Section for the Study of Disease in Children.

President—Sir ROBERT JONES, K.B.E., C.B., F.R.C.S.Ed.

Specimen from a Case of Aneurysm of the Ductus Arteriosus.

By ROBERT HUTCHISON, M.D.

THIS case will be published in full in the *British Journal of Children's Diseases*, April-June, 1922.

Dermato-polyneuritis (Acrodynia: Erythrœdema).

By HUGH THURSFIELD, M.D.

(In collaboration with DONALD PATERSON, M.B.)

(ABSTRACT.)

[Published in full in the *British Journal of Children's Diseases*, January-March, 1922, xix, p. 27.]

A GIRL baby was sent to me at the Hospital for Sick Children at the beginning of February, 1922, with the history that she had been breast-fed up to the age of 8 months, and during that time and for the ensuing month she had been a normally healthy child, indeed unusually advanced for her age. On December 19, 1921, she became ill, had some vomiting for three days and was feverish. After a few days' interval in which she seemed to be normal, and a bright cheerful child she became fretful, whining and disinclined for food. She remained in this condition till the beginning of February when desquamation of the hands and feet began abruptly with redness and swelling of the affected parts. In this condition I saw her, and suggested a diagnosis which proved to be wrong. The history of an illness six weeks previously with the subsequent wasting, desquamation, and, as we found, some albuminuria, conveyed the impression that she had had an attack of scarlatina. At this time though she was fretful and much wasted she had none of the mental symptoms which subsequently developed.

During the next three weeks the severity of the skin lesions waxed and waned, but the chief changes were the rapid alterations in the mental and muscular systems, the result being a mental condition which at first suggested an encephalitis and a muscular condition which resembled extreme hypotonia. It was stated by her mother that she moaned and screamed all day and hardly slept at night, that she was tremulous, that her eyes rolled and that three days before I saw her a second time she had squinted. I saw her again on March 2 and at once recognized that my previous suggestion had been an error and that I was confronted by an affection with which I was unfamiliar. She was admitted to the Children's Hospital in the hope that some of my colleagues might recognize the disease.

Her appearance was at this time striking. Her face showed two patches of high colour on the cheeks and a reddened nose; with a patch of branny desquamation on the forehead. She had two small shallow ulcers on the dorsum of the tongue, but her mouth was otherwise clean, with teeth (sixteen in number) and gums normal. The fauces and tonsils were normal; she had no anæmia and no evidence of rickets. The hair was thinned over the scalp, especially over the right parietal area. She had a slight erythematous rash

on the buttocks. Her mouth was frequently opened widely, with a gape resembling that of a young nestling.

The extremities were cyanosed, slightly œdematous and cold, with the skin peeling off in large flakes from the fingers and toes. The finger-nails were not affected, but the toe-nails appeared to be deformed by the inflammation. The redness, cyanosis and desquamation were limited to the hands and feet, and faded off quickly so that above the wrists and ankles the skin had a normal appearance. There was an offensive mouse-like smell reminding me of the smell of favus. These skin lesions obviously caused her a good deal of annoyance though she did not scratch or rub them so furiously as a child with eczema does. Her general condition with the exceptions to be described was good, though she was obviously wasted. She swallowed well and took food readily, and her bowel actions were normal. She had no fever and her pulse-rate varied from 90 to 100.

She had no paralysis; all movements were performed but the tonelessness of her muscles was striking. She was able to hold up her head, and even to sit up, with marked lordosis, but tended to fall unless supported. She could raise herself into a sitting position with some difficulty; but was quite unable to stand or to bear her weight on her legs. All her movements were performed with extreme slowness, but there was no tremor and there was no inco-ordination. When awake—and she slept very little even at night—she kept up a slow continuous movement, falling forward on her face, and then after a few moments slowly raising herself into a sitting position with a circular movement to the left. The legs were moved very little, most of her movements being confined to the trunk, arms and head.

