that was needed to perfect the cure was, that the right eye should be kept closed for a short time, and proceeded to do so with a strip of plaster and a bandage. After a few days the dressing was removed. The patient has not complained since of the drooping of her left eyelid.

A MODE OF INTENSIFYING HEART-SOUNDS.

(Under the care of Dr. POORE.)

In the out-patient room we also witnessed, among Dr. Poore's patients, a novel application of acoustic principles for the rendering of sounds made in the chest audible to those standing near the patient. The subject of this experiment was a man of middle age with a very loud basic diastolic cardiac murmur. The murmur was one of the loudest we have ever heard. The patient, being stripped, was made to lie flat on his back on a long wooden bench, or couch, without cushions. Dr. Poore then borrowed a walking-stick from one of the students and placed the lower end of it on the sternum between the third costal cartilages. On the opposite end was balanced the sounding box of a guitar, the aperture being directed towards the thorax of the patient. The cardiac sound became immediately audible to everybody standing round (some nine or ten persons) provided the ear was kept below the level of the guitar. The patient himself became extremely conscious of his murmur, and seemed very much amused with the experiment. There was a considerable amount of cardiac thrill, the vibration of which was felt by everybody on placing a finger on the guitar or the walking-stick. Dr. Poore merely regards the experiment as a curiosity, and does not believe that an apparatus similar to the one he extemporised would be of any use for purposes of diagnosis.

CENTRAL LONDON OPHTHALMIC HOSPITAL.

AN INTRA-ORBITAR DERMOID CYST, RESULTING IN ABSCESS; THE CYST REMOVED SUBSEQUENTLY; SATISFACTORY RESULT.

(Under the care of Mr. W. SPENCER WATSON.)

A. S—, aged twelve years, came to the hospital with the upper eyelid and the orbital cellular tissue enormously swollen and inflamed, the eyeball being protruded and thrust downwards. Immediately under the external angular process of the frontal bone, a roundish mass was felt, occupying the centre of the swelling; and growing out of a minute orifice in the skin at this point were three or four short hairs. These had been noticed by his mother ever since his birth, and a serous discharge had, till quite recently, escaped from the opening. Now, however, a probe penetrated only one-sixteenth of an inch into the sinus. There being considerable pain and pyrexia, on Feb. 13th an incision was made into the abscess, and about half a drachm of thin pus let out; the pain after this gradually subsided, though it had before been almost constant, with occasional paroxysmal exacerbations. The eyeball remained displaced, and there was diplopia for several days.

Feb. 28th.—Pain and swelling gone; no diplopia; no discharge; a hard circumscribed nodule occupies the site of the abscess.

April 18th.—The hard nodule, though smaller, remains *in situ*, and though causing no present inconvenience, was thought likely to occasion subsequent troubles. Mr. Watson, therefore, dissected it out from the orbital cellular tissue, through a semilunar incision in the upper eyelid parallel with the eyebrow. It extended as a hard round cord to a depth of about three-quarters of an inch under the orbital ridge, and its removal was much facilitated by passing a small probe from its cutaneous orifice into its cavity during the dissection. The wound was closed by stitches, cotton-wool, and collodion. The crust formed by the dressings above mentioned remained attached to the wound till April 29th, when they were removed, and the wound was found to have healed entirely, without any indication of suppuration, the line of the cicatrix being scarcely distinguishable from the skin on each side. A small collection of pus, of the size of a split-pea, immediately below the line of incision, was opened, and found to be unconnected, or at least not communicating with the original wound.

May 17th.—A small nodule remains in the site of the cyst, which is probably a shrinking cicatricial induration, but giving no trouble to the patient.

The cyst, when removed and cut open, had the usual mucoid lining, with hairs growing from it, so frequently seen in dermoid cysts in this region.

Remarks—These cysts, though very commonly found external to the orbital margin, seldom invade the cavity of the orbit, but when they do are very liable to cause trouble, either by their increase in size and consequent displacement of the eyeball, or, as in this case, by accidental suppuration taking place in or around them. The desirability of an early removal of such cysts is strikingly illustrated by the progress of the disease in this instance. The dry dressings here employed offer many advantages in the treatment of any similar wounds the skin edges of which can be accurately adjusted. 1. They give a fair chance of immediate union by favouring close adaptation. 2. If the union by first intention is not obtained they may still be left attached provided no deep suppuration takes place; and by renewing the collodion (or still better Dr. Richardson's styptic colloid), we may avoid any disturbance of the edges of the wound until a healing action has been set up. 3. In either case the pain and discomfort of changing the dressings, of which patients complain so bitterly, are entirely avoided. 4. Even if deep suppuration should occur it will not be always necessary to remove the crust of colloid or collodion, provided an opening be left sufficient for the escape of discharges. The wound in such a case is only in the position of an abscess with a small valvular opening, instead of being an open sore, and it must often be preferable to have the former condition. 5. The saving of time and trouble to the surgeon is very great. In this case the dressings were not touched (except on one occasion for the purpose of reapplying the collodion) for eleven days, and were then removed altogether.

LIVERPOOL NORTHERN HOSPITAL.

CASES OF SEVERE INJURY TO THE HEAD.

(Under the care of Mr. LOWNDES.)

CASE 1. *Compound fracture of skull and great laceration of the brain.*—E. G—, aged twenty-two, a sailor, was admitted on December 20th, 1871. He had fallen a considerable height on shipboard from a spar on to the deck. He was insensible, and much collapsed. There was a very large scalp wound, and part of the left parietal and temporal bones was completely smashed, and portions were driven into the brain. The pieces of bone that were quite detached were removed, but a large portion of the squamous part of the temporal bone, which was quite loose and driven into the brain, but not completely detached, was simply raised into position; much brain-matter escaped. Wet lint was loosely applied. To have six ounces of brandy.

Dec. 21st.—There have been convulsive twitchings of the mouth all night. He has taken a little fluid nourishment; a calomel purge was ordered.

23rd.—He is better; is sensible and makes signs, but cannot speak.

25th.—Great discharge from head; to be dressed with oakum poultices.

January 2nd.—Still speechless; the whole of the right side is now paralysed.

11th.—The wound is healing well, but there is a large piece of bone bare. When he is asked any question he seems to understand, and answers by moving his lips, but makes no sound. He now eats well, and his tongue, which he cannot protrude, is clean. All the right side, both face and limbs, is paralysed.

12th.—He speaks a little to-day.

29th.—He can move his right arm a little, and is able to put his tongue out.

Feb. 5th.—A large piece of dead bone was removed. He now speaks much better, but cannot say "Yes" distinctly. He is sitting up and eating well.

From this time he gradually improved; the wound healed; the paralysis of the face and limbs gradually disappeared, and the speech improved, though he still articulated badly, and there were many words he could not pro-