case is there definite proof that the prostate was the primary location of the hydatid cyst." Plaggmeyer and Cummings in their exhaustive review, conclude "It is doubtful if hydatid cysts ever originate in the prostate".

SUMMARY

1. A case of hydatid cyst arising from the prostate is presented.

2. The symptoms were those of prostatic obstruction.

3. No reaction occurred following rupture of fluid into the peritoneal cavity.

4. The question of the origin of echinococcal cyst associated with the prostate is still unsettled.

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CASE REPORTS

INTUSSUSCEPTION IN THE NEW BORN*

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Intussusception occurring in the new born is exceedingly rare. So far as can be determined, there have been 17 cases recorded up to the present time. In reviews of the literature, Helmholtz[1] referred to 3 cases, Hess[2] to 2, and Fitzwilliams[3] to 2. Original reports have been made by Tweedy,[4] Dowd,[5] Steele,[6] Perrin and Lindsay,[7] Peterson,[8] Gelston and Sappington,[9] Mayo and Phillips,[10] Schiavoni,[11] Lewis,[12] and Scott.[13]

Of the 17 cases, 7 were operated upon. Dowd's 5-day old infant with an irreducible intussusception requiring resection of one-third of the colon was the only one that survived.

In compiling the characteristic clinical findings, only 5 cases were found described in sufficient detail to be of value. These were recorded as follows: (1) Vomiting—present in all. (2) Blood-stained stools—present in all. (3) Absence of diarrhœa—noted in all. (4) Colicky pain—present in one, not mentioned in 3, although one was described as irritable, and definitely absent in one. (5) Abdominal distension—present in 2, absent in one, and not mentioned in 2. (6) Palpable mass—present in 3, absent in one, and not mentioned in one.

To these reports, the following case, which appears to be the youngest on record, is added:

On August 26, 1944, at 8.20 p.m., a woman was delivered by Cæsarean section, under ethyl chloride and ether anæsthesia, of a male infant at 8 months' gestation. The mother was a 31 year old primipara, who, after 42 hours of poor labour, showed definite evidence of primary uterine inertia. As the fetal heart sounds were becoming slower and fainter, surgical intervention was considered necessary.

The baby weighed 5 pounds 12 ounces at birth, cried vigorously and appeared in excellent condition. He was given synkamin and placed in the premature nursery. There were no unusual symptoms until 16 to 18 hours after birth. He had been taking small amounts of water without vomiting, but during the afternoon of August 27, the day after delivery, he had become restless, cried occasionally, and vomited for the first time at 6.00 p.m., 22 hours after delivery. He had passed no meconium since birth, although a considerable amount was observed in the amniotic fluid at operation. At 8.00 p.m., he had a small green mucoid blood-tinged stool, the first since birth. The vomiting continued, becoming bile-stained. On examination at 9.00 p.m., the infant appeared distressed. The abdomen was distended and on palpation, there seemed to be some generalized tenderness, but no mass could be felt. A rectal examination disclosed nothing unusual. A colonic irrigation yielded only a small amount of blood-tinged mucus, and failed to relieve the distension.

During the next 2 hours, the vomiting continued, and more bloody mucus was passed by rectum. Obviously the infant had intestinal obstruction, and a preoperative diagnosis of intussusception or volvulus was made.

At 12 midnight, 28 hours after delivery, a laparotomy through a midline incision revealed an intussusception of about 2½ inches in length at the ileo-cæcal valve. This was reduced with very little difficulty and the abdomen was closed. The baby was returned to the nursery with a catheter inserted in the stomach, which was to be aspirated every hour. He was given synkamin and a continuous intravenous of 5% glucose in saline. The distension recurred the next morning and persisted despite heat, rectal tube, small saline enemata and stupes. All enemata returned clear, except the first, which contained a few minute blood clots. The temperature rose to 103 degrees, 14 hours after operation, but dropped to normal in 24 hours. The catheter was left in the stomach because bile-stained fluid was being aspirated. The infant gradually became weaker, despite blood transfusions, coramine and oxygen. The distension was slightly reduced, but the respirations became shallower and he ceased to breathe at 9.50 a.m., August 30, 58 hours after operation.

An autopsy performed 4½ hours after death was reported as follows:

Thorax and thoracic viscera.—These showed no changes of special note.

