symptoms may be due to mediastinal tumours or to acute bronchitis, and these conditions must be ruled out. Physical examination is of little value in the diagnosis of tuberculous bronchial glands. The tuberculin test must always be carried out; a negative result is proof of the absence of tuberculosis. An increased shadow round the hilum may be due to causes other than enlarged bronchial glands; its presence in a radiograph must be interpreted together with the other clinical data. A high blood sedimentation rate of 30 to 40 millimetres or more after an hour is in favour of active tuberculosis; a lowering of the rate is of good prognostic significance.

Clinical Memoranda

Fragment of Needle in Foot

(WITH SPECIAL PLATE)

The following case history presents some points that may be of interest.

CASE RECORD

A man consulted me on March 15, 1937, complaining that for the past two years he had suffered recurrent attacks of pain in the right ankle-joint. Latterly this symptom had increased in severity, and on exertion the right foot became swollen.

Clinically the condition appeared to be due to chronic synovitis of the ankle-joint. *X*-ray examination revealed a fragment of a needle lying in the soft tissues below the head of the os calcis (Plate, Fig. 1). Under local anaesthesia a Southey's tube was inserted into the sole of the foot down to the location of the foreign body, using the fluorescent screen. The trocar was removed, leaving the cannula in position. A further *x*-ray photograph (Fig. 2) was then taken by Dr. McDougall, who reports as follows:

"A piece of the eye end of a needle about half an inch long is visible close to the bone in the plantar aspect of the head of the os calcis. In the dorsi-plantar view the foreign body is right in the centre of the foot and about a quarter of an inch from the joint formed by the os calcis and the cuboid. A needle indicator is in position showing the relation of this guide to the foreign body."

Under local anaesthesia a vertical incision about three inches in length was made in the sole of the foot. Using the cannula as a guide, the dissection was carried through the plantar aponeurosis and deeper structures down to the head of the os calcis. The fragment of needle was found under the periosteum. The distal end of the cannula was situated about a quarter of an inch from the foreign body.

Points of interest are: (*a*) the use made of the cannula as a guide; (*b*) the patient had no history of a needle having entered his foot or any other part of his body.

Auckland, New Zealand. J. P. HASTINGS, M.D.

Ischio-pubic Osteochondritis: with Report of a Case

(WITH SPECIAL PLATE)

This uncommon condition has only recently been recognized clinically. Attention was first drawn to it by Van Neck in 1924. Since then a few cases have been described in America and on the Continent, but none has been reported in the British Isles. Probably it does occur with some rarity and only needs a wider recognition of its clinical and radiographic features.

The condition arises before the union between the ischium and pubis is complete. This occurs between 8 and 10 years of age. The case described below was that of a boy 8 years old when first seen. He had been complaining of pains in his lower limbs for four years. In Durham's series the average age of the five patients was 7½ years. Either sex may be affected. The condition may be bilateral or may only affect one side. It is a non-suppurative osteochondritis allied to the disturbances in growing areas met with in Perthes's and Osgood-Schlatter's disease. Durham thought that trauma might be a causative factor in some of his cases. There was no definite severe injury in the present case, but the boy was apt to trip and fall easily, and this may have been a factor.

The child is usually brought to the doctor on account of a limp and of pains in his lower limbs, referred about the hip-joint. The severity varies; in some children the disability is slight, but in others the child may be acutely ill. Two of Durham's patients held the hip flexed and had a temperature of over 102°. On rest in bed the acute symptoms rapidly subside. In bilateral cases all the symptoms may be referred to one side. Examination usually shows some spasm in the adductor muscles, causing a limitation of abduction, extension, and rotation of the hip-joint. Some thickening is to be felt over the ischio-pubic junction, and in the acute stage tenderness is present over the swelling.

Treatment consists in rest in bed till all spasm has disappeared. This will take less than six weeks, although the radiographs will still show the rarefaction and swelling at the ischio-pubic junction. Gradually the bony condition returns to normal.

CASE RECORD

In the present case the mother stated that for four years the patient, a boy aged 8, was easily tired. After walking about a hundred yards he would complain of pains in the calves; he also tripped and fell without apparent cause. The symptoms were not always present, but varied from day to day.

