reason, that the irritation they caused of so delicately constituted a tissue as the lining membrane of the trachea must have tended to increase or produce inflammation, and, considering the temporary constitutional tendency, the induced inflammation would probably be of a diphtheritic nature. The air warmed and moistened by kettles, and the damp gauze covering the tube, not being found sufficient to keep the tube and trachea clear, two drops of a warmed solution of bicarbonate of soda (twenty grains to an ounce of water) were dropped down the tube every half-hour. This, together with occasional washing of the inner tube, and the catching of expectorated matter by the nurse to prevent inspiratory effort sucking it back again, were found to be all that was necessary. If the progress of the case is satisfactory, it is an obvious advantage to know when the tube may be with safety permanently removed. I was helped in the second case by my experience in the first. I placed a piece of cotton fibre in front of the nostrils two or three times a day, and when the expired air moved it I ascertained how the patient bore occlusion of the tube aperture. If satisfactorily, the tube was permanently removed. In the second case it was on the fourth day after the operation, and in the first case on the fourteenth. It probably would have been removed earlier in the first case had it been watched in the same manner. As constitutional treatment, these cases were all given, in doses varying with their age, sulphate of quinine, bromide of potassium, and sal volatile. The objection raised to this prescription was that bromide of potassium is a depressant, and therefore injurious in a depressing disease. I have given it to adults as well as to children, and they were all more composed under its exhibition than without it.

In one case, C. C—, a perfect cast of diphtheritic membrane of the trachea, its bifurcation, and smaller bronchi, was coughed up through the tube. So perfect a cast is it that one may suppose that the soda solution may have loosened the membrane, or that the bromide of potassium may have some action resembling its allied salt, iodide of potassium, in the action the latter has in bronchitis in the liquefaction of the sibilant rhonchi, and if so, the bromide of potassium and allied drugs may be granted some day an exfoliatory effect on diphtheritic membrane. The only remark on the cases necessary is to point out the fatal case of C. H—, aged one year and eight months, whose case was so hopeless from the first that the operation being performed at all was a questionable advantage. Besides being a badly nourished and emaciated infant, there were before operation dulness and tubular breathing at the base of the right lung, so that this can hardly be regarded as a fair trial case. The other two fatal cases were decidedly promising ones compared with the two cases of recovery.

G. M—, aged two years and three months. Family and previous history very good. Had been ill two days before admission. On admission the child was otherwise well nourished and healthy-looking. Lips cyanosed. Eyelids puffy. Marked inspiratory stridor and general signs of dyspnoea. Sinking in of ribs. Instinctively trying to produce vomiting by inserting the fingers into the back of the throat. Temperature 99°4'. A trace of albumen was found in the urine with the nitric acid and picric acid tests. Membrane on both tonsils; no limit to be seen below, and apparently spreading behind uvula. Also a profuse discharge from the nose. No hæmorrhage. Glands enlarged. Operation performed. Tube removed on the fourteenth day after it. The albumen eventually increased to one-third, and disappeared gradually; no casts; few red blood-corpuscles. Left hospital twenty-six days after admission. No paralysis. Complication: bronchitis.

M. M. S—, aged three years and ten months. Family and previous history good. Had been ill three days before admission. On admission, the child was otherwise healthy-looking and well nourished. Membrane on both tonsils, more on right than left. Glands of neck enlarged. Inspiratory stridor and marked dyspnoea, not so marked as in the above case. Temperature 98°6'. Trace of albumen in urine. After operation the temperature rose to 105°; it gradually came down next day and remained down. The albumen eventually increased to one-fifth, and disappeared gradually. Tube left out on fourth day after operation.

A. M. S—, aged one year and six months (sister to the above patient). Had been ill for three days after her sister had been admitted. On admission, the right tonsil was covered with membrane. Glands of neck enlarged. Trace

of albumen in urine. Inspiratory stridor and cyanosis, and general sign of dyspnoea. Death occurred about sixteen hours after operation. No necropsy was allowed.

C. C—, aged four years and ten months. Family and previous history good. Had been ill for two days before admission. Both tonsils covered with membrane. Glands enlarged. Inspiratory stridor and general signs of dyspnoea. Temperature 101°8'. Ceased breathing during operation, but revived on insertion of tube. Died nineteen hours after operation. This is the case in which the cast spoken of above was expectorated. No necropsy was allowed.