Abdomen and abdominal viscera.—The edges of the abdominal incision were firmly bound by a fibrinous exudate, while only a minimal amount of hæmorrhage was noted in the surrounding area. A considerable amount of fibrin covered the serosal surface of the intestines binding the loops of these together by delicate adhesions. No purulent material was noted. The œsophagus was normal while the stomach was congested and filled with a large amount of gas as as well as a small amount of bile stained mucus. Both the small and large bowels were considerably

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distended throughout with gas and contained in addition a considerable amount of soft pinkish material, while the intestinal wall was thin and markedly congested. Areas of hæmorrhage were noted throughout, but there was no evidence of any recurrence of the intussusception. The vessels of the mesentery were also considerably congested. The liver weighed 140 grams and was normal in its external configuration. The capsule was thin, transparent, smooth and glistening throughout. The parenchyma was of a yellowish brown colour and a small hæmangioma, measuring about one cm. in diameter was noted near the anterior margin of the upper surface of the left lobe. The gall bladder was filled with clear mucus, while the biliary ducts were not remarkable. The spleen, pancreas and adrenals were essentially normal; the spleen weighing 5 gm., and the adrenals together weighing 6 gm. The kidneys together weighed 28 gm. and were covered with thin, smooth, glistening capsule which stripped with ease, revealing a firm reddish brown surface beneath, the fetal lobulations being well marked. The cut surface showed no disturbance of the cortical medullary ratio, but the pyramids were found to contain numerous fine bright yellow lines, converging towards their apices. The kidney pelves, ureters and bladder were markedly distended with pale yellow urine containing numerous minute bright yellow specks resembling pollen in water. Microscopic examination of the urine showed it to contain large numbers of red cells, granular casts and epithelial cells.

Despite the gross appearance of the kidneys, little of note was to be seen on microscopic study. The glomeruli for the most part were of a small, rosette-like, compact, cellular structure similar to those usually seen in fetal specimens. The occasional glomerulus, however, was encountered in which a small amount of subcapsular fibrillar deposit was apparent, although no actual blood cells were encountered. The cytoplasm of the convoluted tubules was in many areas granular, fenestrated and disintegrating, while the nuclei stained poorly or were completely lost. Here and there collecting tubules were encountered, the lumina of which were slightly distended with pale, acidophilic, granular material, the nature of which could not be determined, though it showed little resemblance to albumen. No inflammatory changes were encountered in the kidney, the abnormalities which were present being of a purely degenerative nature, and probably toxic in origin.

COMMENT

The symptoms in this case were typical of intussusception at any age, with vomiting, blood-stained mucoid stools, and absence of diarrhœa. The infant undoubtedly experienced some abdominal discomfort as demonstrated by its restlessness, but there was no evidence of the colicky pain characteristic of intussusception in older infants. In surveying the previously reported cases which were described in detail, definite pain was recorded in only one case.

A preoperative diagnostic x-ray was considered unnecessary, as the signs of intestinal obstruction were so apparent.

The actual time of onset of the intussusception is difficult to establish. It is unlikely that it occurred until several hours after delivery, as the infant's behaviour was entirely normal for the first 16 to 18 hours. According to Ladd,[14] blood appears in the stool probably 4 to 12 hours after onset. In this case, it was first noticed 24 hours after birth, which fact, when correlated with the symptoms, would suggest an onset at about 16 hours after delivery.

SUMMARY

So far as can be determined, 17 cases of intussusception in the new born have been recorded in the literature. The clinical findings of 5 are tabulated; the only cases described in detail. An additional case occurring during the first day of life is reported.

In preparing this paper, I wish to thank for their collaboration Dr. R. E. D. Cargill who conducted the delivery: Dr. H. B. Moffatt who reduced the intussusception, and Drs. M. O. Klotz and F. W. Hanley who performed the autopsy.

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BOECK'S SARCOID

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Sarcoidosis is a comparatively rare and obscure chronic inflammatory skin condition. The literature on the subject in the journals and standard textbooks is very meagre. This paucity of information and the good therapeutic results obtained, have stimulated me to report the one case in my experience diagnosed as Besnier-Boeck's-Schaumann's disease.

The patient, Mr. J.D., aged 33, first came to me in November, 1941, with a chronic granulomatous nasal condition with marked telangiectasis and bulbous enlargement of the nose, the condition spreading laterally to both malar eminences. This had been present one year. It appeared at first to be a typical case of lupus erythematosus, and later as the patient's nose grew progressively larger, looked like rhinophyma.

The general physical examination was essentially negative. The concentration of hæmoglobin was 15.3 gm., the flocculation test for syphilis was negative; the x-ray of the right ankle was negative and x-ray of the chest showed mid- and superior-mediastinal widening bilaterally, which was presumed to be on the basis of the sarcoidosis. X-ray of the hands and feet showed widening and irregularity of the shafts of the fourth and fifth metatarsals on the left; this, likewise, was presumed to be associated with the sarcoidosis.