The boy was pale, of average height and weight, and had large and unhealthy tonsils. Nothing abnormal was noted on inspection. Movements at the hip-joints were full, with the possible exception of a slight diminution of internal rotation in the left hip. Palpation of the ischio-pubic rami revealed a slight thickening in the descending ramus. This swelling was not tender. The reflexes and sensation were normal. An *x*-ray examination showed swelling and rarefaction at the ischio-pubic junction, typical of osteochondritis. The condition was present on both sides, but was more marked on the right side (see Plate).

It was thought that the septic tonsils might have been a factor in the boy's pains and condition. The tonsils were accordingly removed by dissection. When seen six weeks later the patient was much improved in every way, but he was not yet allowed to exert himself. A radiograph taken at this time showed a lessening of the rarefaction, but the bone was not yet normal.

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Belfast. Ulster Hospital.

Clubbing of Fingers and Toes associated with a Congenital Lung Cyst

(WITH SPECIAL PLATE)

The following case appears to be interesting enough to be placed on record.

CASE RECORD

A commercial traveller aged 50 was referred to the out-patient department for investigation on account of glycosuria. He gave no history suggestive of diabetes mellitus, and the urine did not contain sugar, acetone, or diacetic acid. Blood sugar was found to be 0.085 per cent. two hours after a meal containing carbohydrates. On closer interrogation the patient stated that he had been taking large doses of aspirin for headaches. There was no history of previous illness; but since 1917, when he was gassed in France, he had developed some cough with a little sputum. This had never been blood-stained; there was no dyspnoea on exertion and no other symptom of cardiovascular embarrassment.

On examination the patient appeared to be a normal healthy man, rather younger than his age. He was not cyanosed. Attention was immediately called to the fingers, which displayed a noticeable degree of clubbing, with nails curved like an inverted watch-glass and of a moderately livid tinge (Fig. 1). It was soon discovered that the toes showed a similar abnormality (Fig. 2). The patient repeatedly stated that he had always had large nails, and remembers quite distinctly his mother telling him that they had been so since childhood. No information was obtained as to whether this peculiarity had occurred in other members of the family. The

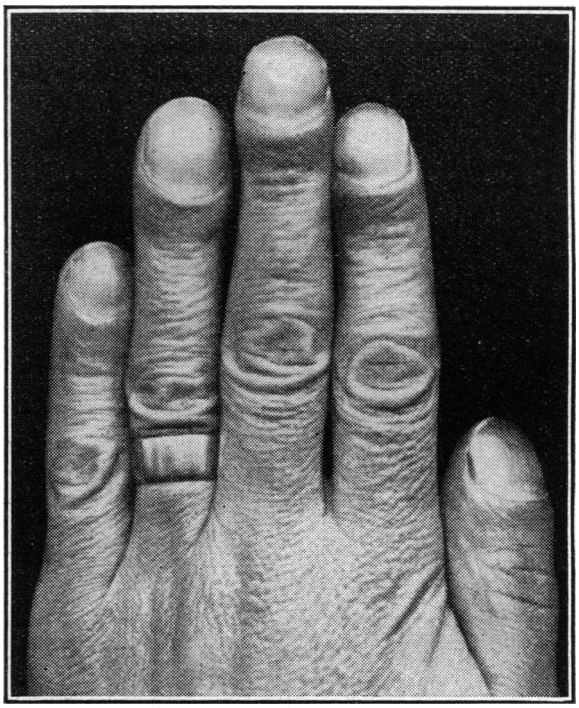

FIG. 1.—Photograph of left hand, showing a noticeable degree of clubbing.

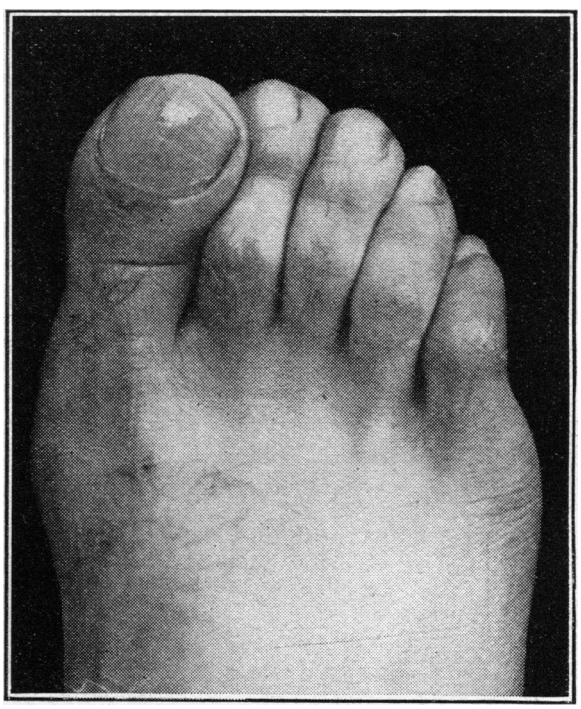

FIG. 2.—Photograph of right foot, showing clubbing of toes.

patient is an only son, and lost his father when still very young. His mother lives in Canada.