When her attention was attracted she appeared to take an intelligent interest, but after a few moments an expression of pain was shown on her face by a contraction of the muscles and a low cry with the wide gaping movement of the lower jaw. She would grasp an object in her hands but would let it fall shortly.

The reflexes were all present and normal except that on a few occasions the left plantar reflex was definitely extensor. Occasionally also there appeared to be some spasmodic rigidity of the legs and arms, but this was momentary and ordinarily the limbs were unusually lax and hypertonic. The electrical reactions were normal.

Sensation in so young a child, and in such a condition, is exceptionally difficult to estimate, but we formed the opinion after many trials that in the extremities from the elbow to the fingers and from the knee to the toes sensation to a pin-prick was distinctly defective. She appeared to feel a pin-prick on the body and face normally, though she seemed to be insensitive to a prick in the ear for a blood-count.

The cerebrospinal fluid was quite normal. There was no change in either ocular fundus and the squint noted by her mother was not seen in the hospital. Her blood-count showed: red-blood corpuscles, 5,127,000; white-blood corpuscles, 18,200; hæmoglobin 90 per cent. The polymorphonuclear cells were 58 per cent.—10,500, and no abnormal leucocytes were observed. There were no diphtheria bacilli in a swab taken from her nasopharynx, and no abnormal organisms in the stools.

Summary.

A previously healthy child is suddenly attacked by an undiagnosed, probably febrile, infection; after some weeks of ailing, fretfulness and anorexia she develops marked skin, neuro-muscular, and mental symptoms; with a

tendency to exacerbations of the skin lesions from time to time. The condition is stationary or possibly slowly improving.

Neither the name "acrodynia" nor that of "erythrœdema" seems to us to be sufficiently descriptive, and we have ventured to use the term "dermato-polyneuritis" as being more expressive of the chief phenomena of the disorder.

Postscript.—Since the foregoing account was written the child has died of an acute intussusception.

Erythrœdema.

By F. PARKES WEBER, M.D.

THE paper is published in full, with illustrations, in the *British Journal of Children's Diseases* for January to March, 1922, p. 17.

Case of Double Inguinal Hernia in which both Sacs were removed through a Single Transverse Suprapubic Incision.

By PHILIP TURNER, M.S., F.R.C.S.

C. G., AGED 2 years 2 months, was admitted to hospital on February 12, 1922, for double inguinal hernia. At the operation a transverse incision, about 3 in. in length, was made about 2 in. above the pubes. The sheath of the rectus was exposed and the skin and superficial tissues were undercut so that on retraction the aponeurosis of the external oblique was exposed on either side as far as Poupart's ligament. The left side, on which the hernia was the larger, was first dealt with. The method employed for the removal of the sac was one which I described before the Section in 1912.[1] An incision was made through the external oblique, over the internal abdominal ring, and the lower margin of the internal oblique was then drawn up so as to expose the sac and the spermatic cord just below the internal ring. After these structures had been freed and drawn through the incision in the external oblique, the sac was separated from the cord and isolated up to the internal ring. Below, it was found to be continuous with the tunica vaginalis, so that after it had been ligatured above, a second ligature was applied where it joined the tunica vaginalis, and the intervening part removed. The testicle, which had been pulled up into the wound, was then pushed back along the inguinal canal into the scrotum, and the incision in the external oblique was closed. The superficial tissues were then retracted to the right and a hernial sac of considerable size, but not continuous with the tunica vaginalis, was removed by the same procedure as that employed on the opposite side.

The advantages of this operation are that the wound is well away from the groin, and that it is in a favourable position for subsequent dressings and nursing. The incision is particularly useful for those cases in which there is a definite hernia on one side, while, on the other, there is perhaps a slight swelling or a doubtful history of the occasional appearance of such a swelling. In this case the definite hernia can be treated and the other inguinal canal be explored for the presence of a sac.

[1] *Proceedings*, 1912, v, pp. 135-137.