On another occasion a patient was seen with a small elastic swelling near the head of the right epididymis. It felt like one of the cysts which are so commonly met with in that situation, but it was not translucent. A small trochar and cannula were used to empty the supposititious cyst, but only a little blood ran out, and the lumen of the trochar was partially blocked with a scrap of soft tissue. This was pronounced by the pathologist to be sarcomatous. The testicle was removed and a small sarcomatous tumour found in the body of the testis close to the head of the epididymis.

In conclusion, you will remember when confronted with a young and ambiguous tumour to assume an attitude of intellectual humility, and carefully eschew diagnostic omniscience and infallibility.

For knowledge is of things we see.

NOTE AND REFERENCE.

[1] I am told that Mr. Shaw has been timed to have the section ready in two minutes. [2] The Surgical Anatomy of the Breast and Axillary Lymphatic Glands, *Edinburgh Medical Journal*, June and July, 1892.

CONCERNING PADS UPON THE FINGER JOINTS AND THEIR CLINICAL RELATIONSHIPS.

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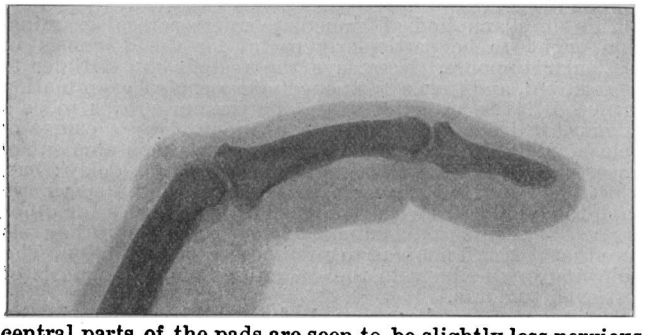
THE lesions which form the subject of the present communication are not in themselves serious, but it is desirable that those who practise medicine should be familiar with them, if only that they may distinguish them from other and more serious troubles which they simulate to some extent.

The pads in question formed the subject of a short paper, based upon the observation of three cases, which appeared in the volume of the *St. Bartholomew's Hospital Reports* for the year 1893 (vol. xxix, p. 157). Since that time I have met with other cases in which such pads or nodules were present, and as these additional cases throw some further light upon their clinical relationships, I venture to return to the subject.

They form excrescences which are almost confined to the dorsal aspects of the interphalangeal joints of the proximal row, and are only very rarely seen upon the terminal joints of the fingers. They are usually present upon the fingers of both hands, but in their distribution there is no striking symmetry. They vary considerably in size, and may be no larger than split peas, or may be as large as the halves of hazel nuts. Although usually central in position, they may incline to one or other side of the joint.

When the fingers are extended the pads are moderately soft, and can be moved, to some extent, upon the underlying structures, but when the fingers are flexed they become firm and hard and are no longer movable.

There are no indications of disease of the joints over which they lie, and such pain as is felt is referred to the pads rather than to the joints themselves. In a radiograph picture (see figure) the bones appear normal as also do the joints, but the



central parts of the pads are seen to be slightly less pervious to the Roentgen rays than the remainder of the soft structures of the fingers.

Sometimes the lumps are quite painless, but more often pain, of various degrees of severity, is complained of, especially when the fingers are flexed, and tenderness is elicited by the slight traumatisms which are unavoidable in daily life. Occasionally the development of them is attended by more severe pain, which may even shoot up the arm as high as the elbow.

The pads may make their appearance at any period of life, and when once formed they appear to be permanent. Patients who exhibit multiple pads usually state that they did not form simultaneously but at intervals. The growth is usually rapid and may occupy as short a period as a few weeks. In some cases the formation of each pad is attributed to some slight injury, such as may result from impact against a piece of furniture or a blow from a cricket-ball. In other instances no such cause is assigned.

I have had no opportunity of examining such a pad *post mortem*, and am therefore unable to give any account of their structure, but their clinical features recall those of thickened bursae, and it is difficult to doubt that they are mainly composed of fibrous tissue.

Of twelve cases of which I have notes, seven were in males and five in females. In five cases the pads appeared before the patients had reached the age of 20 years, and in three of these at an earlier age than 15 years. On the other hand, in one case they developed at the age of 60 years. In one case they were said to have been present for 42 years. Three patients gave clear histories of similar lesions in near kinsfolk.

The pain and swelling in the neighbourhood of the finger-joints is apt to excite apprehension of further developments, but there does not appear to be any connexion between these pads and any of the morbid conditions which are usually grouped together under the names of rheumatoid or osteo-arthritis. It should be mentioned, however, that two elderly patients had well-marked Heberden's nodes in addition to the pads.

Of the three cases described in 1893, the pads were associated with Dupuytren's contraction of a finger in one, and the father of a second patient was said to have that deformity.

The association thus suggested is much more clearly brought out by the larger number of cases now available, and it seems impossible to doubt there is an intimate connexion between the two conditions, or that they have a common cause. On the other hand, it is clearly the case that the pads usually develop at a much earlier period of life than does the contraction of the palmar fascia.

Of the twelve patients no less than six themselves exhibited Dupuytren's contraction. In most instances the puckering in the palm was well marked and the contraction was quite of the ordinary kind, but in one or two there was merely a fibrous thickening on the palmar aspect of a little finger, causing flexion, but without any obvious implication of the palmar fascia.

The fathers of three other patients, and also of one of the six already referred to, were said to have fingers so drawn down, and in one of the three remaining cases the occurrence of Dupuytren's contraction in the family was not inquired into. Thus in no less than nine out of the twelve cases there was a parental or personal history of such contraction, and the association in so large a proportion of the cases of two lesions, neither of which can be described as common, can hardly be fortuitous.

Dupuytren's contraction, although hardly a gouty lesion, is usually held to be connected with gout. It might perhaps be styled a para-gouty lesion. It is therefore of interest to consider the history of the twelve patients in this connexion. Only one patient had himself suffered from attacks of articular gout. In four cases there was a definite history of true gout in direct ascendants, in five the history was doubtful on this point, and in the remaining five neither family nor personal history of gout was forthcoming. The connexion with gout is clearly less obvious than that with Dupuytren's contraction.

I know of no plan of treatment which is of any avail in reducing the size of the pads or in causing them to disappear, and it is seldom that the pain and inconvenience which they cause is very serious. Beyond the fact that a patient who develops them in early life appears to be liable, as time goes on, to develop Dupuytren's contraction of the palmar fascia, they do not seem to possess any grave prognostic significance.

BEQUESTS TO HOSPITALS.—Under the will of the late Mr. William Riley, of Leamington and Birmingham, who died on May 1st, a sum of £3,050 is appointed to be held in trust, as to £800 for the Warneford Hospital, Leamington, as to £1,000 for the Queen's Hospital, Birmingham, and as to £1,250 to the General Hospital, Birmingham, in each case for the same purpose, namely, the establishment of a bed to be called after the testator.