The heart was not enlarged and the sounds were clear. There were occasional extrasystoles without subjective distress. An electrocardiogram was normal, except for occasional ventricular extrasystoles. His blood pressure was 130/80. The lungs expanded normally and on percussion gave a

slightly hyperresonant note. On first examination a small group of crepitations were heard over the right interscapular region: this finding was not confirmed in subsequent examinations. A radiograph of the chest showed a moderate degree of chronic bronchitis and emphysema, such as is often found in patients who have been gassed. The sputum was negative for tubercle bacilli, and the sedimentation rate was 6 mm. at the hour. A blood count showed normal values for red blood cells, haemoglobin, and white blood cells, with normal distribution.

The right lung was then injected with lipiodol by the intratracheal route and a bronchogram was taken (see Plate). This led to the discovery of an unsuspected cavity about half an inch in diameter in the right upper lobe. The distribution of the lipiodol was normal in the other bronchi. Unfortunately the patient refused to undergo injection of the left lung on account of a mild iodism after the first injection.

DISCUSSION

Two points are obviously of interest in the diagnosis of this case: first, what is the nature of the cavity shown in the bronchogram; and, secondly, can any relation be established between the condition of the lungs and the clubbing of the fingers and toes? The most probable explanation of the cavity is that it is a lung cyst. There is no evidence, either local or systemic, of tuberculosis or of non-tuberculous lung infection. The outlines of the cavity are not shown in the chest radiograph. As to the second point, it is evident that no recent infective or other pathological process could explain the clubbing of the fingers and toes, as this occurred very early in childhood. A causal relation might, with the greatest reservation, be assumed with a congenital lung cyst, especially as we do not know whether a bronchogram of the left lung would have shown a similar and perhaps more extensive process. But I would like to stress the words "with the greatest reservation."

One fact certainly emerges from the study of this case—that is, the importance of bronchography. I think it is worth while emphasizing this point, as in a recent paper Dr. Seaton (1938) stated that clubbing of fingers without an apparent cause is not uncommon. I venture to suggest that this statement is rather far-fetched, and that the condition would be found to be quite infrequent provided the cases were investigated thoroughly enough and a chest was not dismissed as normal merely on clinical and radiological evidence.

As I myself am presenting a case of congenital clubbing of the fingers and toes it is obvious that it is not my wish to deny the existence of such a condition: the familial incidence in some cases, as reported in Dr. Seaton's very interesting paper, would indeed be sufficient to establish it firmly.

SUMMARY

A case of congenital clubbing of fingers and toes is described in which a radiograph of the chest did not show any marked abnormality, while a bronchogram revealed an unsuspected cavity in the right upper lobe. The nature of this cavity, believed to be a lung cyst, is discussed, with its possible relation to the clubbing of the fingers and toes.

The importance of bronchography in the diagnosis of obscure cases is emphasized.

I wish to express my gratitude to Dr. Ernest Fletcher, physician to Queen Mary's Hospital for the East End, for permission to publish this case and for helpful advice and criticism.

E. MONTUSCHI, M.D.

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Rupture of an Ovarian Dermoid

(WITH SPECIAL PLATE)

So uncommon is the rupture of an ovarian dermoid that the following case seems of sufficient interest to be recorded.

CASE RECORD

A single woman aged 55 was admitted to Charing Cross Hospital as an emergency under the care of Mr. R. A. Fitzsimons, on whose behalf I saw the case and by whose permission these notes are published. She was seized with a sudden sharp pain all over the abdomen but felt more severely in the right iliac fossa. She was emphatic that it was not of a colicky nature and in no way resembled bowel pain, and stated that the abdomen was sore to the touch. Two days previously she had vomited, and on the onset of the acute pain there had been a feeling of fullness in the abdomen with retching, but no recurrence of the vomiting. The bowel habit over many years had been constipated, with a definite feeling of obstruction to the passage of the faeces. There was no disturbance of micturition; her menstrual periods, which began at the age of 17, had been regular, although painful, until an uneventful menopause at the age of 50. The only point of interest in the past history was a bilious attack two months prior to admission—since a hand passed up to the liver at the time of operation revealed the presence of gall-stones.

