patient's condition varies almost momentarily, and requires almost momentary variations in the mode of administration of the anæsthetic. I believe that many of the victims of chloroform might have been still alive if the administrator had not attempted to do that which, in my opinion, nobody, except in extraordinary circumstances, is justified in doing—namely, the performing of the double office of surgeon and anæsthetist.

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.

GUY'S HOSPITAL.

CLINICAL REMARKS ON ALBUMINURIA; ON EMPYEMA; AND ON TYPHOID FEVER.

(By Dr. WILKS.)

Albuminuria.—Albumen may appear in the urine as the result of a cold. The explanation of this seems to be that the cold sets up in the uriniferous tubules a condition closely resembling that found in the bronchial tubes when they are affected. When the kidney recovers itself the albuminuria disappears. But a cold may give rise to acute tubular nephritis; and even this may be recovered from. The albuminuria dependent on the inflammation produced in this manner is very different from that which occurs as a result of a chronic degenerative change in the tubules of the kidney, which is itself often only a part of a general condition. Their respective prognoses are different. It is difficult to say the exact time at which albuminuria, as a result of acute tubular nephritis, becomes incurable. There is no doubt that many persons who have been condemned have recovered. Dr. Wilks formerly thought that if dropsy and albuminuria, as a result of acute tubular nephritis, lasted six months, cure was impossible. But he thinks so no longer; for he has seen cases recover after a much longer period than this. One of the first places in which dropsy, as a result of renal disease, shows itself is the sub-conjunctival tissue. Drs. Bright and Barlow always looked to the conjunctivæ when kidney disease was suspected, and laid great stress on the presence or absence of œdema of this part. When œdema is present the conjunctivæ look bright and glistening, and the eyes appear suffused with tears; but an examination will show that the fluid is beneath, and not upon, the mucous membrane.

Empyema.—In empyema the lung of the affected side becomes contracted, condensed, and unable to expand; consequently, when the fluid in the pleural sac becomes absorbed, the chest walls gradually retract. On the healthy side the lung becomes the seat of a compensatory hypertrophy, just as one kidney enlarges if the action of the other be interfered with. The cure of a case is therefore very tedious, as time must be allowed for the recession of the firm and resisting chest walls. The walls must fall to the lungs, as the lungs cannot expand to the walls. It is impossible for the lung to expand when covered with a layer of lymph. Dr. Wilks was unable to expand a lung post mortem by means of the bellows, in a case of pleurisy of but six weeks' duration, but when he removed the layer of lymph from the visceral pleura, expansion was readily performed. If there are no signs of absorption of the pus, it is the best treatment to make a free opening into the sac, and evacuate the contents. The cavity will then gradually close, partly by the formation of granulations, but chiefly by the recession of the chest walls. Care must be exercised to prevent decomposition of the matters that collect in the sac. This is best done by washing out the cavity several times daily with some carbolic acid solution or Condy's fluid.

Typhoid Fever.—It is sometimes very difficult to diagnose typhoid fever; for, on the one hand, it may present chiefly

head, lung, or intestinal symptoms, while, on the other hand, ordinary affections of these organs are often accompanied with pyrexia. It will often be found exceedingly useful in diagnosis to follow the history of the case. In fact, a diagnosis may sometimes be made by reading the notes of a case when a personal examination of the patient gives only negative results. This will be found to be the case more particularly in typhoid and typhus fevers. These two diseases may closely resemble each other in their clinical aspects, but by paying attention to their history, their mode of onset, and their course, a diagnosis may often be positively made where doubt previously existed.

LONDON HOSPITAL.

TUBERCULAR DISEASE OF THE LEFT TESTIS AND LEFT VESICULA SEMINALIS AND VAS DEFERENS.

(Under the care of Mr. RIVINGTON.)

In his work on the Testis (p. 320), Mr. Curling states that M. Gosselin has often detected by digital examination in the rectum an affection of the vesiculæ seminales and prostate in cases of tubercular disease of the testicle. That M. Gosselin's assertion is correct there can be little doubt, and the following case shows that disease of the vesiculæ may be readily detected by rectal examination. In many cases occurring in English practice it has not been found because it has not been looked for.

