The first indication in the treatment of ophthalmia neonatorum is cleanliness. The infant's eyes should be washed directly after birth, and the greatest care be taken that the same sponges, cloths, water, &c., are not used for the mother and child. The latter should not be exposed to cold winds or draughts, or bright, glaring light, &c. If its eyes are red and irritable, and there is a little muco-purulent discharge, a weak collyrium of sulphate of zinc or alum (one or two grains to an ounce of distilled water) should be applied two or three times daily. But if the inflammation runs high, and the discharge is thick, creamy, and copious, stronger astringents must be employed. In out-patient practice, where we cannot see the patients daily, the use of the following injection will be found the best mode of treatment:—Sulphate of zinc, two grains; alum, four grains; distilled water, one ounce. Some of this is to be injected, with a small glass syringe, between the lids every fifteen or thirty minutes during the day, and every two or three hours at night; the frequency of the application and the strength of the injection varying with the exigencies of the case. Before it is employed, the eye should be cleansed with an injection of lukewarm water, so that the discharge may be washed away. Every day or two a drop of a strong solution of nitrate of silver (from four to ten grains to the ounce) may be applied. If only one eye is affected, the other should be protected against contagion by a firm pad of cotton-wool and bandage, this being removed twice daily so that the eye may be washed. If the patient can be seen once or twice daily, I prefer to apply the mitigated crayon of nitrate of silver (one part of nitrate of silver to one or two parts of nitrate of potash) to the conjunctiva, as we can regulate and localise its effect better. The lids being well everted, the crayon is to be lightly applied to the palpebral conjunctiva, its action being at once neutralised by a copious application of salt and water. If there is great swelling of the conjunctiva, the latter is to be freely but very superficially scarified with a small scalpel directly after the neutralisation of the caustic. Then cold (perhaps iced) compresses should be applied to the lids, to diminish the inflammatory reaction, and assist in the contraction of the blood-vessels; but great care and circumspection are required in their employment, for if they are continued too long they may prove very injurious. If the edges of the lids are sore and excoriated, a little citrine ointment should be applied. When the disease presents the cyanotic character, and the discharge is thin and flaky, the nitrate of silver must be used with great caution. Wecker recommends small doses of mercury in such cases. Should the cornea become cloudy or ulcerated, atropine drops (two grains in an ounce of water) are to be used three or four times daily, the astringent treatment being continued as before. If the ulcer threatens to perforate, it should be pricked with a fine needle, and the aqueous humour be allowed to flow off very gently; this may have to be repeated several times. If perforation has taken place, and there is prolapse of the iris, the latter should be pricked with a needle, and on the aqueous escaping the prolapse will collapse, and then a firm compress bandage should be applied. It may be advisable to repeat the pricking of the prolapse several times. If the prolapse is large, it should first be pricked, and then snipped off with a pair of scissors. When the perforation of the cornea is extensive, and the lens is bulging into it, an incision should be made in the cornea and the lens be allowed to escape, a firm compress bandage being at once applied. We may thus succeed in saving a sufficient amount of clear cornea to permit of the formation of an artificial pupil at a subsequent period, and thus perhaps save a certain degree of vision.

SANITARY MATTERS AT THE ISTHMUS OF SUÉZ.—M. de Lesseps alludes, in his report, to the sanitary state of the men employed on the canal works; and states that, in 1859, the population consisted of 25 Europeans and 125 natives; in 1868, there were 16,010 Europeans and 18,248 natives; whilst now, in 1869, there are no less than 22,843 Europeans and 19,557 natives. It is curious to note how the number of Europeans increases with a diminution of the works. The mortality, excluding the cholera year, remained at about one per cent., whilst it is 2·40 per cent. in France. It is sad to relate that, out of the eleven medical men who have been employed since the beginning of the undertaking, six have perished: four of them died in 1869.

ON

ALBUMEN IN THE URINE, SOMETIMES IN CONJUNCTION WITH THE COLOURING MATTER OF THE BLOOD, AS A CONSEQUENCE OF SURGICAL DISEASES AND OPERATIONS.*

BY HENRY LEE, F.R.C.S.,
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DURING the years 1837–8 I collected together several cases which occurred in the wards of St. George's Hospital, in which the urine was albuminous, but in which there was reason to believe that there was no disease of the kidneys. In most of these cases the presence of albumen was accounted for by the ascertained disease of the bladder or of the prostate gland. This, however, was not invariably the case. One instance in particular occurred, which left a permanent impression upon my mind. A patient had albuminous urine, and in the absence of any ascertained disease of the bladder Sir B. Brodie diagnosed the affection as a disease of the kidney. An issue was ordered in the loins. The patient maintained that his back was sound, and that the disease was below, pointing to his perineum. Sir Benjamin told the patient that he must yield to his judgment upon the point. This the patient refused so to do, and backed his own opinion by leaving the hospital. What the result was in this case I had no means of ascertaining; but the constancy with which the man affirmed that the disease was not in his back led me to think whether, after all, he might not possibly have been right.