On examination the patient did not appear ill; her temperature was 99°, the pulse 116, and her tongue clean. The abdomen was diffusely tender and rigid, more so below the umbilicus than above, and more to the right than to the left of the midline. No abdominal mass was palpable. The rectum contained a quantity of constipated faeces, and a mass of similar consistency in the pouch of Douglas was thought, wrongly, to be faecal material in the sigmoid colon. A diagnosis of mild unlocalized peritonitis was made, probably not of appendicular origin. Operation was advised and accepted.

A lower paramedian incision was made and the peritoneal cavity was found to contain fluid resembling sebaceous material, of which some three pints were removed by suction. The source was found to be a collapsed left ovarian cyst; the site of rupture, through which hair was protruding, was on the right-hand side, the solid portion occupying the pouch of Douglas. The cyst was removed, appendicectomy performed, and a drain left down to the pelvis. The tumour measured some eight inches in diameter, and its contents are shown in the photograph here reproduced (see Plate). *Staphylococcus albus* was grown on culture of the fluid. Dr. H. W. C. Vines reported as follows upon the specimen: "A multilocular simple dermoid cyst presenting no unusual features." There was no drainage, and the patient made an uninterrupted recovery, being discharged on the fourteenth day after operation.

K. L. JAMES, M.S., F.R.C.S.
Charing Cross Hospital, W.C.2. Surgical Registrar.

H. Mai (*Münch. med. Wschr.*, March 18, 1938, p. 393) reports on the use of convalescent serum in the treatment of acute anterior poliomyelitis in children. His statistical survey embraces 335 cases, of which 145 were treated with convalescent serum while 190 had no serum. The serum had no effect when given in either the preparalytic or paralytic stage. The mortality among the children treated with serum was higher than among the children who had no serum, but this was probably due to the fact that recourse to serum was frequently had in very severe cases with signs of respiratory paralysis. On the whole the serum proved neither useful nor harmful.

F. C. PYBUS AND E. W. MILLER: HEREDITARY BONE TUMOURS IN MICE

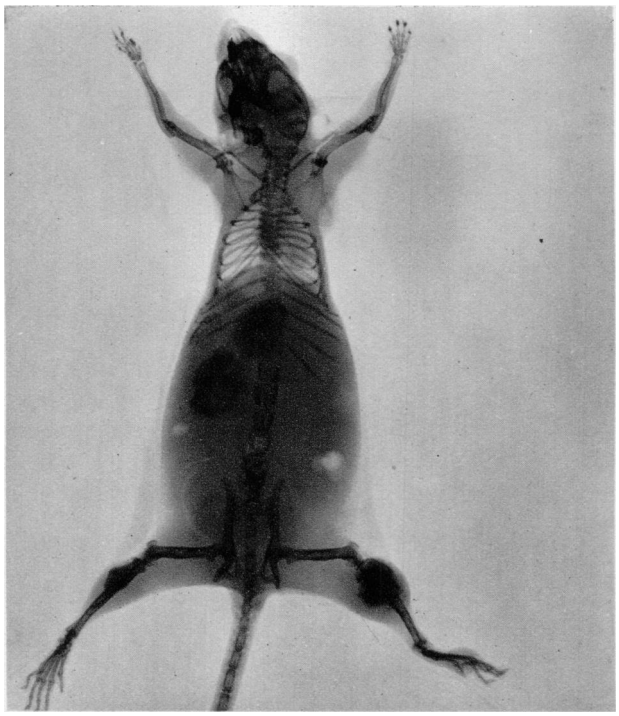


FIG. 1.—Radiograph of mouse 2773, showing osteogenic sarcomata of both tibiae and one lumbar vertebra; also large bony metastases in liver.

