INSTRUCTIONS GIVEN TO PATIENTS.

CARE OF INGROWING TOE NAILS.

Cut a V in the middle of nail twice a week, with round-ended scissors. Never use pointed scissors; these are harmful to the nail.

Scrape the surface of the middle of nail with the scissors blades twice weekly. This stimulates growth here and slows it at the sides where the ingrowing is taking place. Wash feet daily quickly; do not soak in a bath.

Apply a *very little* iodine daily to the sore spot with the end of a match and also apply a small clean dressing. Avoid all cleansing of the sides and under part of the nail and on no account cut off the corners until they project beyond the end of the toe.

Wear a stout-soled shoe or boot which fits comfortably, and also a thicker sock or stocking than usual. These socks should be changed every other day or worn alternately with another pair.

A word of warning may not be out of place here with regard to very chronic ulcers or sores about the hallux, and even about the foot. Occasionally they follow a wound and may be in the middle of a callosity. I have seen two about the toe nail, thus justifying the inclusion of this paragraph in this article.

It is always sound practice to examine the pupils, the knee-jerks and reflexes to exclude a possible underlying nervous disease. A still rarer condition, of which I have seen two cases in the past eighteen months, is that of spina bifida; and in both inspection of the patient's back revealed a tuft of hair on a fatty pad in the lumbar region and suggested, whilst X-ray confirmed, the diagnosis of spina bifida occulta.

A thorough cleansing of the lesion, careful

B.I.P.P. application to the wound, good padding and a stout plaster of Paris casing will bring about healing. The B.I.P.P. prevents the smell which usually occurs when plaster is applied over a wound.

CLINICAL NOTES ON THREE CASES OF PURPURA HÆMORRHAGICA.

By W. ERNEST LLOYD,

M.D., M.R.C.P.,

Assistant Physician, Westminster Hospital.

THE first case was a man, aged 21, and the history of his illness was as follows: He was quite well until five days before admission to hospital. The first symptom was profuse bleeding from the rectum. Two days later he noticed "red spots" on his face, and the urine was dark in colour. On admission, patient was unconscious. Petechiæ were present on the face and limbs. His temperature was subnormal but went up to 101.5° F. before death. His breathing was stertorous, and he was incontinent of urine which contained much blood. The knee- and ankle-jerks were not obtained. Lumbar puncture produced a hæmorrhagic fluid. The patient died twelve hours after admission. Permission to do a post-mortem examination was not granted, so that it is impossible to state the origin of the blood in the cerebro-spinal fluid.

The second case was a man, aged 20, and the history was as follows: He was quite well until three days before being admitted to hospital. The first symptom was hæmatemesis associated with abdominal pain, and his doctor suspected an acute gastric ulcer as being the cause. On examination, numerous petechiæ were present in the region of the elbows and knees. Both the tonsils were enlarged and unhealthy. There was some tenderness in the epigastrium,

The spleen was not palpable at this time, but later it became palpable. Two days after admission, hæmatemesis returned and there was much abdominal discomfort associated with incontinence of fæces which contained much blood. Examination of the blood showed only a slight secondary anæmia, and the blood-platelets numbered 440,000 per c.mm. The coagulation time was within normal limits. There was moderate fever and the pulse-rate varied between 90 and 120. As the melæna continued, the patient's general condition became worse, but it improved after two blood transfusions. Ten days after admission he developed hæmaturia, and this persisted throughout his stay of fourteen weeks in hospital. Further crops of petechiæ appeared from time to time, but after the first month in hospital, all bleeding had ceased except for the bleeding from the kidneys. Later, signs of nephritis developed. There was oedema of the eyelids and epithelial casts were present in the urine. Urea concentration test, after 15 grm. of urea, showed definite renal damage, the percentage of urea in the urine being as follows: After one hour, 1·29 per cent.; after two hours, 1·34 per cent.; and after three hours, 1·15 per cent.

As the tonsils were unhealthy, tonsillectomy was advised on many occasions during the patient's stay in hospital, but on each occasion the patient's father refused to give his consent. Two teeth had been removed without any abnormal bleeding, but this was not sufficient to convince the father that there was no contra-indication to removal of the tonsils.

The patient was seen a year after leaving hospital, and his urine still showed the presence of much albumin, many red blood-cells and epithelial casts.

The third case was a boy aged 15, and the history in this case was as follows: He was quite well until four days before admission to hospital, when he noticed "red spots," and some bruising on his arms and legs.

