
The authors report 4 cases of gangrene in young subjects.

Case I. A boy of 44 years fell suddenly ill with all the signs of an acute, but indefinite, general infection. Examined 3 weeks later, he presented total dry gangrene of the left foot, both ears, and a circular patch of cutaneous gangrene over the left patella. There were signs of endo- and pericarditis. The gangrenous zones separated, and the foot detached spontaneously after 2 months at the ankle joint, it being necessary only to divide the ligaments. The child recovered.

Case II. A child of 6 months, following on an acute fever (probably diphtheria), showed gangrene of an ear, a hand and both feet.

Case III. A boy of 7 years, with multiple stigmata of chronic tuberculosis, after a 6 months' illness presented a dry gangrene of the left foot and part of the lower limb. Amputation 4 months later through the thigh; recovery. Examination of the vessels of the amputated limb showed both endarteritis and endophlebitis.

Case IV. A boy of 14 years, without any apparent cause, developed a perforating ulcer of the big toe which required amputation of the toe. One year later, a gangrenous patch appeared on the dorsum of the second toe, which also was amputated. In his 16th year, he developed a perforating ulcer of the sole of the foot, which was amputated (Sedillot); permanent recovery. The vessels showed evidence of endarteritis; the cause of the vascular lesion remains unknown, but the authors have eliminated syphilis and Buerger's disease.

In a general survey of the question, the authors show that practically all recorded cases in young subjects have occurred after a general infection. Gangrene may be due to one of four different factors: an embolus of cardiac or aortic origin, thrombosis of the great vessels of the limb, arteritis, or capillary thrombosis. The co-existence of vascular spasm with infection plays a large role in the development of such cases of gangrene. High amputation, in the authors' view, is contraindicated in young subjects; they prefer to wait till separation has taken place. Embolectomy would appear very difficult of accomplishment in children with small vessels, and in the course of an acute infection.

Tannic Acid Treatment of Burns. (Beekman: Arch. Surg., 1929, xviii, 803.)

From June, 1919, to August, 1928, 434 children were admitted to the Children's Surgical Service at the Bellevue Hospital, New York. Most of the burns were of the second or third degree, and involved more than 10% of the body surface. Scalds were more frequent in children under 6 years, while burns occurred more often in the older group.

Prior to the introduction of the tannic acid treatment in November, 1925, 320 children had been treated by various methods, with a mortality rate of 27.5%; in the second group, following 114 children treated by tannic acid (5% solution) only 17 died (14.9%).

Beekman's conclusions are as follows:—

1. The tannic acid method is the most satisfactory treatment so far devised for burns in childhood.
2. In a series of 434 cases of burns in children, the mortality was decreased from 28% to 15%.
3. This decrease was the result of a decrease in the death-rate from toxemia by two-thirds.
4. Toxic absorption in burns takes place within 24 hours of the occurrence of the burn. The highest mortality from toxemia occurs in the period between the 24th and 72nd hours.
5. The average hospital stay of patients was increased by six days by the tannic acid treatment. This is probably due to the fact that children with severe burns lived who otherwise would probably have died.
Giant Spleen in a Child of 12 years cured by Splenectomy. (Szekely: Zb. f. Chir., 1928, lv, 2192.)

From the notes given, it is difficult to determine which type of splenomegaly is here concerned. The hypertrophy had existed for some 6 or 7 years, progressing steadily without pain or fever. The state of the patient, a girl of 12 years, was grave; wasting, arrested growth, marked anemia (r.b.c., 3,000,000; Hb. 60%). The spleen extended from the lower costal margin to the pubes, and crossed the middle line.

Under the diagnosis of Banti's disease, the spleen was removed, the operation proving none too easy owing to severe adhesion formation. When removed, the spleen weighed 1,500 grammes, and measured 46 x 22 cms. Histological examination showed fibro-adenitic change.

Now, 5 years after the operation, the child is in a state of perfect health; she has developed normally, has grown 16 cms., and has a normal blood picture. W. D.

Hypertrophic Pyloric Stenosis. (Heile: Dtsche. med. Wochschr., 1928, liv, 1453.)

Heile has operated upon 64 infants suffering from hypertrophic stenosis of the pylorus, with only 3 deaths. He makes a special plea that the internists would refer these infants for surgical treatment at an earlier period of the illness than is usual.

He stresses the importance of the differential diagnosis between pylorospasm and true hypertrophy, particularly by radiographic examination. If the x-rays show that the pylorus permits of the passage of part of the meal administered, H. considers that one may wait; possibly even some of the small "soft" tumours which he has observed during the course of operation may recede spontaneously. But, on the other hand, if the stenosis is complete, one must operate without delay. The Rammstedt operation is the procedure of choice. Only in the very rare cases where the dilated and atonic stomach is incapable of sending its contents through a widened pylorus is gastro-enterostomy a justifiable addition.


The clinical recognition of this uncommon condition is important owing to the risks attending its spontaneous rupture. The majority of cases occur during the first year of life, at a time when adequate examination of the throat is difficult. The outstanding symptom is stridor, on both inspiration and expiration, and aggravated by the horizontal position. A previous history of acute naso-pharyngeal trouble is frequent; in any case in which this is followed by restlessness and one-sided enlargement of the cervical glands, the question of retropharyngeal abscess should arise. Owing to the difficulty of swallowing, mucus collects in the throat, causing the rattling and stertorous breathing so often met with in the later stages; anorad, or gurgling respiration during sleep is a constant symptom. The upper aerodigestive tract of the patient and the course of events, the more pronounced are these symptoms. Torticollis is frequently associated, and its presence should suggest retropharyngeal abscess before anything else.

Inspection of the throat in infants is often deceptive; it should be followed by direct palpation with the finger in all suspicious cases. An accompanying trismus may cause difficulty. An undue prominence of one faucial pillar is an important sign that may be easily overlooked. Slight edema of the soft palate may also be seen.

Once an abscess has formed surgical measures and evacuation of the pus are indicated; in the stage of lymphadenitis, before true suppuration, very real harm may be done by incision, owing to the likelihood of general sepsis following. According to the authors, the best results are obtained under light ether anesthesia, unless the child is desperately ill.


Peterson believes that the incidence of appendicitis in early childhood is increasing. The disease is more insidious in children than in adults, the inflammatory process spreads more rapidly, and the intoxication is more severe. Preoperative purgation and procrastination are the factors responsible for the high mortality rate.