four hours. On the 19th, when the child was next seen, the conjunctiva had a healthier colour, and was more granular; there was no membrane to be seen; the lotion was ordered to be used three times a day. On the 26th there was again a small amount of membrane, this time on the lower lid, the conjunctiva covering the mucous surface of the upper lid was still granular, and no membrane could be seen there. The lids were again somewhat oedematous. The appearance of the conjunctiva, where the pseudo-membrane existed, was very like that which would be caused by painting the surface with white paint. When next seen—namely, on March 1st, both oedema and membrane had disappeared. During these three days the lotion had again been used every four hours.

From this time until March 15th the same lotion was continued, and applied three times a day. Notwithstanding the absence of any visible morbid exudation, the oedema and swelling of the lids disappeared; and on the 15th it was noted that there was slight cicatrisation on the upper lid. The quinine lotion was then discontinued, and a mild lotion of boracic acid (two grains to the ounce) was substituted for it. This was used for a fortnight, when the patient was discharged as cured.

Remarks.—Mr. Tweedy observed that what he regarded as the success of the treatment of this case might not unreasonably foster the belief that the diagnosis was erroneous, and that the disease was not diphtheritic conjunctivitis at all, but rather an anomalous form of purulent ophthalmia. In anticipation of this objection, he called attention to the time at which the disease began, to its one-sided character, to the tense and brawny oedema of the lids, to the smoothness and pallor of the conjunctiva, to the reappearance of the peculiar phenomena when the applications of quinine lotion were prematurely reduced in frequency, and lastly to the sequential cicatrisation. True, it would be easy to overlook the real nature of such a case if it were a unique instance. But this and similar cases could only be recognised and understood by reference to the behaviour of typical examples of the disease. In the most pronounced form the characteristics of diphtheritic conjunctivitis are sufficiently conspicuous to arrest the attention of any moderately observant practitioner. The risk lay in overlooking the milder degrees, which at any time might be aroused into such activity as to lead to the rapid destruction of the cornea. The application of a solution of nitrate of silver, which is almost of essential service in the treatment of ordinary purulent ophthalmia in infants, is almost invariably disastrous when the conjunctivitis partakes of the genuine pseudo-membranous character. Mr. Tweedy referred to a case that had occurred in his own practice a few months before as an illustration of this. Arthur E. H.—, aged three weeks, was taken to the hospital for severe inflammation of both eyes on Oct. 9th, 1882. The right eye began to be inflamed when the child was a week old, and a few days later the left became affected. When first seen at the hospital (a fortnight after the beginning of the disease), the right palpebral conjunctiva was covered with thin, sticky, dirty-looking adherent pseudo-membrane; the cornea had sloughed and the iris was prolapsed. The left palpebral conjunctiva had a similar pseudo-membrane upon it, and was but very slightly vascular; the cornea was hazy throughout its whole extent, and had a well-marked abscess at the outer and lower part. Quinine lotion was ordered to be used every hour. Three days later the lids were apparently free from pseudo-membrane and presented the usual spongy, bright-red appearance of ordinary purulent ophthalmia. The cornea was rather cleared and the abscess more circumscribed. The discharge was likewise more purulent. Thinking that the special interest he had taken in the investigation of diphtheritic conjunctivitis might have induced him to exaggerate the gravity of this particular case, Mr. Tweedy adopted the actual indications of purulent ophthalmia and applied a ten-grain solution of nitrate of silver to the everted lids. Though the quinine lotion was continued every hour as heretofore, when the patient was taken to the hospital a few days later the left cornea had sloughed and perforated, and the iris was prolapsed. Had vascularity and swelling of the conjunctiva and the purulent discharge observed at the second visit been taken as an indication of the second or purulent stage of diphtheritic conjunctivitis, rather than as controverting the original diagnosis, the cornea, damaged as it was, might, Mr. Tweedy believed, have been eventually saved by persistent employment of the quinine lotion and by abstention from the nitrate of silver. In further support of the specific character of this pseudo-membranous conjunctivitis, he referred to a case seen

in consultation with Dr. John Williams about eighteen months ago. An infant, about a week old, presented the signs of mild simple conjunctivitis, which was treated with weak alum lotion. In about ten days the inflammation had apparently passed off, and the child opened the eyes without difficulty. Suddenly the right lid swelled, and within twelve hours the cornea assumed the appearance of ground glass and became infiltrated at the lower part. Dense infiltrated pseudo-membranes soon appeared on the palpebral conjunctivæ of both eyes. Quinine-lotion was used every hour, day and night, and both corneæ were ultimately saved, though at one time during the treatment the child had suffocative attacks, and it seemed doubtful whether it could survive.

LEEDS GENERAL INFIRMARY.

ABDOMINAL TUMOUR; ASPIRATED THREE TIMES; FLUID CONSISTING APPARENTLY OF ALTERED BLOOD; SUBSEQUENT DISAPPEARANCE OF THE TUMOUR AFTER AN ATTACK OF DIARRHOEA AND COLIC.

(Under the care of Dr. CLIFFORD ALLBUTT.)

