PROGRESSIVE MUSCULAR DYSTROPHY—(Erb.).

By Assistant Surgeon N. L. MOOKERJEE,

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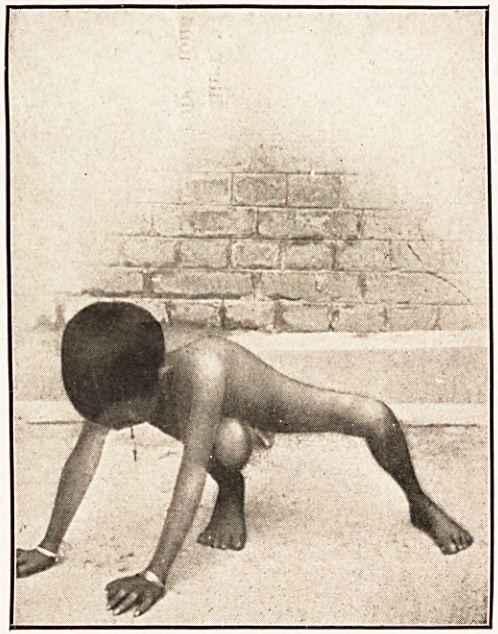
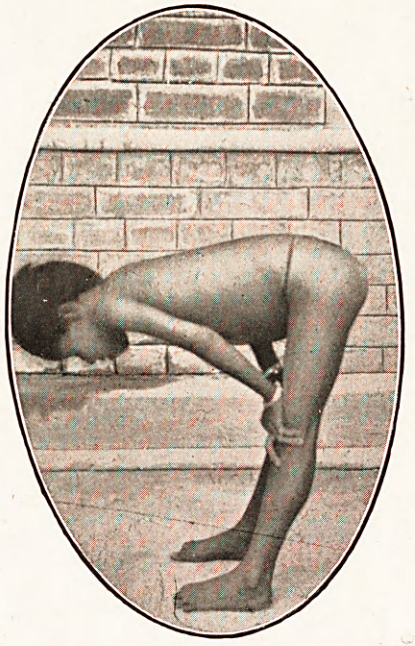


First Stage.

Second Stage.



Third Stage.

Raynaud's Symmetrical Gangrene by Dr. John Ed. Morgan, of the Victoria University, and it struck me at once that I had also treated a similar case in 1908, but that of the nature of the case I was ignorant up to this time. The disease is so rare that I have thought it my excuse for publishing my notes, and I think that they will be useful to my fellow workers :—

A. B., a policeman, resident of Northern India, Mahomedan by religion, aged about 40, came under my treatment while I was in charge of Babra Dispensary (Kathiawar) in the year 1908. He was a man of middle stature, thinly built, and cachectic in appearance. No history of syphilis.

He said that his disease began about three weeks ago with paroxysms of tingling and burning pains in the fingers and toes, and that during the paroxysms the fingers were becoming slightly swollen and livid. This condition gradually became worse, till the pain became almost constant. The fingers and toes on admission were quite numb and he could not feel a touch or a prick. He could not lift anything with the fingers nor could he eat also. The colour of the fingers and toes was bluish which in a short time became black, the blackness commencing at the tips. The nails also became black and the disease extended as far as the metacarpo and metatarso phalangial joints and the skin became shrivelled up. All the fingers and toes were affected rapidly, and the man was in a great fright. He became very nervous and went away home on sick leave.

The treatment adopted by me was enveloping the parts in cotton-wool and giving him tonics and stimulants. My diagnosis of the case was dry gangrene of the fingers and toes, although my suspicion was aroused on account of the symmetrical situation of the disease.

This disease was first described by Raynaud in 1862. It is characterized by local vascular changes in one or more of the fingers, for the most part symmetrically on the two sides of the body, resulting very often in gangrene.

Three types are described: a syncopal; an asphyxial; and a gangrenous.

The first thing noticed is a pallor and numbness of one or more of the fingers or toes, usually the corresponding finger or toe on both sides, coming on in attacks lasting an hour or more. This pale or syncopal stage is generally followed by a reactionary stage of congestion and heat, with swelling and lividity, in which the tip of one or more of the fingers or toes or the ears may be of a dark purple colour. There is usually a good deal of pain. Sometimes the pale stage is very definite, sometimes it is wanting, or it may be so transient as to be unobserved. Occasionally the entire hands are involved. After a certain number of these attacks gangrene occurs at the tip of one or more fingers or toes or of the ears. The dead part becomes separated from the living in the usual way and the ulcer that is left heals normally.

TREATMENT.

This consists in keeping the parts warm by enveloping them in cotton-wool and protecting from exposure to cold. The most efficacious remedy is the use of battery constant or interrupted current. Thyroid gland and nitroglycerine are beneficial especially in the syncopal type. The pain is relieved by morphia which acts in a double way in asphyxial cases by giving tone to the vessels.

PROGRESSIVE MUSCULAR DYSTROPHY (Erb.).

BY N. L. MOOKERJEE,

ASSISTANT SURGEON,

Pilgrim Hospital, Gaya.

A HINDU Rajput boy, aged about 7 years, belonging to the District of Palamau, was brought to the Pilgrim Hospital, Gaya, on the 9th April, 1915, for the treatment of a series of complaints, prominent among which was his difficulty in getting up from the sitting posture. The patient is said to have been suffering from this difficulty for about three years and is gradually getting worse.