Chas. C—, aged twenty, was admitted into the London Hospital on the 13th February, 1872, with tubercular disease of the left testis. The disease began two years previously with smarting pain in the urethra. Six months before admission he noticed a discharge of yellowish slime (gonorrhœa?), which lasted about a month. At times the urethra was hot and inflamed. Eighteen months ago his testicle swelled, and a sinus formed, which discharged matter and then healed, leaving a small scar. Three or four hard lumps were perceptible along the epididymis, but there were no enlarged glands in the groin. On examining the patient per rectum, Mr. Rivington noticed a hardness in the prostate on the left side, and, proceeding backwards from the prostate on the left side, a hard cord-like body similar to a thickened vas deferens, and a more lobulated body outside this, such as would be produced by enlargement of the vesicula seminalis. On the right side the vesicula seminalis could just be discriminated, the contrast between the two sides being very marked. Mr. Curling examined the patient a month afterwards, and corroborated the opinion formed, that the vesicula seminalis and vas deferens were affected and thickened, probably from the presence of tubercle. There was no pain in the testicle, nor had it increased in size lately. The cord on the same side was natural as far as the inguinal canal.

It may be noted that the patient had had hip-joint disease on the left side eight years ago. The left hip-joint was ankylosed, and an old scar of a healed sinus remained six inches below the trochanter major. The left leg was shortened two inches, one inch being due to the femur, and one inch to the defective growth of the tibia and fibula.

The patient was ordered cod-liver oil and steel, with injections of a mildly astringent character to check the urethral discharge. It was considered inadvisable to excise the organ.

RUPTURED JEJUNUM.; ABSENCE AT FIRST OF SERIOUS SYMPTOMS.

(Under the care of Mr. RIVINGTON.)

John R—, aged thirty-two, brewer's man, was admitted February 19th, 1872. Patient was walking across a plank laid over a brewer's vat, when he missed his footing, and fell a distance of sixteen feet. When he came to the hospital he was examined by the house-surgeon, who was unable to detect any sign of a serious injury, and, consequently, gave him an out-patient's ticket. Later in the day he returned, complaining of pain in the chest and also at the lower part of the belly. He was admitted as a case of contused chest. The patient was a very stout man, with much fat on his body, and it was therefore difficult to examine satisfactorily his ribs and sternum. His water was drawn off, and it was like dark tea, without blood. He

vomited once when he came in. Subsequently he had a disposition to vomit, but did not bring up anything. When seen about 5 o'clock by Mr. Rivington he did not exhibit the usual signs of the injury from which he was suffering; he did not complain of pain in the abdomen; he was not sick, and he was not in a state of collapse. In the course of the evening severer symptoms came on, and he died on the following morning at 11 A.M. At the post-mortem examination the jejunum was found ruptured near the duodenum, and the sternum was fractured.

SEQUEL OF A CASE OF SYPHILITIC CARIES OF SKULL,
WITH ABSCESS IN THE BRAIN.

(Under the care of Mr. HUTCHINSON.)

This patient, Oliver H—, who was progressing favourably at the time of our last report (see page 334), became worse about the first week in September. His hemiplegia, which had somewhat diminished, again increased, and became almost complete as regards motion; and at about the same time he again had several convulsive seizures, with unconsciousness, the convulsions being chiefly on the left side. The abscess had closed, and, although it was reopened and discharged freely, his symptoms were not relieved, and he died on September 14th.

The post-mortem examination was made forty-eight hours after death, after decomposition had much altered the abdominal and thoracic organs; there were no evidences of syphilis in any of them. In the kidneys were a great many very small calculi (probably uric acid). In the brain, a sinus was found passing from the external opening down through the corpus striatum, a great part of which was destroyed and converted into greenish, fetid, puriform fluid. The brain-tissue, for about a quarter of an inch around the abscess, was much discoloured and of a greenish hue. There was no trace of meningitis anywhere excepting close around the fistula, where the membranes were firmly adherent, but only over a very limited area. There was no inflammation of the lateral ventricle, nor was the thalamus opticus involved.

ROYAL LONDON OPHTHALMIC HOSPITAL.

EXTIRPATION OF THE EYEBALL, TOGETHER WITH REMOVAL OF THE CONJUNCTIVAL SAC.

(Under the care of Mr. J. F. STREATFEILD.)

A YOUNG married woman, near her confinement, who had lost her left eye by inflammation many years before, came to the out-patient department of the hospital on the 18th ult., on account of pain in the damaged eye, and of failing sight and obscuration in the other. The lost eyeball was very soft and quite blind; the pupil was closed by total posterior synechiæ, and the iris bulged forwards. Mr. Streatfeild remarked that this latter condition is one of the most urgent in which iridectomy is called for; but in this particular case nothing short of extirpation of the diseased eyeball would be of any avail. This operation was therefore proposed, and the patient consented on condition that the lids should be closed. She was told that if this were done she would not be able to wear an artificial eye, but she said she did not wish to wear one, as she knew someone who had an artificial eye, and that it was more trouble than it was worth. Under the circumstances, simultaneous removal of the conjunctiva and eyeball was determined on. Mr. Streatfeild observed that since he began to destroy the conjunctival sac in cases of extirpation, where the patients could not, or would not, wear the artificial substitute,* he had never before had a case in which the sac was destroyed at the time of extirpation of the globe.

