(Fig. 2) can be briefly described as follows. There is, in the first place, a strong straight-backed wooden chair and on the right side of the seat is affixed a vertical arm. This arm is hollowed out to receive a smaller vertical arm and to this, in its turn, is attached at right angles a flat horizontal piece of wood. On that part of the horizontal piece which is nearly opposite the middle of the back of the chair (more correctly, facing the patient's mouth when he is seated in position) the laryngoscopic portion of the apparatus is placed (Fig. 2). The last-named part of the machine consists of a small electric lamp and two circular mirrors, each of the latter being three inches in diameter. Clear, unimpeded images of the larynx, or reproductions of any intralaryngeal operations which may be in progress, are reflected upon these mirrors. The examiner or operator looks through an opening in the sleeve of the electric lamp and thus gets a view of the larynx, as in the ordinary manner, except that he is only able to use one eye at a time. The inconvenience caused by this is almost negligible. The small modifications

FIG. 3.

Showing the method of examination. The light is thrown into the patient's mouth and the laryngeal image is projected from the laryngoscopic mirror on to two mirrors, one of which is seen close to the examiner's right eye. The faint impression of the larynx, which can be seen in the plate, is clear and well illuminated in the actual apparatus.

which I have thought useful are the construction of a detachable apparatus in which the essential laryngoscopic portion can be affixed to any laryngeal lamp-holder or upright, thus rendering the machine more portable and convenient and also considerably reducing its cost. Also, I am producing an apparatus by which four laryngeal cases can be shown (if necessary in rapid succession) to a number of observers simultaneously. The apparatus has been shown to the Laryngological Society of London and at other meetings and it is, I understand, being adopted at a number of teaching hospitals. Finally, the method is not proposed to supplant, for the student, the personal examination of the larynx but rather to stimulate his interest in the subject and to supplement his practical studies. The apparatus is made (in England) by Messrs. Armstrong and Brother, opticians, Deansgate, Manchester.

Manchester.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A NOTE ON FIBRO-MYOMA OF THE BULBAR CONJUNCTIVA.

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THE occurrence of a fibro-myoma in this position is unusual and receives only slight passing mention in ophthalmic writings. This instance is perhaps worthy of note as the situation of the tumour involved the possibility of dangerous extension which would not only have interfered with vision but might have completely destroyed the utility of the eye, besides the ulterior risk of serious consequences connected with the fact of its very rapid and active recurrence. The growth unfortunately occurred in a medical colleague and he, probably quite correctly, associates the incidence of the tumour with an accident which happened to him while engaged in his professional duties. When he was breaking a tube of vaccine at a patient's house on August 12th of last year, a small piece of the glass flew up, struck against his right eye, and remained lodged there; it gave rise to much pain at the time and was only removed with difficulty and after considerable effort on the part of those in the house. He gave the incident no further thought until a month later, in September, when he noticed a small point of redness at the site of the recent injury in his right eye, on the sclera close to the inner edge of the cornea. This slowly increased in size and at the same time became thickened, but was not associated with pain, discomfort, or any other inflammatory symptom. There was never any question about the possibility of this being a modified form of vaccine pustule, as the lapse of time did not correspond, nor did it bear the least resemblance to such an inflammation.

The patient at once sought medical advice and used the various applications prescribed, but without producing any alleviation. The local condition soon became much aggravated, the growth increasing both in area and thickness very rapidly, so that on Oct. 12th, two months after receiving the injury, he obtained the able services of one of his friends, a surgeon, to remove the growth; this was skilfully performed with scissors and the small tumour was removed from the surface of the eyeball as completely as possible. When I had occasion to see the eye some days after this operation the wound had healed and there was only a slight redness present, limited to a portion of the sclera on the inner aspect of the globe opposite the palpebral fissure; there was no trace apparent of any extraneous morbid tissue remaining on the eye. The patient felt no local sense of irritation, there was no lacrymation, and only some tenderness of the eye on exposure to wind or to a draught of cold air.

On Nov. 28th, 47 days after the previous operation, I was consulted on account of the sudden reappearance of the growth and found that on the same site—viz., over the inner aspect of the sclera, close to the margin of the cornea and opposite the palpebral fissure, there was a very considerable accumulation of new solid tissue, upon, and closely connected with, the subjacent scleral layer; this surrounded, but avoided covering, the area occupied by the former tumour, thus giving the appearance of there being a wide depression in its centre. The growth measured four millimetres horizontally, three millimetres in vertical diameter, and was approximately one millimetre in thickness; it was of a brownish red colour and was semi-transparent; its surface was polished and its margin was distinct and clearly defined; there was entire absence of any sign of inflammation accompanying it. Each day it showed markedly rapid increase both in size and thickness, so that on Nov. 30th I was compelled to remove it entirely.

My first incision was made in the normal conjunctiva surrounding the tumour and then by very careful and complete

dissection I excised from this marked-out area all the tissue lying superficially to the sclera. The surface thus exposed on the globe of the eye was a comparatively large one, but it healed gradually and satisfactorily and became completely covered with new epithelium without the formation of any cicatricial contraction. On Dec. 16th, 16 days later, the eye was quiet and the bandage and dressings were left off. Three days afterwards, when I was examining the eyes minutely by oblique illumination, I for the first time saw on the margin of the upper eyelid of the right eye (the eye which had been affected) a delicate fine eyelash which was inverted and rubbed against the surface of the globe, almost exactly at the point formerly occupied by the tumour. The eyelash was epilated and has not made any further appearance. Whether this had existed previously and taken part in the causation of the tumour or in its recurrence are questions which must remain undecided. The offending eyelash was an exceedingly fine one and could only be seen when examined through a lens of high magnifying power.