FOR the following report we are indebted to Mr. J. F. W. Silk, house-physician.

J. H. M.—, aged thirty, a tailor, was admitted on Sept. 7th, 1882, complaining of pain in the abdomen and constant sickness. He gave the following account of himself. About four years ago he first began to suffer from pain in the abdomen, coming on mostly after food, and associated with flatulence and acid eructations. This was put down to ordinary indigestion, and the attack passing off in the course of a couple of months he remained tolerably free from pain up to about five months before admission, when it recurred, and was accompanied by vomiting. At the same time he noticed a hard lump, the size of a closed fist, in the epigastric region, which, he says, disappeared a few days after the other symptoms had subsided. The whole duration of this second illness, including the disappearance of the tumour, was not more than ten days. Subsequently he had three precisely similar attacks, in all of which he noticed the tumour, and in all, except the last, this tumour disappeared in the intervals of comparative good health. The fifth and last attack commenced on June 18th, 1882, and although he was only confined to his bed a fortnight, he never recovered completely, as on former occasions, and the tumour, instead of disappearing as usual, increased in size. The pain and vomiting became more marked about a fortnight before admission, and he lost flesh. The first attack, four years ago, was ascribed to mental anxiety; the subsequent attacks are all associated by the patient with excess either in eating or drinking—e.g., “a heavy supper,” “a copious draught of ginger-beer,” &c., but beyond that no definite exciting cause can be made out. Both the family and personal history are good. He denied all venereal affections, and as far as one could make out, there were no signs of syphilis about his person; he has been very temperate, and on the whole has lived a remarkably regular life, free from any serious illness.

On admission he was found to be a highly intelligent man, with an anxious worn expression. The pain obliged him to sit up in bed, and he was constantly vomiting. He retained nothing but fluids, and of those preferred lemonade and other cool watery drinks; he was most free from pain when his stomach was distended with large quantities of such fluids. There were no signs of any excessive emaciation. The layer of adipose tissue was well developed, especially in the abdominal walls, but the whole muscular system was flabby and ill-nourished. On palpating the abdomen, a distinct rounded tumour could be felt occupying the whole of the epigastric region, extending downwards to the level of the umbilicus, and laterally beneath the ribs, inclining rather to the left of the median line. It was elastic and freely movable from side to side; but its connexions, partly on account of the thickness of the abdominal walls, could not be made out with anything like certainty. It did not, however, seem to be attached to either the liver or spleen, which, as far as could be judged from the areas of dulness, did not appear to be enlarged. The deepest inspirations only caused a very slight downward displacement of the mass, and nothing like an hydatid “thrill” could at any time be detected. There was no ascites or cutaneous oedema, and no cardiac or pulmonary lesion. The urine was highly coloured, and contained much mucus. The

temperature was quite normal. He remained in hospital for nearly three weeks, and with careful dieting and complete rest, the urgent symptoms above-mentioned abated, the tumour became less apparent, the urine regained its natural appearance, and the mucus disappeared. He went out at his own request on September 23rd to attend once a week as an out-patient. He was readmitted on Nov. 15th, 1882. Although the vomiting had not returned, and the pain was much less, the tumour had increased in size and had extended a couple of inches below the umbilicus. Its connexions were still a mystery, and even under ether nothing further was made out. While under the influence of the anæsthetic the long fine needle of a small syringe was plunged to a depth of about three inches into the tumour, and about a drachm of dark-brownish viscid fluid withdrawn. This fluid was highly albuminous, but gave no reactions with any of the usual tests for bile; microscopically it showed large numbers of broken-down blood-cells, granules of colouring matter, and some larger and more perfect nucleated cells of an epithelial type, but the most careful search failed to reveal anything in the shape of a hooklet.

On November 30th the tumour was aspirated at a point about three inches above the umbilicus, and thirty-two ounces of a fluid exactly similar to that described above were withdrawn; viewed *en masse*, it had a greenish tinge. Great relief followed the operation, and the tumour became less prominent and tense, although it by no means entirely disappeared.

On December 13th, as the tumour had nearly regained its former dimensions, it was again aspirated an inch below the seat of the former operation, and fifty-one ounces of the same dark-coloured fluid were withdrawn. After this second operation it was noticed that the right side of the tumour had diminished to a much greater extent than the left; so on the 16th another aspiration was performed, the point selected being about an inch and a half to the left of the second puncture. Thirty-two ounces of fluid were withdrawn, resembling in all respects that previously obtained. Immediately after the third aspiration the tumour collapsed, and could only be made out as an indefinite feeling of resistance on deep pressure in the epigastric region, as it did not subsequently increase in size, and the patient's general health was greatly improved. He was discharged on Dec. 26th, 1882.

After his discharge he was seen at irregular intervals as an out-patient, and up to the beginning of March of the present year remained free from pain and vomiting, the tumour gradually reappearing. About the 14th of that month he had a sudden and severe attack of abdominal pain and vomiting; this was followed by diarrhoea, the motions being quite black and loose. From that date, the patient said, the tumour has entirely disappeared, and when seen on May 11th there were certainly no signs of anything like a tumour to be made out in any part of the abdomen; and, except for an occasional feeling of "biliousness," he says that he has been perfectly well ever since March.

