to attempt to rectify the malposition. An incision was made through the mucous surface of the cul-de-sac, and after dividing several layers of fascia, the eyeball was found in a loose but strong fibrous capsule. The eyeball was much smaller than I had expected, rather less than a small marble; the part exposed was formed of a very thin semi-transparent membrane containing fluid, but not tense. It was obviously useless, and I left it *in situ*. The wound healed readily by first intention. I can suggest no explanation of the malposition.

SUCCESSFUL SUTURE OF TENDONS ELEVEN WEEKS AFTER THE INJURY.

BY T. PRESTON GOSTLING, L.R.C.P. LOND. &c.

JOHN L—, aged forty, came to me on Dec. 13th, 1889, with the following history. Eight weeks previously, while engaged in trimming rose trees, the knife he was using slipped and inflicted a transverse wound on the outer side of the left wrist, one inch about the thumb. This wound was allowed to heal by granulation, no advice being obtained until it was found that the thumb could not be moved voluntarily, at which time the patient was comforted by being told that "some nerves were cut across, and that voluntary movement would return in the course of time." On Dec. 13th, 1889, the left hand was of little use, as the thumb was flexed into the palm and adducted, so that the patient was unable to pick up a book or to hold anything unless the thumb was first lifted up and the article to be held placed between it and the hand. Any variety of passive movement was possible, but the only active movement which remained was extension of the terminal phalanx, the thumb being rendered motionless owing to the unopposed action of the flexor longus pollicis, adductor pollicis, and the flexor brevis pollicis. At the base of the first metacarpal bone, and one inch above it, there was a transverse scar an inch long, on the outer surface of the left wrist. Just below this the distal ends of the tendons of extensor primi internodii pollicis and extensor ossis metacarpi pollicis could be easily felt, but the position of the proximal ends could only be indistinctly made out five inches off on the back of the forearm. On Jan. 8th, 1890, eleven weeks after the accident, the patient being under chloroform and an Esmarch's bandage being on the arm, an incision was made from the site of the distal ends of the tendons to the supposed position of the proximal ends. The distal ends were found at once, and it was then discovered that the synovial sheath was blocked at the site of the scar for three-quarters of an inch by a mass of connective tissue. This was cut through and the sheath slit up until the proximal ends of the tendons were found. All four ends were smoothly rounded off, and no adhesions had been formed. Unfortunately the ends of the tendons were five inches apart, and it was found to be impossible to bring them nearer together than three-quarters of an inch. However, the ends were cut off, and they were then stitched together with two catgut sutures each. One or two small vessels were tied, and the wound was closed by silk sutures without any drainage, the tourniquet not being removed until a wool dressing had been firmly applied, after which a special splint was put on in such a way as to keep the thumb fully extended. The wound healed by first intention. On Friday, June 27th, about six months after the operation, the patient was shown at a meeting of the Worcestershire and Herefordshire branch of the British Medical Association, having all the active and passive movements of the thumb perfect.

Worcester.

SIMPLE TREATMENT IN MIDWIFERY: AN INTERESTING CASE.

BY JOHN WHITEHOUSE.

ON March 16th, 1890, I was sent for to attend Mrs. P—, who was in labour. When I arrived I found her pulseless, with two ordinary chamber vessels filled with blood, which she had lost. On examination I found the placenta covering the os, which was fully dilated, but could not make out the presentation. I began to pare the placenta on one side, and must have passed my hand almost

to the fundus, but could not reach the edge. I therefore began on the other side. While doing this she had two or three pains, and the blood gushed out with each pain in a stream. Not being able to reach the edge, and another pain causing another stream, I pushed my hand straight through the mass of placenta and pulled down a foot. After this child was delivered an alarming gush of hæmorrhage took place. I examined once more, and found the membranes presenting again. I ruptured these and pulled down another foot. Hæmorrhage taking place, I passed my hand again, and for the third time came on membranes presenting. I broke them, and brought down another foot. Soon after the birth of the third child, what I took to be a small placenta came away, with one cord attached. After ten more minutes I removed the placenta remaining, which was certainly twice the ordinary size, and must have covered the greater part of the uterine wall. On looking at the first piece of placenta, instead of being one itself, it was evidently about a fourth of the whole placenta, torn across by me in thrusting my hand through it, and not one separate from the other. The woman made an uninterrupted recovery. In this case, as in others I have seen, the turning without chloroform acted more as a stimulant than a shock, as it caused the woman to moan—about the only sign of animation she exhibited—and I could feel the thready pulse of the mother with the other hand while pulling down the foot, which became imperceptible between each turning. I have now attended in Newcastle 600 cases, of which I have the record, 42 of which I have attended for other medical men, and twelve months' cases of my own of which I can get no record, without a single death, so that at the least I must have attended 700 cases. I have not for the last 400 cases used ergot; in fact, I never carry it, and hæmorrhage is far rarer than when I used it in a routine manner. I have not employed chloroform above twice, and I never use any form of antiseptic lotion except tepid water—the best antiseptic of all; in fact, my only experience for the last five years in lotions in midwifery lies in a single case, in which a physician in consultation dropped a disc, I fancy, of corrosive sublimate, and washed out the uterus.

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.

METROPOLITAN FREE HOSPITAL.

CASE OF CARCINOMA OF BREAST, ASSOCIATED WITH POLYURIA AND SECONDARY GROWTHS IN THE BRAIN;
NECROPSY; REMARKS.

(Under the care of Mr. WALSHAM.)

THE occurrence of carcinomatous growths in the brain, secondary to primary disease of the breast, is not frequently met with, and here it is not possible to say whether this was the only part secondarily affected or not. The secondary deposits presented the characters which such growths assume in this situation, but it is somewhat remarkable that a greater variety of symptoms was not caused by them. The importance of the case, however, depends on the fact that one of the malignant growths extended into the fourth ventricle, producing pressure on the floor, and that the patient presented the symptom of polyuria for ten weeks before death. We have thus another contribution to the series, not a very large one, in which this symptom has been proved to be associated with definite coarse lesion in the fourth ventricle. Dr. Kahler¹ collected twenty-two cases of simple persistent polyuria, associated with coarse cerebral disease. Of fourteen necropsies, tumours mostly of the base were found in ten. Of the remaining four, one showed atrophy of the right half of the medulla, another superficial congestion

¹ Sajous, 1888, *Zeitsch. für Heil.* 1886.