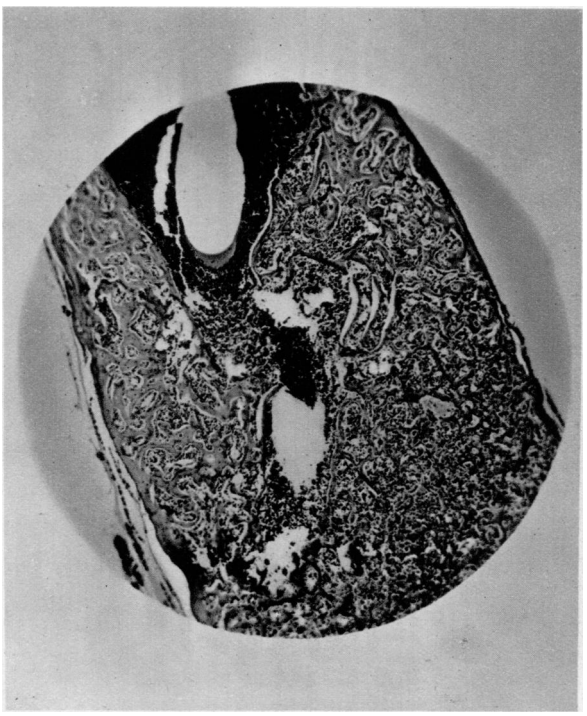


FIG. 2.—Longitudinal section of femur from mouse 2121: osteogenic sarcoma with some normal marrow still remaining. Haematoxylin-eosin: Ilford green filter (Micro 3). Obj. 2/3″; eyepiece × 5.

K. L. JAMES: RUPTURE OF OVARIAN DERMOID

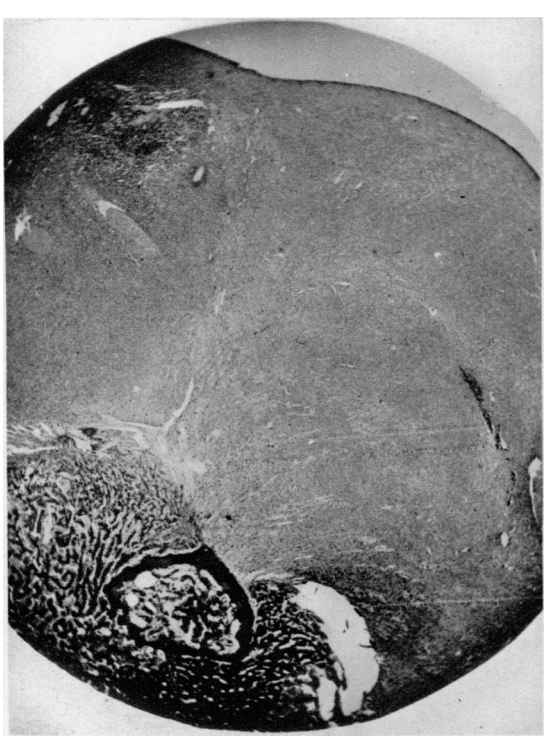
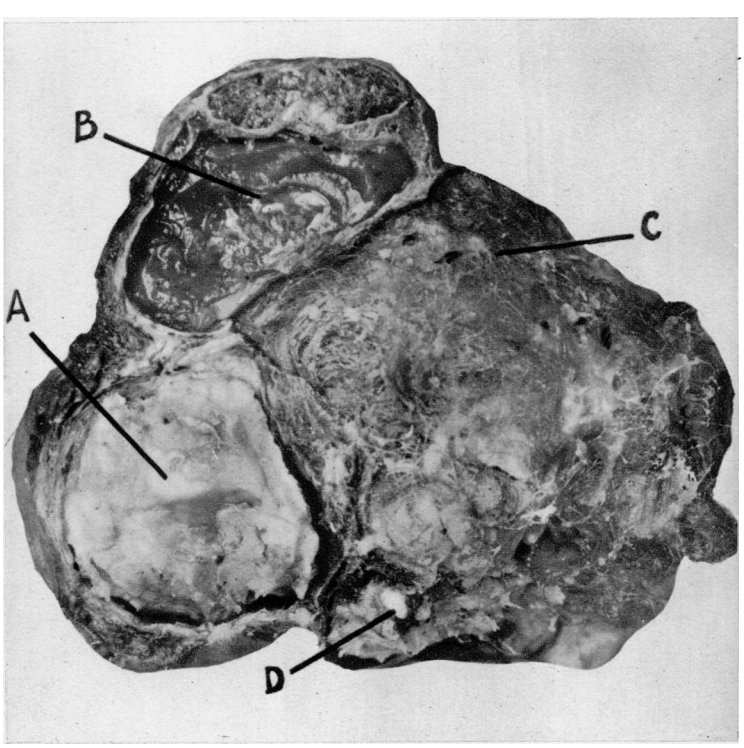
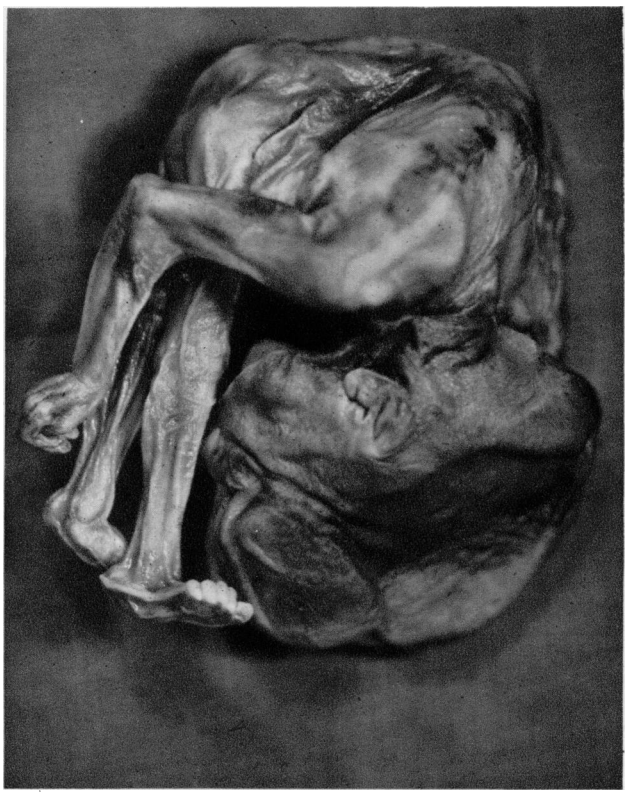