Remarks.—The cyst in this case seems to have been composed of at least two cavities, probably communicating, but not freely. The sudden disappearance of the tumour, as if by communication with the bowel, is remarkable; and although one can hardly expect that this disappearance will be permanent, still, from the fact that the tumour is now, after the lapse of two months, quite imperceptible, one is almost led to hope that such may be the case. In every other respect it resembles closely the first of the cases cited by Dr. Bristowe in his "Clinical Remarks on Abdominal Sanguineous Cysts," reported in THE LANCET of May 5th. The case cannot be said to be complete; and the subsequent history of the patient will, as far as possible, be carefully watched; but even in its present incomplete form it presents so many points of interest that it is not, perhaps, unworthy of record.

ST. VINCENT'S HOSPITAL, DUBLIN.

A FATAL CASE OF UNCOMPLICATED ACUTE RHEUMATISM;
REMARKS.

(Under the care of Dr. QUINLAN.)

FOR the following notes we are indebted to Mr. Kenna, house-surgeon:—

Kate C—, aged twenty-two, single, of delicate appearance, was admitted on Friday, May 11th, suffering from acute articular rheumatism. She had been ailing for seven

days; no previous attack. Both wrists, both elbows, and the left knee were swollen and immovable, and very painful; tongue yellowish white; copious acid perspiration; no cardiac lesion; no subcutaneous nodules. Temperature 103° 8' F.; pulse 120. Ordered fifty-grain doses of salicin in milk, commencing at noon; also a quarter of a grain of morphia, hypodermically. At 6.30 P.M. she had taken six doses; the pain of joints was not so severe; temperature 100° 8'; pulse 112. Ordered the salicin every second hour if not asleep.

May 12th, 9.30 A.M.: Articular pain completely gone; slept a few hours during the day; temperature 100° 5'; pulse 120. Ordered sixty grains of salicin every second hour until evening. 6.30 P.M.: A little articular pain; temperature 101°; pulse 120; the patient restless. Ordered a sleeping draught containing chloral and bromide of potassium. To continue the salicin every second hour.—13th, 9.30 A.M.: Slept well during the night; articular pain gone; heart normal; temperature 100° 6'; pulse 128. To continue salicin.—14th, 9.30 A.M.: Slept without a draught; free from pain; heart normal; she is, however, feverish and uncomfortable; intellect quite clear; temperature 100°; pulse 116. To continue salicin. 6.30 P.M.: Temperature 102° 8'; pulse 112. At 11.30 P.M. the patient suddenly became delirious and violent. The temperature rose very much; but, as she had to be kept in her bed by the efforts of three persons, it could not be exactly ascertained. She died about a minute before midnight.

Remarks by Dr. QUINLAN.—Having recently put forth some very successful cases of acute rheumatism treated by large and frequent doses of salicin, I feel it incumbent to publish this, the first of a large number of them in which the result was unfavourable. The very high admission temperature, and the frequent temperature exacerbations, marked this case from the beginning as one of those virulent ones that used to be the dread of physicians and an opprobrium to medicine. I am almost inclined to regret that, with this knowledge before me, I did not begin with sixty-grain hourly doses, and adhere to them until the temperature was decisively lowered and the disease evidently subdued. Probably, however, in so virulent a case the result might have been the same. It is remarkable that, although the temperature heightened again and again, the influence of the drug in relieving the articular pain was immediate and complete. Something also might have been done by blistering the epigastrium, a procedure which often does good in severe cases, and that quite irrespective of cardiac complication. The fatal issue does not in the least shake my confidence in salicin. It shows, however, that we have something yet to learn about the exact method of using it, and that we do not yet always administer it with sufficient boldness.

Medical Societies.

EPIDEMIOLOGICAL SOCIETY.

Outbreak of Cholera in Egypt.

At a meeting of the above Society on Wednesday, July 4th, Dr. J. M. Cunningham, Sanitary Commissioner with the Government of India, read a paper on the "Sanitary Lessons of Indian Epidemics." The President of the Society, Dr. George Buchanan, F.R.S., introduced the subject by the following memoranda concerning cholera:—

1. *Narrative.*—Cholera reached Europe by way of Egypt for the first time in 1865. Before that date, its course from Asia had been through the Russian Empire. At the first appearance of cholera in Europe, over forty years ago, it began in Great Britain fifteen months after its introduction to Europe. At its second appearance, it began with us in England after about the same interval. Its third appearance does not admit of comparison with the others. At the fourth appearance of cholera in Europe, when it came by way of Egypt, it was epidemic in the Hedjaz in May; it appeared at Alexandria on June 2nd; was at Malta, Smyrna, and Constantinople before the end of that month; and appeared in Spain and Italy and at Marseilles during July. Spreading somewhat widely in Europe during the next two months, it was at Southampton on September 17th, and on Nov. 3rd it was witnessed at New York. In the