C. H—, aged one year and eight months. Family history good. Had always been delicate; no actual disease. Had been ill some days before admission. No accurate history. Weakly, delicate, and badly nourished child. Membrane on both tonsils. Glands enlarged. Inspiratory stridor and laryngeal obstructive signs. Dulness at base of right lung and tubular breathing. No urine could be obtained for examination. Temperature 101°. Death occurred thirteen hours after operation.

Victoria-street, S.W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

THE OPERATION OF PERITOMY, WITH NOTES OF TWO HUNDRED AND FIFTY CASES.

BY A. VERNON FORD, M.R.C.S.,

SURGEON TO THE PORTSMOUTH AND SOUTH HAMPSHIRE EYE AND EAR INFIRMARY, AND OPHTHALMIC SURGEON TO THE GORDON BOYS' HOME.

THE operation of peritomy was first practised in 1862 by Dr. Furnari of Paris, and was afterwards largely used in cases of pannus by Mr. Critchett. Some statistics upon the subject are to be found in the London Ophthalmic Hospital Reports (vol. iv., p. 182). Of late years it has fallen to some extent into disuse, and this is, in my opinion, largely due to its having been applied to lesions for which it was not properly adapted. In suitable cases it is still of the utmost value to the ophthalmic surgeon. I would especially recommend it in those troublesome cases of keratitis, ulcerative, vascular, strumous, and suppurative, which are the opprobrium of our eye wards. Prolonged courses of drops and lotions have little if any effect upon such cases, while peritomy rapidly brings about a subsidence of the inflammation and a quick return to the normal transparency of the cornea. The increased pressure within the cornea arising from the separation of the strata, or by a blockage of the intercellular spaces and canals, is directly dependent upon the blood-supply of the part. Now, as the cornea derives its blood-supply principally from the conjunctiva, the local depletion consequent upon a division of its vessels, and of the loops which surround its circumference, would naturally tend to promote a healthy reaction, and facilitate the absorption of those stagnant cellular elements which separate the strata, and so interfere with the refraction of the cornea. After an experience of 250 cases, I am confident that peritomy yields unexceptionable results in the class of affections which I have indicated. It is useless to continue week after week to prescribe sedative and astringent lotions, when the case terminates too often in dense opacities which permanently impair the vision, and leave behind them amblyopia, astigmatism, and a host of evils. Without pressing my opinion unduly, I would submit that the operation is worthy of a trial, and that it is to be regretted that some of our best known text-books contain hardly any reference to so simple and effective a mode of treatment. Peritomy practised in a large out-patient department, involving as it does the use of anaesthetics, entails considerable labour upon the surgeon and his assistants. This is more than compensated for, however, when we find young patients who have suffered from all the distressing symptoms of photophobia, lachrymation, and blepharospasm coming back a few days after a thoroughly performed peritomy, and interviewing their doctor with an erect carriage and with a clearing cornea, through which day by day the light is more equally refracted.

As regards the operation itself, I do not believe in partial peritomies, and I take great care to thoroughly dissect the subconjunctival tissue right up to the margin of the cornea. The after-treatment consists in the use of mild astringents and antiseptics, boracic acid (ten grains to one ounce), or yellow oxide of mercury ointment (from four to eight grains to one ounce), to encourage the absorption of opaque elements. The general constitutional condition is, of course, a separate factor, which must be treated in each case upon its own merits. I make it a rule never to have recourse to peritomy until I find that milder measures are useless. If after a week's ordinary treatment the local condition is not improved, I have then no hesitation in operating. In all cases after operation I employ a compress of cotton-wool held in place by a bandage, shades being in my experience as often injurious as beneficial. I may say, in conclusion, that I have found peritomy useful in the chronic forms of keratitis, threatening staphyloma and degeneration of the corneal structure, but not so much so as in those acute and subacute affections for which it is, in my opinion, specific.

Southsea.

"BILIOUS ATTACKS."

BY ANGEL MONEY, M.D., F.R.C.P.

THE bilious attacks occurring in neurotic individuals are very different paroxysms from those seen in habitual or occasional over-feeders. A clean tongue—often "geographical" or desquamating too freely in patches,—a scanty high-coloured lithatic urine, a sallow face, white motions, dilated pupils, low spirits, and absence of energy, constitute the clinical entity in many cases of "bilious attacks." These are very common in neurotic children with dainty appetites, in whom to suppose that irritation and vascular engorgement of the viscera, from over-feeding, exist, would be ridiculous. A sharp purge to these patients may do more harm than good, though it is possible to set the viscera working again by such sudden means. An inadequate liver may be the cause of a toxæmia, and the poison in the blood may have a selective action on the mental centres, originating lowness of spirits—melancholia; this is the view most favoured by the laity, but it is often incorrect. In truth, a mutual tension between the viscera and the brain exists—reciprocity rules the realms of the human body as it does the social organism. The truth appears to be that the viscera may go wrong as the result of being under-charged with nervous energy, and they simply cease to work effectively because of defective nervous enervation. The correct treatment is not a dose of castor-oil, but a tablespoonful of wine at once and a teaspoonful of syrup of the hypophosphites thrice a day for one week.