FIG. 3.—Mouse 3155. Transverse section of humerus, showing osteogenic sarcoma within shaft, surrounded by osteogenic and spindle-celled sarcoma, rapidly growing and infiltrating muscle. Van Gieson: Ilford blue and yellow filters (Micro 2 and 4). Obj. 1″; eyepiece × 5.



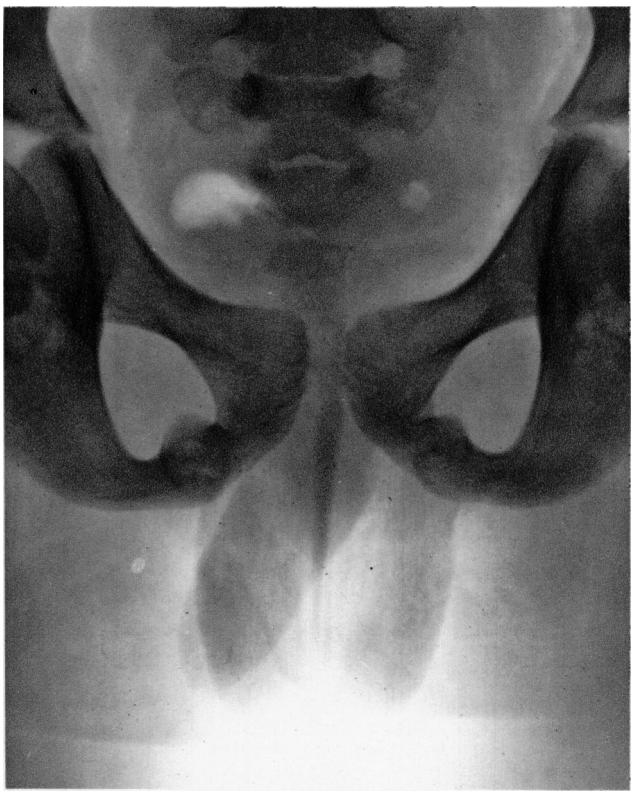
Photograph of the tumour in section. Note fatty sebaceous material (A); green jelly-like secretion (B); matted hair (C); and a tooth (D).

RONALD REID: A CASE OF ABDOMINAL PREGNANCY



The foetus.

GEORGE D. F. McFADDEN: ISCHIO-PUBIC OSTEOCHONDRITIS



Radiograph showing swelling and rarefaction at the ischio-pubic junction typical of osteochondritis.