Many years after this I met in consultation, at Sir B. Brodie's, Dr. Owen Rees and the late Dr. Seth Thompson. The patient was an eminent and well-known engineer. He had albuminous urine. He was supposed to be labouring under disease of the kidney, and a most unfavourable opinion of his case was given. The patient went to Egypt, and returned apparently very much improved in health. He now worked night and day, and often retained his water for many consecutive hours. At the time when one of his greatest works was achieved he was seized with an attack of apoplexy, and died a few days afterwards. Upon a post-mortem examination, there was no disease of the kidney to account for the albumen in the urine, but a most remarkable condition of the right ureter was discovered. The ureter on this side was very much dilated throughout. About its centre was a hard knot, which, upon examination, was found to be caused by an intussusception of all the coats of the canal. At this part the ureter was not contracted; on the contrary, the little finger could be passed along it without disturbing the intussuscepted portion. The mucous membrane here was intensely vascular. It was no doubt from this congested knot that the albumen, which for many years had been present in the urine, was derived. The post-mortem examination in this case was conducted by Mr. Charles Hawkins and myself.

During the last year I read before the Clinical Society a paper in which I gave the details of a case in which a large quantity of albumen was habitually present in the urine. This patient had caries of one of the bones of the forearm and of one of the ribs. The case I regarded as having its origin in specific disease. Under specific treatment the affected bones were restored, and after a time the albumen entirely disappeared from the urine. When this case was read, some of the most eminent pathologists present were disposed to look upon the presence of albumen in the quantity described, as indicative of disease of the kidney. This disease they supposed must have been cured by the specific treatment. On the other hand, I was inclined to regard the presence of albumen in the water as a consequence of the disease which was going on in other parts of the patient's system.

Quite recently two cases have come under my care which have appeared to me to demonstrate that when the blood is

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contaminated in consequence of accident or disease, albuminous water may be the result, without any organic disease of the kidney. The albumen in such cases, together with the colouring matter of the blood, may escape in very considerable quantities.

CASE 1.—W. R.—, aged twenty-two, was admitted into St. George's Hospital, under my care, on the 25th of April, 1869, for varicocele.

On the 6th of May I performed the usual operation for that disease. There was some slight bleeding at the time.

The following day (May 7th) the skin between the needles had become greatly distended by the effusion of blood. The skin over the effused blood sloughed on the 8th, the pulse was 112, and the tongue furred. The next day the urine had assumed a dusky-brown colour.

May 10th.—The urine was of the colour of decoction of sarsaparilla; it contained an abundant deposit, and was albuminous.

11th.—The urine passed in the morning was almost black. That which was voided in the afternoon was "smoky." He was now better. Pulse 86; skin natural.

13th.—The slough between the needles was separating. Urine still albuminous.

14th.—The urine was now almost clear, and contained no albumen.

The wound healed readily; and the patient was discharged on the 2nd of June.

Dr. Beale was good enough to examine for me the urine passed in this case. He reported that "the black and almost opaque urine was of specific gravity 1030. It contained, in 1000 grs., 71 grs. of solid matter. The deposit consisted of triple phosphate and globules of urate of soda. The black colour was not due to blood-corpuscles, but to colouring matter adherent to very minute granules of urate diffused through the urine, but not in solution. When the urine was evaporated, the extract had the ordinary appearance, and exhibited no unusual colour whatever."

I had an opportunity of seeing this patient and examining his water during the third week in July. He was then in perfect health, and his urine quite natural and free from albumen.

CASE 2.—A. C.—, aged forty, was admitted into St. George's Hospital on Jan. 2nd, 1869. Five years previously he had been wounded by a musket-ball in the lower part of the neck. The wound healed, and he resumed his duty at the expiration of seven weeks. After a short interval, however, several abscesses formed in the neighbourhood of the old cicatrix; these gradually destroyed the greater part of the soft tissues on the right side of the neck. No fresh abscess had, however, formed for the last four years, but during that time he had suffered much from what he called rheumatism. On Dec. 31st, while stretching his neck in shaving, he felt an unusual sensation. The next day there was a swelling at the part, which he supposed to be a boil. This swelling gradually increased; it pulsated uniformly over its whole surface, and the skin covering it became quite black. The common carotid was tied on January 8th, 1869, and a drawing of it was made on the 11th.