This was followed by bleeding from the nose and from his gums, and later he noticed that his urine was dark in colour. His previous health had been good. On examination, there was a profuse purpuric eruption on both arms and legs especially marked below the elbows and knees. There was a subconjunctival hæmorrhage in the right eye. The urine contained blood. The tonsils were enlarged and unhealthy. The spleen was not palpable. His temperature varied between 98° and 100° F. At this time the blood-count was as follows: R.B.C. 3,000,000 per c.mm., W.B.C. 7,000, and the hæmoglobin percentage was 60. Three days after admission, the blood coagulation time was three and a half minutes, but the bleeding time was increased to twenty minutes. Blood-culture proved to be sterile. He continued to bleed from the gums, and ten days after admission he had a very profuse epistaxis which persisted for some time, and in all the patient lost nearly a pint of blood. Further crops of purpura appeared and the R.B.C. fell to 1,880,000, and the hæmoglobin percentage to 30. A blood transfusion was given with good results. On the next day, further petechiæ appeared, but all signs of bleeding had ceased after the first fortnight in hospital. At this time the blood-platelets were only 11,300 per c.mm., and as the hæmoglobin percentage had fallen still further until it was only 23, another blood transfusion was given. A few days later, although there had been no history of pain, the patient developed a discharge from the right ear and the pus on culture grew a hæmolytic streptococcus. His condition subsequently began to improve, and this improvement appeared to coincide with the discharge of pus from the ear. His anæmia steadily improved and the blood-platelets increased to 234,000 per c.mm. Twelve weeks after admission the tonsils were removed, and it is interesting to note that culture from the tonsil also grew a hæmolytic streptococcus. The boy has remained in very good health

for the ten months which have elapsed since he left hospital.

Summary: Three cases of purpura hæmorrhagica are described in young men aged respectively 15, 20 and 21 years. The sudden onset of the illness in each case, together with fever, suggests that the condition was infective in origin. In two cases the infection was associated with septic tonsils. One of these patients developed nephritis, and in the second patient, hæmolytic streptococci were found in the pus from a discharging ear and in the tonsil after removal. The third patient died within six days of the onset of his illness with signs of intracranial hæmorrhage.

ROUND THE HOSPITALS.

THE LONDON TEMPERANCE HOSPITAL.

CANCER OF THE STOMACH—SUB-TOTAL GASTRECTOMY.

Mr. HERBERT J. PATERSON operated upon a woman, aged 57, who was admitted for abdominal pain and vomiting. The patient stated that she had suffered from indigestion for some years, but for the last year or so had been much worse. She complained of pain coming on half an hour after food, accompanied by much flatulence and occasional vomiting. She had been on a milk diet for two years. At one time the pain had been relieved by taking more food but latterly this had not been so. During the past few months she had lost her appetite completely, had suffered from frequent vomiting, and had been losing flesh rapidly. On several occasions the vomit had been dark, like "coffee grounds," but she had never noticed any blood.

On admission, the patient was very thin and emaciated. The stomach was dilated, there was visible peristalsis, and a small, movable lump opposite the cartilage of the tenth rib on the right side.

Gastric analysis showed absence of free hydrochloric acid and a low total acidity, and a diagnosis of gastric carcinoma was made.

After a week's careful preparation, the abdomen was opened, and a soft, diffuse growth of the pylorus was seen. There were several large glands in the vicinity of the growth, and a chain of enlarged glands extending along the lesser curvature up to the lower end of the œsophagus. Investigation showed that it was possible to remove the growth completely, and accordingly a posterior gastro-jejunostomy was performed at the cardiac end of the stomach, close to the œsophagus, as a preliminary to partial gastrectomy at a later date. An enlarged gland was removed and examined, and found to be carcinomatous.

Mr. Paterson said that unless the patient was in unusually good condition, he preferred to operate in two stages, namely, first to perform gastro-jejunostomy, and then three or four weeks later to perform a radical operation. The only objection to this method was that the patient might improve so much after the gastro-jejunostomy that further operation was declined. The advantages of this procedure are, first, that the mortality-rate is reduced very materially by the two-stage operation. Secondly, the patient can be fed up after the gastro-jejunostomy, and is in far better condition for the second operation. Thirdly, if the patient does not improve definitely after the gastro-jejunostomy, it suggests the possibility of the existence of secondary growths, so that the question of a second operation may have to be reconsidered.

The patient improved rapidly after the gastro-jejunostomy, and three weeks later the abdomen was reopened and seven-eighths of the stomach and an inch and a half of the duodenum, together with all the enlarged glands up to the œsophagus, were removed. Mr. Paterson emphasized the importance of preventing shock in these cases. Patients with carcinoma have but little reserve resist-