J. P. HASTINGS: FRAGMENT OF NEEDLE IN FOOT

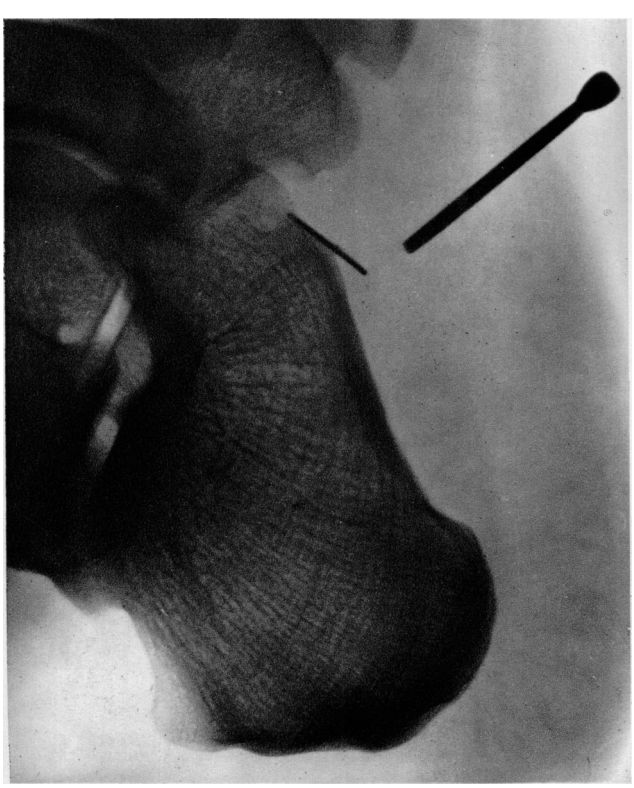


FIG. 1.—Radiograph showing a fragment of needle lying in the soft tissues below the head of the os calcis.

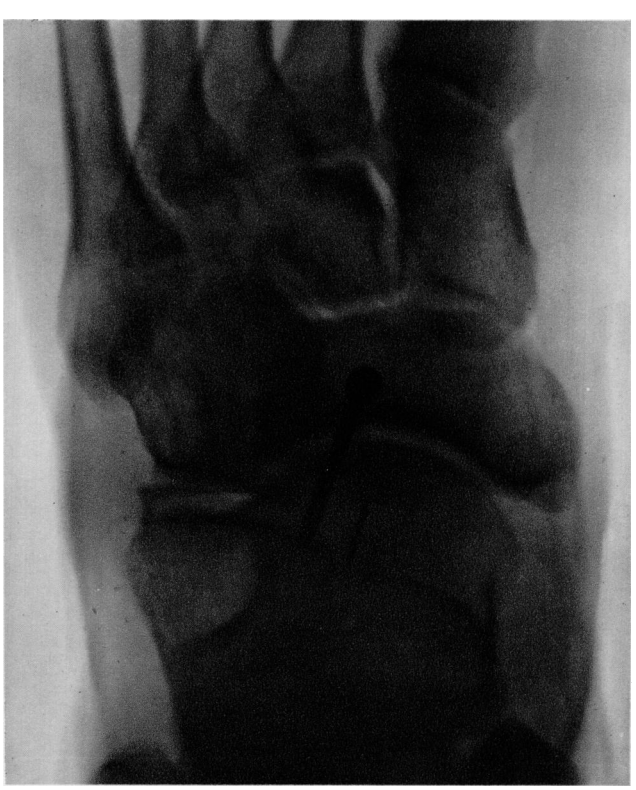


FIG. 2.—Radiograph showing the position of the foreign body in relation to the guide.