My clinical clerk had tested the water in this case previous to the operation, and had found it free from albumen.

Jan. 13th.—A drop or two of blood oozed through the skia covering the tumour, which was reduced in size, and had entirely ceased to pulsate.

14th.—The urine was of a very dark colour, and very albuminous.

15th.—Dr. Ogle, who was good enough to see the patient with me, reported that "the urine was very albuminous. It contained no casts of the uriniferous tubes. Its specific gravity was 1029. It contained no appreciable amount of sugar." Some puriform fluid, containing broken-down coagula, was discharged from the wound.

16th.—The wound was looking well, and appeared to be healing.

A second drawing was made on the 13th of February, when there was very little discharge from the wound, which had nearly closed. The patient never, however, regained his general health. The albumen in the urine continued. He suffered much from pain in the chest and upper part of the abdomen. He gradually became much emaciated, and died. Unfortunately no post-mortem examination could be obtained.

Independently of the cases which have fallen under my own care, I have known of others in which, after a surgical operation or disease, the urine has become albuminous, and sometimes has remained so for a very considerable period. I have also been informed of two cases in which the urine at the same time became very dark-coloured, and was supposed to contain blood. The cases which I have given, although few in number, are, I think, sufficient to show that albumen in large quantities may be present in the urine as a secondary affection dependent upon disease in some distant part. Such an affection must be carefully distinguished from any local disease capable of producing albumen in the ureters, bladder, or urethra. In both classes of cases the albumen may be produced independent of any organic disease of the kidneys, and in both it may be mixed with the colouring matter of the blood. From the cases which have come under my notice I am inclined to believe that in the first class the colouring matter of the blood is found independent of any blood-corpuscles; and that in the second the colour depends upon the blood-globules themselves. All the cases which I have known in which the peculiar colour of the urine, to which I have drawn attention, has accompanied the secretion of albumen as a secondary affection, (independent of any disease of the kidney, and independent of any affection in the urinary channels themselves,) have been instances in which there was evidence, more or less distinct, of coagula having formed in some part of the vascular system. These coagula have been disintegrated and removed. The colouring matter of the blood has disappeared with the other portions of the coagula; and when we find this same colouring matter reappearing in a disintegrated form in the secretion of the kidneys, we are justified, I think, in concluding that the matter so eliminated formed part of the coagula which had been disintegrated, and removed in the course of the circulation.

Savile-row, August, 1869.

ON A CASE OF TABES MESENTERICA AND SECONDARY CHRONIC PERITONITIS.

BY EDWARD ELLIS, M.D.,

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WILLIAM D.—, aged four, residing at Battersea, was admitted an in-patient at the Victoria Hospital on April 28th, 1869. His previous history (for the notes of which, as also for many of the observations made during his stay in the hospital, I am indebted to the present house-surgeon, Dr. F. M. Pierce) showed that he had always been delicate. Six months previous to admission he had measles, followed by swelling of the abdomen, which partially subsided. He had no pain during this illness. Two months later the swelling, which had almost disappeared, returned, and continued to increase, without pain, up to the day of admission. Has generally been a lively child, with good appetite. There is strong suspicion of his having had scarlatina; but the mother cannot be certain. He has not had any jaundice since the present illness. Both parents appear healthy, and they have no other child with glandular swellings.

General state on admission.—A small, dark, strumous-looking child; face pale; lips red; angles of mouth sharply defined; the genal lines well marked; cervical glands of both sides much enlarged, the skin being movable over them. There is an eczematous patch behind the right ear. The upper and lower extremities are much emaciated, and there are two or three small ulcerating surfaces between the toes. The ribs are small, elastic, and irregularly ossified. The abdomen is round, much enlarged, and marked by numerous tortuous veins. Measured over first lumbar vertebra horizontally to $1\frac{1}{2}$ inches above the umbilicus, the circumference was 24.5 in.; from the tip of the ensiform cartilage to the upper border of the pubes, 10 in.; from the umbilicus to the right superior iliac spinous process, 5.5 in. The umbilicus protrudes more than an inch. Fluctuation well marked in all directions. The splenic dulness slightly