that they may be boiled; change the shoes frequently so that the leather does not become sweat-laden, and swab the insoles with dilute lysol. Bathe the feet in the morning with potassium permanganate solution (1/20,000). Dust the feet after bathing with the following powder, Acid Salicylic, grains 5; Pulv. Amyli, Talc, Zinc Oxide, Pulv. Acid Boracic aa drachms 2. At night bathe the feet and apply lotio calaminæ, to which has been added 1 per cent sulphur præcipitate. Another useful application is Acid Salicylic 5 per cent, Acid Tannic 10 per cent in Alcohol (65 per cent), painted on morning and evening after bathing the feet in warm boracic solution.

Pityriasis rosea cases numbered 20, or 1 per cent. For some years we have been interested in the occurrence of the disease after wearing new under-clothing that has not been washed before wearing. When fleece-lined underwear was more fashionable, as it seems to have been about ten years ago, it was quite common to find the disease occurring after wearing an unwashed suit of this material. The disease responds readily to treatment. A useful application is phenol, 1 per cent in linimentum calaminæ applied freely many times a day, and a daily sodium bicarbonate or boracic sponge-bath. Erythema doses of ultra-violet ray increase exfoliation and shorten the course of the disease.

CONCLUSION

It is evident that the most common diseases in the skin clinic are contagious, namely impetigo, scabies and tinea.

The next most common are allergic in origin, namely eczema and dermatitis venenata.

A variety of treatments is necessary in the majority of skin diseases. I have referred to some routine methods that have proved of value over a period of years.

Case Reports

A CASE OF APPENDICITIS WITH MOST UNUSUAL SYMPTOMS

BY WILLIAM OLIVER STEVENSON

Hamilton, Ont.

Mrs. D.B., aged 41, was admitted to St. Joseph's Hospital, Hamilton, on the evening of February 23, 1938.

Past history.—Married; one child twelve years of age; no further pregnancies; her last menstruation, six days in duration, was completed one week previously. The patient had always been a very healthy woman, and, other than a confinement, had never been ill until about three years ago, when she began to have attacks of backache in the lower lumbar region which would last about ten days at a time. She stated that the only relief she got was to stand against a hot radiator and rest as much as possible. These attacks of pain would come irregularly every two to four months.

Present illness.—Three days prior to admission she had a return of this backache, which persisted throughout the three days, and was felt to be a little higher in the left loin as well. She went to bed and called her physician, who attended her prior to admission. He thought he could elicit some tenderness in the left iliac fossa on deep palpation. The build of the patient was such as to render physical examination very difficult. She weighed approximately 230 pounds, and had a very heavy abdominal wall, with at least five inches of fat in the form of a pendulous apron which hung down six inches below the vulva. As the patient did not improve and the temperature was rising, she was admitted to hospital.

Physical examination.—Further examination elicited the following. The patient had neither vomited nor felt nauseated at any time; there was no abdominal rigidity, no flatulence. The bowels had moved normally six hours before. The site of pain, which was of a dull aching character, was in the left lumbar region above the crest of the ilium; slight discomfort was felt on deep pressure in the left iliac fossa. The temperature rose rapidly, and by 11 p.m. was 104°; pulse 96; and respirations 22. The patient did not look ill and was quite able to partake of her liquid diet. Urinalysis of a catheter specimen was specific gravity 1.022; acid; an occasional pus cell; a trace of albumin; no sugar. Red blood count 5,200,000; white blood count 40,200; the differential count showed 78 per cent polymorphonuclears, of which 25 per cent were young; the lymphocytes were normal. A blood culture was taken which remained negative over several days. Blood chemistry gave urea 25.9 mg.; creatinine 1.85 mg.; and blood sugar 0.21 per cent.

Pelvic examination revealed no vaginal discharge, a normal-sized uterus, and no masses could be made out; there was no tenderness nor pain. The lungs were clear and no evidence of an infection could be found in the nose and throat.

Diagnosis.—The diagnosis of this case of obviously inflammatory origin was very obscure. A twisted and ruptured ovarian cyst with some intra-peritoneal hæmorrhage was considered. The appendix was thought of, but the absence of intra-peritoneal subjective symptoms and objective signs was against any inflammatory condition within the peritoneal cavity. The patient was therefore put on fluid diet, with an electric heater over the left loin, and, pending the result of the blood culture, she was given an immediate dose of 25 grains of prontylin, followed by 10 grains every four hours, with a like amount of soda bicarbonate.

Progress.—During the next three days there was no change in the absence of intra-peritoneal symptoms or

signs, but on the fourth day the patient began to complain of pain in the right lumbar region high up in the neighbourhood of the kidney. A perinephric abscess was thought of at this time, as the pain was quite acute. At no time did she vomit or lose her appetite for fluids, nor was there any interference with normal bowel movements. Under the influence of prontylin the temperature in three days was reduced to 101°, but the pulse had risen to 112 and the white blood count was 37,000. Examination per vaginam was still negative. The facial aspect remained the same, except that the patient was obviously very tired. At this juncture the prontylin was stopped because she had had heavy dosage and a slight cyanosis had begun. On the morning of the seventh day the temperature had risen again to 104.5° and the white blood count to 40,000. No localization of the inflammatory process could be made out and the pain had ceased in both lumbar regions. The pulse had risen to 130; the urine still showed only an occasional pus cell and a few red blood cells. It was quite obvious that this woman was in a desperate state. Despite stimulation and intravenous therapy she became comatose at 8 p.m. and death occurred two hours later on March 3rd.

