Clinical Notes :

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

EXTRAORDINARY RETENTION OF A PESSARY.

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THE following case was brought under my notice not long since. Considering the length of time the instrument had been worn uninterruptedly it seems to me to be worth putting on record.

I was called to attend a woman in the eighty-third year of her age, then suffering from an attack of influenza, from which, however, she made a complete recovery. Towards the end of her convalescence the nurse in charge informed me that the patient had a somewhat foul-smelling vaginal discharge and that there was a tendency to frequent micturition and action of the bowels. Having ordered a vaginal douche, the other symptoms being left alone temporarily, the patient then proceeded to inform me that she was wearing an instrument—for previous prolapsus uteri—that had been introduced by the late Dr. Paris when she was fifty years of age, and, further, that the instrument had never once been removed. The story seemed to me incredible at the time, as it appeared quite unusual that any instrument could be retained *in situ* for a period of thirty-three years and yet cause no trouble locally. Inconvenience there certainly was, which was probably increased of late by the cough following influenza. However, the patient still persisted and begged me to remove it, assuring me at the same time that an instrument had been inserted thirty-three years ago and that it now felt as if it would be expelled from the vagina as, using the patient's expression, "it seemed to come down." It was, therefore, my duty to make a per vaginam examination, and no sooner was the finger introduced than a hard body was met with. I then digitally explored for the purpose of its withdrawal. It felt like a piece of flat board, the rounded edges of which seemed deeply embedded in the anterior and posterior walls of the vagina. Passing my finger still higher I reached what I thought to be its upper limits. From lying across the vagina as it did the instrument, as it were, divided the cavity into an upper and a lower portion, and in that position it was fixed. By gentle traction I removed it, and it proved to be the old-fashioned circular wooden or disc pessary, two and a half inches in diameter. On examination I found that what corresponded with the anterior edge of the pessary when *in situ* was thickly coated for fully an inch and a half with a deposit of a chalky nature, while on the corresponding opposite edge was a similar deposition, though not nearly so marked. The odour from the long-retained "foreign body" was particularly unpleasant.

The authenticity of the dates can be vouched for, as the patient's memory was perfectly clear upon the point and, moreover, her daughter was able to corroborate her mother's version in every particular.

Ventnor, I. W.

A CASE OF NÆVUS OF THE OCULAR CONJUNCTIVA.

BY W. DEVEREUX, M.A., M.B. CANTAB.,
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THE following case may prove of interest to the readers of THE LANCET on account of its rarity.

A patient consulted me in August, 1895, with reference to a growth on the conjunctiva close to the edge of the cornea. He first noticed it about sixteen years previously and consulted a surgeon, who treated it for some time with powdered alum, which was flicked into the eye, but with no apparent benefit. On examination I found a round nœvus of the conjunctiva about the size of a small pea on the outer side of the cornea. It was quite sessile and did not involve the sclerotic at all. There was a broad leash of conjunctival

vessels running up to the growth from the outer canthus. I prescribed collyrium zinci sulphatis (two grains to one ounce) and the nœvus for a time decreased in size. In December the nœvus began to increase again, having grown to the size of a large pea, and was beginning to involve the cornea, which showed signs of commencing interstitial keratitis at its outer edge. As the growth projected from the surface of the eye for about a quarter of an inch considerable hæmorrhage occasionally ensued when the patient closed his eye, and also when he went out in a high wind. The leash of vessels running to it had greatly increased in size. As the collyrium zinci sulphatis had been again tried without any benefit I determined to ligature the growth. The eye having been anæsthetised with cocaine, a few drops of atropine introduced, and the eye speculum inserted, the nœvus was drawn away from the eye with a pair of fixation forceps. I then passed across the base of the growth a small straight Hagedorn's needle threaded with a No. 1 double silk ligature. While the needle was still in position across the base of the growth a second threaded needle was passed underneath and at right angles to it. This was drawn through and its loop of silk divided. The first needle having been drawn through its loop was also divided. My assistant then seized six of the ligature ends while I tied in a reef knot, the two ends left hanging out belonging respectively to the first and second loops. I then tied four other ends in a similar manner in each case, drawing the knot against the base of the tumour. The last two ends were then drawn on very tightly so as to bring the knots of the nooses towards the centre of the growth, and these were then firmly tied. The ends of the ligatures were cut off and the eye dressed with a pad of Gamgee tissue and bandaged. The tumour sloughed off in three days, the eye being kept under the influence of atropine for about a week. No conjunctivitis or pain followed the operation. Two months later there was only a slight scar where the nœvus was situated, the keratitis had cleared up, and the leash of vessels had nearly disappeared. Ten months after the operation there had been no recurrence of the growth, and the scar was imperceptible.

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NOTE ON A CASE OF ACUTE GLAUCOMA IN WHICH SIGHT WAS RESTORED AFTER PROLONGED ABOLITION OF PERCEPTION OF LIGHT.

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THE patient was a married woman aged sixty-seven years. Twelve years ago she was roused about three o'clock in the morning by a violent pain in the right eyeball accompanied by vomiting, great prostration, and loss of perception of light (glaucoma fulminans). A consulting surgeon was called in, some drops were used, and general directions were given, but no operation was suggested, and the patient went on from bad to worse until the eye was completely lost (glaucoma absolutum consummatum). Three months ago the left eye was attacked during sleep, with precisely the same symptoms—pain, vomiting, prostration, and loss of perception of light. Notwithstanding her bitter experience with the right eye similar treatment was adopted for the left, and it was not until three weeks had elapsed that I was called in. I then found the eyeball stony hard, the cornea steamy, the iris muddy, the pupil dilated to a rim, and the patient profoundly insensible to the most brilliant light. I immediately excised a large piece of iris (about a fourth), taking care to establish a filtrating cicatrix, an operation which was exceedingly difficult (as all who have had experience will understand);¹ but on its completion the painful symptoms ceased as if by magic, and sight was gradually restored, so that she can now with a little trouble read newspaper type, without glasses

1 "The anterior chamber has to be entered at its extreme rim, where the sclerótica overlaps the cornea close in front of the iris, which often bulges much and which must on no account be pricked lest the vitreous humour or lens immediately behind should be wounded, in either case a most serious complication. The bulging of the lens and the dilatation of the pupil add to the risk of injury to the lens; a little blood, too, escaping into the anterior chamber, either before or after the excision of the iris, may obscure the parts from view and add to the chance of involving the vitreous humour or lens."—Bowman: Selected Papers, p. 237.