T. H. S. TIZZARD: KERATOPLASTY

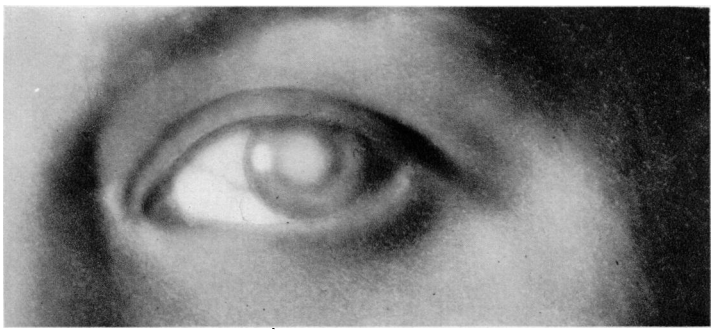


FIG. 1.—Left eye before operation

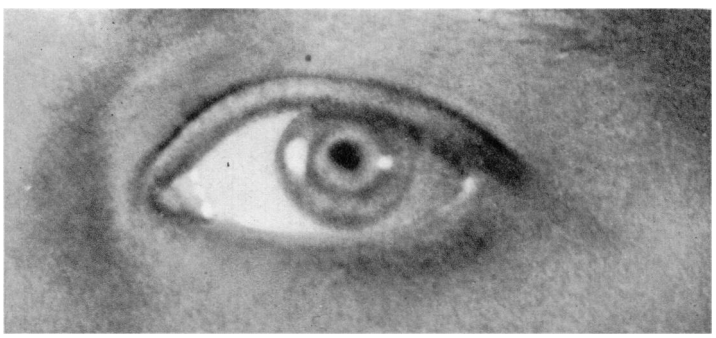
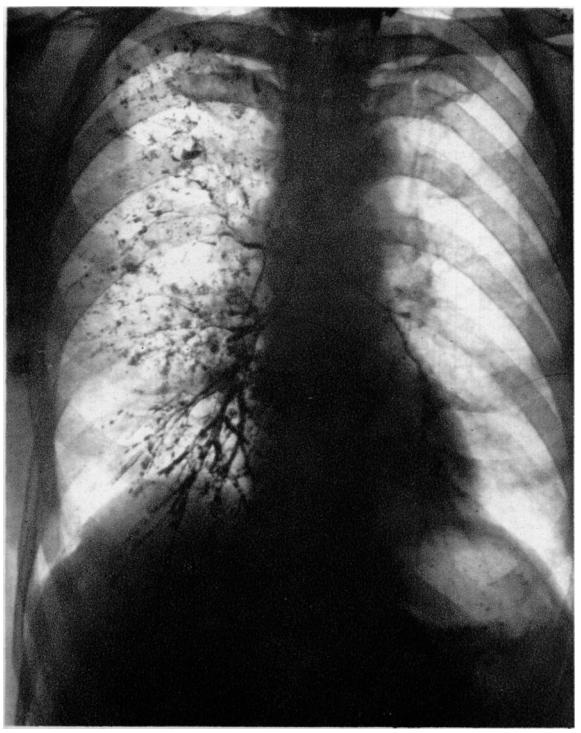


FIG. 2.—Left eye five months after operation.

E. MONTUSCHI: CLUBBING OF FINGERS AND TOES ASSOCIATED WITH A CONGENITAL LUNG CYST



Bronchogram of right lung.

J. L. RYCE: SUPERIOR PULMONARY SULCUS TUMOUR

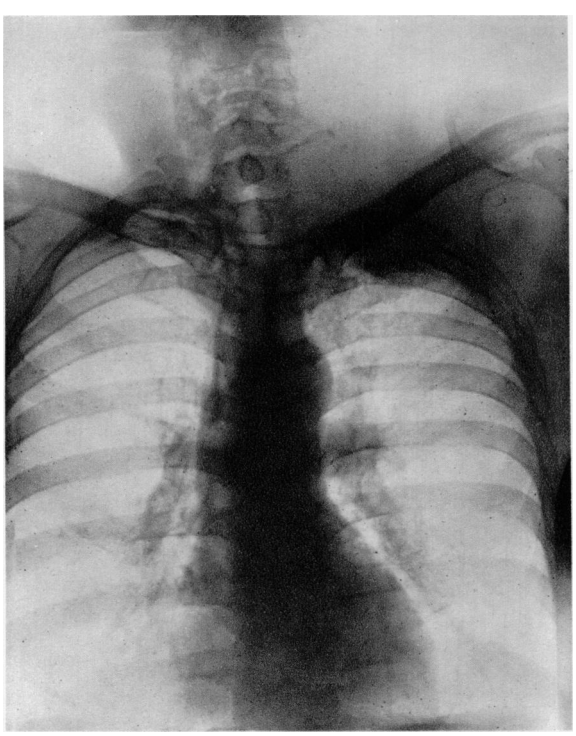


FIG. 1.—Radiograph of chest, September 15, 1937. Note erosion of seventh cervical vertebra and disappearance of first and part of second left ribs.

FIG. 2.—Section of tumour.