The disease first manifested itself in two of the patient's elder brothers, one of whom died about three years ago, from gradual exhaustion, having become completely bed-ridden, and the other, aged about 12 years, is now in an absolutely helpless condition, entirely depending for locomotion on an improvised cart made from a box. The father and mother of the child are free from any such complaint, but it is said that a maternal uncle of the child died of a similar complaint, which was not clearly understood.

The child is ill-nourished. The muscles of the calves are increased in volume and those of the shoulder girdle distinctly relaxed and rather atrophied, and there is slight drooping of the shoulder joints. The shoulders are characteristically "loose," and when the child is lifted with hands under the arms, the shoulders reached the level of the ears. The shoulder blades are prominent particularly at the lower angles which has given them the peculiar winged appearance. The arms look disproportionately longer than usual, on account of relaxation of the muscles. The abdomen is protruding and the spine is curved with distinct lordosis. The gait is waddling. In getting up from the floor to standing posture, the pathognomonic position assumed may be described in three stages :—

In the first stage, the child turns over sidewise on all fours and attempts to raise the trunk using his arms as levers; in the second stage he supports his trunk on all fours by being as if doubled up; and in the third stage the hands are moved along in turns to reach the knee on which he climbs up to assume the erect

posture. A photo of each of the stages mentioned above, and which are not found in text-books, has been taken for demonstration of the positions the patient has to pass through. The difficulty is progressively though slowly increasing, and it is feared that the patient will also become bed-ridden soon. The intellect of the child is unaffected and there are no sensory symptoms. The deep reflexes are slightly modified and the electrical excitability of muscles is also weak.

The patient has got a mixed type of muscular dystrophy. The disease is characterised by prominent family predisposition with juvenile attack but cannot be grouped under any of the clinical forms described in the text-books. The photos attached hereto will be, I believe, of great academic interest.

A POCKET ELECTROSCOPE.

BY F. D. BANA, M.B., M.R.C.P.,

Grant Medical College, Bombay.

THE following is a sketch outline and description of a small pocket electroscope devised by me and demonstrated at the Local Branch of the British Medical Association. The special features which commend it are :—

1. It is inexpensive.

2. It is portable and can be carried in the pocket.

3. All the parts are easily detachable and replaced.

4. It is aseptic.

5. The spatulate form can also be used as a tongue depressor and as a simple throat illuminator at the bed side or where illumination by day light is inadequate.

6. It can be used as a trans-illuminator of the accessory sinuses of the nose in a perfectly dark room.

b Indiarubber tubing same size as glass tube. It serves as a sheath and limits the light anteriorly from a small pea-lamp.

c screwed on one end by making a little spur on to the end of the tube in a blow-pipe flame.

d is the closed end of half a test-tube fitting the rubber sheath and serving as a protector to the lamp *c*; thus encased the electroscope can be held in the mouth by the patient closing the lips. It can be cleansed with lotion or sterilised by boiling if necessary.

e is a second coverlet which can be slipped over the first coverlet *d*. It consists of gutta-percha or any suitable material impermeable to light enveloping all except one-third of an inch at the closed end. In this form the frontal sinuses can be illuminated.

f are wires connecting lamp to an Ever Ready Battery.

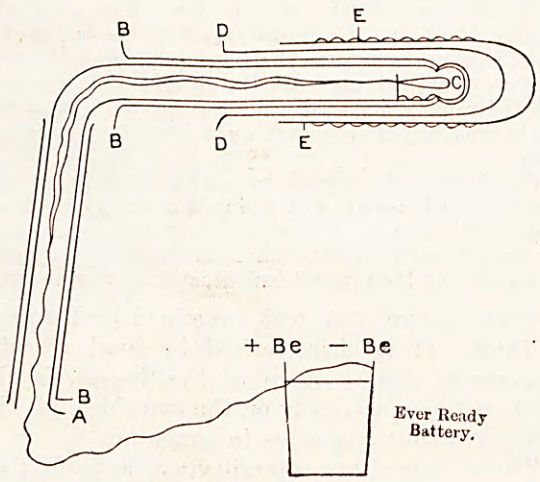


FIG. B.

The spatulate form (B) is identical in all respects to the first except that a bigger glass tubing, about eight inches, is required which is bent at the centre to a suitable angle to form a handle for a tongue depressor.

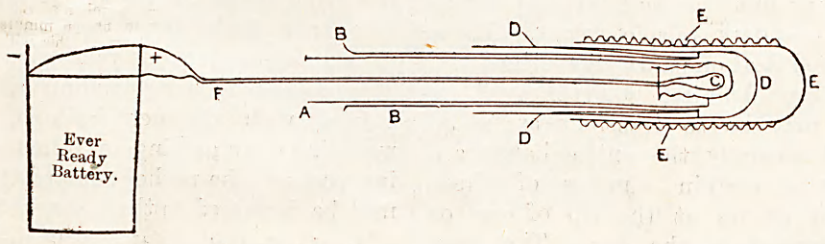


FIG. A.

a is a stout glass tubing, internal diameter ½ inch and 6 inches long, made from glass tubing by filing off successive lengths of 6 inches and rounding the edges in a blow-pipe flame.

Although no originality is claimed, I think it worth recording from the point of view of its portability and cheapness and the ease with which parts can be replaced.