Harley-street, W.

PLEURITIC EFFUSION OF NINE YEARS' DURATION, TREATED BY THORACENTESIS.

BY T. F. RAVEN, L.R.C.P.

J. D—, aged thirty-six, was seen by me early in March. He complained of dyspnoea, irritative cough with puriform sputa, and debility. He was somewhat cyanotic. The right chest was evidently "waterlogged." He gave the following account of himself. Nine years ago he was suffering from difficulty of breathing and pain in the side. He was admitted into Charing-cross Hospital, and, finding that the physician was determined upon thoracentesis, he took fright and left. Ever since then he had been subject to dyspnoea, which had gradually but surely increased upon him. On March 5th I drew off with the aspirator four pints and a half of blood-stained and rather thick serum. It resembled, in the patient's words, "beef-tea." Great pain, resulting probably from the stretching of old adhesions, followed the operation, and lasted for thirty hours; but the relief was great. A fortnight later nearly three pints of similar fluid were withdrawn. He seemed to feel the shock of the operation severely, and the pain which followed was both more acute and more protracted than on the first occasion; still the result was good, and the physical signs began to abate. Five weeks afterwards, about eight ounces of turbid yellow fluid were extracted by means of a cannula and indiarubber tube.

This operation occasioned but little shock, and scarcely any pain resulted. Since then he has steadily improved, and although there is still some dull percussion and deficient respiratory murmur over the affected side, owing doubtless to thick adhesions, and perhaps some residual fluid, yet he is free from pain and capable of following his occupation.

I record this case on account of the exceedingly chronic character of the effusion, which during nine years had not been converted into pus; and also to indicate the results which may be obtained by thoracentesis in very long-standing pleuritic effusion.

Broadstairs.

CASE OF SPONTANEOUS EXPULSION.

BY WM. LANGRAN, L.R.C.P. EDIN., &c.,

MEDICAL OFFICER, AXMINSTER WORKHOUSE.

ON the morning of April 16th I was hurriedly sent for by my friend Dr. W— to assist him at a difficult midwifery case. On arriving, I was informed that the woman had been in labour two days with her second child, when the midwife, discovering an arm presenting, sent for Dr. W—, who endeavoured to turn, and succeeded in bringing down a foot, but could not turn the child. I found the right hand and left foot presenting, and also failed to turn. The pelvis was very roomy, and I had no difficulty in feeling the face in the hollow of the sacrum. We were considering the necessity of performing embryulcia, when the woman had a very severe pain, and I distinctly felt the head move further down, and at the same time the foot receded. By making some traction on the protruded arm, which was advancing further out, the patient was delivered of a large-sized dead child. I have no doubt that delivery would have been accomplished without any assistance with another pain. The mother has made an uninterrupted recovery.

Axminster.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

CHARING-CROSS HOSPITAL.

SUBCRANIAL AND SUBDURAL HÆMORRHAGE AFTER INJURY; LOCALISATION OF EFFUSION; TREPHINING; DEATH; NECROPSY.

(Under the care of Mr. BELLAMY.)

ANY contributions to brain surgery are of importance and value, and, when from the symptoms the lesion has been localised, of peculiar interest, and pregnant with suggestion for future operative undertaking. In the case of a primary lesion of the brain, the condition of the scalp or of the bone will often assist materially in the localisation of the lesion, but in this instance the diagnosis had to be made from the symptoms which developed on recovery from the concussion. These symptoms were those met with in cases of hæmorrhage following laceration of the brain, and, as usual in such injuries, there was marked rise of temperature. From their increasing severity it was evident that unless the man could be relieved by operation death would soon ensue. Mr. Bellamy therefore trephined, and that the operative treatment employed was that best calculated to relieve the patient's symptoms was proved by the condition of parts found at the time of operation, and later at the necropsy.

George B—, a man aged fifty, was admitted on Thursday, April 25th, apparently suffering from symptoms of severe concussion, the result of a fall from a scaffold. He was collapsed, with a temperature of 95.5°. He vomited soon after admission, and continued doing so till the evening.