After administration of bichloride of methylene, which is always given to Mr. Streatfeild's patients, the operation was performed in the following manner:—The lower lid being held down and strongly everted by the forefinger of an assistant, the conjunctiva was cut through close to the free margin of the lid, and dissected off the tarsal cartilage; the conjunctiva was next cut through at the outer and inner canthus. The globe was then drawn well downwards, and the fold of conjunctiva between it and the upper lid was next dissected from the subjacent soft parts, but as the

conjunctiva could not be easily separated from the upper lid it was left to be removed by caustics at some future time. In this manner all the conjunctiva, with the exception just named, was dissected up. The extirpation of the globe was now completed in the ordinary manner.

Dec. 5th.—The soft parts of the orbit are granulating and are drawing the lids closely to them.

OPERATION TO RELIEVE LACHRYMATION DUE TO
EVERSION AND CLOSURE OF THE PUNCTA
LACHRYMALIA.

The patient was a young woman who had been affected with tinea ciliaris in both eyes for many years. Nearly all the eyelashes had disappeared, the lids were everted, and both lower puncta apparently closed. The patient being put under the influence of bichloride of methylene, the edges of the lids were well cleaned, and the left lower canaliculus slit up with a Weber's knife. The right lower punctum could not be made out. It was therefore determined to slit up the upper canaliculus and reach the lower one by passing a curved probe along it from the lachrymal sac in the manner recommended by Mr. Streatfeild in the Royal London Ophthalmic Hospital Reports, vol. iii., p. 4. The thin end of a Bowman's lachrymal style was bent at a right angle, and passed into the sac from the upper canaliculus, and an attempt was then made to pass it along the lower canaliculus, but the thickening of the tissue would not allow of the yielding probe being directed with sufficient certainty and force to accomplish this. A more suitable instrument with a more considerable curve was found in the use (as suggested by Mr. Tweedy, the clinical assistant) of an obsolete strabismus hook, the shape of which closely resembles an ordinary button-hook, with the end prolonged horizontally instead of being sharply curved. The lower canaliculus was easily reached with this instrument, which passed readily outwards through the punctum. The canaliculus was then slit up and kept open by daily probings.

Dec. 5th.—The raw surfaces of the edges of the lids are healed; the canaliculi are patent, and there is no more lachrymation.

LIVERPOOL NORTHERN HOSPITAL.

TWO CASES OF STRANGULATED HERNIA.

(Under the care of Mr. LOWNDES.)

Strangulated Scrotal Hernia relieved without opening the sac.—Robert B—, aged fifty-six, a tall, stout man, was admitted on the afternoon of June 9th, 1872, with a very large scrotal hernia, which came down seven hours before, and which he was unable to reduce. He has had hernia for several years, but has always been able to reduce it himself, and has worn a truss. He had vomiting before admission, none after, but he suffered great pain. At 6.30 P.M. chloroform was given, and as reduction could not be effected, an incision was made over the external ring, and the sac exposed. There was found to be a tight stricture at the ring, which was freely divided; some tight fibrous bands were also found constricting the neck of the sac, which were divided, and on division gaped considerably. The hernia was now easily reduced. The wound was sponged with a solution of carbolic acid, and brought together with numerous stitches of carbolised catgut, and covered with a compress soaked in carbolised oil. An opiate was given. The next day he was quite easy, and had passed wind freely. The wound healed by primary union, and the patient went out perfectly well on June 22nd.

Strangulated Inguinal Hernia complicated with ascites; peritonitis; death.—W. D—, aged forty-two, a labourer, was admitted on the afternoon of the 3rd of November, with an inguinal hernia of moderate size on the right side, which, he said, he was always able to return until two days before admission. He had been ruptured since last July. For about two years he had suffered from ascites, for which he had been twice tapped, the last time about two months ago, when, he said, sixty-three pints were drawn off. Two days ago (Nov. 1st), while he was at work, the hernia came down under his truss, and he was unable to return it. He continued however to work, and kept the truss on. His bowels were moved that evening; but the tumour soon after be-

* See THE LANCET, vol. i., 1872, p. 821.