Post mortem.—Post-mortem examination revealed the following important points. There was no inflammation within the peritoneal cavity, simply about 20 c.c. of clear peritoneal fluid in the pouch of Douglas. The uterus and adnexa were normal. The cæcum occupied a low position in the right iliac fossa and the appendix was wholly extra-peritoneal, extending over the right iliac artery across the back of the true pelvis into the root of the sigmoid mesentery. It was nothing but a gangrenous mass with a bulbous tip, which had ruptured at this point. Absorption from this had apparently spread up into the aortic glands on both sides of the vertebral column through the trunk lymphatics, and on the left side every gland was nothing but a pus sac. The perirenal fat contained multiple abscesses, and this condition reached as high as the diaphragm. On the right side a similar condition was present and had reached as high as the perirenal fatty tissue. All of this inflammatory process was therefore behind the posterior parietal peritoneum. The remainder of the examination was essentially negative.

REMARKS

This is the first case of its kind that the writer has ever experienced in many hundreds of cases of acute appendicitis. The absence of the usual symptoms can be put down to the absence of intra-peritoneal involvement. It also lends substantiation to the views of Zachary Cope concerning the silence of the parietal peritoneum on the posterior abdominal wall. There is no question that absence of pain on a vaginal examination was due to the presence of the appendix already gangrenous and perforated.

A case of this kind makes one stop and think what the consequences would have been had the usual operation for an appendix been attempted, or if one had explored the abdomen for a twisted and ruptured ovarian cyst. The surgeon would only have transformed a post-peritoneal infection into a generalized intraperitoneal one, with the same fatal result.

ACUTE DIVERTICULITIS OF THE ASCENDING COLON

BY R. V. B. SHIER

Toronto

On March 17, 1936, Miss E.M., aged 55, sent for her physician, Dr. H. K. Detweiler, because she had had generalized abdominal pain for 36 hours. The pain centralized about the umbilicus and a few hours after the onset she noted a temperature of 102° F. Her physician found definite acute tenderness midway between the costal margin and the anterior superior spine on the right side, and found her temperature to be 102°. She was immediately sent into hospital. Here the findings were corroborated, and as her leucocyte count was 15,500 and the urine negative for pus, a diagnosis of acute retro-colic appendicitis was made and operation advised.

Under spinal anæsthesia the abdomen was opened through a split muscle incision. The cæcum was delivered and with it a normal appendix. It was noted that a mass was present involving the ascending colon at the junction of its middle and upper third. The mass was visualized by deliberately dividing the abdominal muscles between clamps. It was found to be covered with fibrin, more especially on the mesial side of the colon. It was certain that this mass was inflammatory, and it was decided to exteriorize the ascending colon and hepatic flexure. This was done by the usual Mikulicz method, the involved bowel being removed by cautery.

The specimen was found to be a solitary diverticulum of the ascending colon and was reported on as follows by the Pathological Department.

"This specimen consists of a portion of ascending colon and attached mesenteric tissues. The intestine measures about 8 cm. in length and has a fairly uniform width of 7 cm. when opened. The mesenteric tissues are markedly indurated and injected, and the central part, near the wall of the bowel, appears somewhat necrotic or degenerative. The wall of the bowel is thickened by œdema and the mucosa shows much œdema and a moderate amount of injection. In the centre of the wall of the bowel is a large ulcerated, perforating area, measuring about 1 cm. in diameter, extending through the wall into the mesenteric fat for about 1.3 cm. This area forms a sac in which there is a fæcolith measuring about 1.1 cm. in diameter. The wall and base of this ulcer or sac-like projection are rough, and apparently not lined by mucous membrane but made up of inflammatory products and covered by exudate.

"Microscopically, one small section from the edge of the lesion shows extensive ulceration of the mucosa, the superficial layer showing necrosis and there is an acute inflammatory infiltration. The reaction is not specific in character. There is no evidence of malignancy. The fat from behind the cæcum contains large areas of hæmorrhage and forms the base of the ulcer. This appears to be a diverticulum in which the epithelial lining has disappeared due to the acute inflammatory process. The presence of a fæcolith favours this diagnosis rather than that of simple ulcer with perforation."

For the first week the post-operative progress was stormy due to localized peritonitis. This gradually subsided and at the end of a month, on account of the free focal discharge and the depressed condition of the patient, it was felt that something should be done to hasten recovery. As the original wound held considerable infection it was decided to open the abdomen and do an anastomosis between the terminal ileum and the transverse colon. The following are the details of this operation.