A careful histological examination of the recurrent growth was made after its removal and the following report was obtained: "After fixation in alcohol sections were made, placed in carbolio thionin, and stained. Result of examination.—Fibro-myoma. The cells are elongated, with rod-shaped rectangular nuclei, filling all the stroma which is fine, ribbon-like, and very crowded. At the periphery there are some vessels containing blood and some groups of microbes (probably ulceration)."

I understand that a similar result was yielded by microscopical examination of the tumour which was originally removed. Since the removal of the bandage and dressings over the eye no application or local medication has been employed, and the eye presents no indication, except on most minute and careful observation, of its recent condition and there is every reason to believe that permanent relief has now been obtained.

Manchester-square, W.

NOTE ON A CASE OF SO-CALLED "SPONTANEOUS FRACTURE" OF THE FEMUR FROM SECONDARY MALIGNANT DISEASE WITH SUBSEQUENT FIRM BONY UNION.

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WE record the following case on account of its extreme rarity. According to Mr. S. Boyd, in his article on fractures in Treves's "System of Surgery," there are only some four or five on record. The patient, a married woman, aged 47 years, had her left breast removed for scirrhus 14 months prior to the date of fracture. The scirrhus was one of rapid growth, was fairly advanced, fixed to the pectoralis major, and there was palpable gland implication. She had had increasing weakness of both legs (? due to advancing cachexia) for six months prior to fracture and for the same length of time had "rheumatic" pains in both thighs. As these pains were more definitely localised over the future site of fracture it seems possible that they were due to implication of nerve fibrils in the growth. On Dec. 6th, 1902, while the patient was in the act of stooping to pick something up off the floor the left thigh suddenly snapped. She was admitted to the Newport and Monmouthshire Hospital two days after the accident and remained there till she died. On admission she was found to have sustained a fracture of the left femur at the junction of the upper and middle thirds. The limb was put up on a McIntyre splint. Thinking an ununited fracture was inevitable no extension was applied to the limb; we thought it would give her needless pain, so the limb was merely allowed to rest on the splint, being frequently taken down to guard against splint sores. Not much attention was paid to the condition at the site of fracture for the reason mentioned above. On Jan. 26th, 1903, however, seven weeks after the accident, an examination of the part showed that union had taken place. There was at this time a recurrence at the site of the removal of the breast as well

as a mass in the liver. The patient got steadily weaker and died from secondary malignant disease on Feb. 15th.

Neurosis.—The site of fracture was cut down on and the upper half or so of the femur was removed *en bloc*. Such firm union of the fragments was found that they could not be torn apart even on the exertion of considerable manual force. A mass of cancerous growth was found wrapping the upper third of the femur loosely round and eroding it at the site of fracture—i.e., the upper end of the lower fragment and lower end of the upper—but the rest of the femur was uneroded. The conjoined mass of callus and malignant tissue cut like a scirrhus but with a gritty sensation at parts. It apparently extended from a chain of malignant glands which passed down from behind Poupart's ligament and seemed to have acquired an attachment to the periosteum. There was distinct overlapping of the fragments and to this union seems to have been due, for by this means unimplicated portions of periosteum were brought into apposition, not the diseased extremities of the fragments. A paring was taken from the mass in the neighbourhood of the end of one of the fragments and sent to the Clinical Research Association for microscopical examination. The report was as follows: "The tissues consist of periosteum and young bone with some adjacent fat and cellular tissue. They are all thickly infiltrated with narrow lines of scirrhus carcinoma."—Occurring as this case did subsequently to removal of a rapidly growing scirrhus, the result being firm union of the fragments and the condition of overlapping suggesting a possible explanation of departure from the sequence of events which is usual in such cases, we have thought it right that the case should be published.

NOTE ON A CASE OF TRANSPOSITION OF THE VISCERA.

By EDWARD LIDDON, M.D. EDIN.,

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THE interesting case reported by Dr. William Hartland in THE LANCET of April 9th, p. 1017, reminds me of a very similar instance that came under my notice some years since when holding the appointment of honorary physician to the Taunton and Somerset Hospital.

A young man, aged 19 years, was admitted with pneumonia of the left base, and on examination it was discovered that all the viscera were transposed, the heart and spleen to the right, whilst the liver lay beneath the left ribs. He was a source of much interest to myself and to all my colleagues whilst he remained in the hospital. He made a good recovery from his illness and went into service near Brighton and for some years continued in good health. He had never been robust and always carried a "high colour," but until his attack of pneumonia he had suffered from no serious illness. His father died from some form of heart trouble; his brother, who had been a groom in my stable, was healthy and possessed no malformation. It was from him that I heard of my hospital patient's well-doing for some years after he left this neighbourhood.

Taunton.

CENTENARY OF THE RUSSIAN MEDICAL COUNCIL.—

On April 22nd the Russian Medical Council completed its 100th year dating from its first session. It was founded on Dec. 31st, 1803, by order of the Minister of the Interior, Count Kotchubye, and was formally opened on April 9th, 1804. At the first gathering of the Council the Sovereign order for its constitution was read and a committee of five members was chosen to draw up the rules, duties, and prerogatives of the Council. It is proposed to celebrate its first centenary in a special manner on April 9th, 1905.

HOSPITAL FOR EPILEPSY AND PARALYSIS AND OTHER DISEASES OF THE NERVOUS SYSTEM.—The committee of management announces that the annual meeting will be held at the New Hospital, 4, Maida-vale (near the end of St. John's Wood-road), at 4.30 P.M., on Thursday, May 5th, at which hour Mr. Charles Drummond, the treasurer, will take the chair. The annual report and financial statement for the year 1903 will be presented. After the meeting the New Hospital, now in full work, will be open for the inspection of those who attend this meeting.