with the epiphysis. The limb was placed on an angular wire and tin-plate splint, and dressed with dry dressing. As soon as the healing process was fairly established the child made wonderful strides towards recovery, and was discharged on Nov. 13th, 1882, with a useful limb, capable of all ordinary movements.

Remarks by Dr. SWANN.—I have kept the child under observation ever since her discharge from hospital, and at the time of my showing her to the Leeds and West Riding Medico-Chirurgical Society she walked with a hardly perceptible limp, and was in perfect health. She is thoroughly well at the present time. The following points are of interest:—1. Erichsen says, where the disease is extended into the malleolar arch, and where the whole of the os calcis is diseased, no alternative remains but amputation, resection not leaving a useful foot. The above case certainly does not tally with this, as the whole of the os calcis was removed together with the astragalus &c., and an almost perfect limb has resulted. 2. The bones removed contained extensive plugs of tuberculous material. The child is now, four years after the operation, in perfect health. Did the operation by removing a focus of tubercle save the patient from becoming tuberculous? I deem this a question of importance with regard to one's action in future cases of strumous bone disease. 3. The first operation on the os calcis was useless, and I now regard it as having been a waste of time, as I believe partial operations on children's bones are rarely successful, and a free and wide exploration is safer in the first instance.

MEDICAL COLLEGE HOSPITAL, CALCUTTA.

IRREDUCIBLE PROLAPSE OF THE RECTUM TREATED BY AMPUTATION; RECOVERY.

(Under the care of Mr. O'CONNELL RAYE.)

A HINDOO male, aged forty-four, was admitted suffering from prolapse of the rectum of several days' duration. The protruded parts were livid and ecchymosed, with here and there isolated patches of sloughing mucous membrane. The mass was about the size of the clenched fist. The patient was in great suffering and much exhausted. He was placed under chloroform, and careful, prolonged efforts were made to reduce the prolapse, but without success. The measures commonly recommended for the relief of irreducible prolapse—such as excision of strips of mucous membrane, scoring with the actual cautery, nitric acid, &c.—seemed scarcely suitable for this patient, as the bowel had been protruded for several days, and was in a very doubtful state of vitality. Mr. Raye therefore resolved to amputate the protrusion level with the encircling skin. He acknowledged that he should almost certainly have to open the recto-vesical pouch, but hoped, nevertheless, to be able to keep the peritoneum free from contamination. The parts were carefully examined lest they should contain a loop of intestine.

For the operation a Wood's hernia needle was used, armed with a stout silk ligature about two yards long. The needle was introduced along the left index finger within the protruded bowel as far as the level of the anal orifice. The point of the needle transfixes the protrusion from within, and emerged on a level with the skin. A loop of the silk was caught, and held while the needle was withdrawn within the lumen of the bowel. The bowel was again transfixed on the same level, with the needle still threaded, so that the point emerged on the external surface of the prolapsed rectum about one inch away from the first puncture. Another loop of the silk was there similarly caught and retained. This procedure was repeated, just as in the ordinary method of ligaturing a nœvus in sections, until the entire mass was included. The external loops were then cut and tied, and thus each included portion was separately secured. The next step was to amputate the mass. Expecting to meet the pouch of peritoneum, Mr. Raye began in front by carefully cutting until he came upon this structure. He dissected the pouch from its surroundings in the manner employed with the sac in some of the modern operations for radical cure of hernia. When the pouch was thus secured, it was raised out of the way and the prolapsed rectum amputated just below the transfixing ligatures. There was no hæmorrhage. Two of the ligatures had transfixed the pouch. He divided these two ligatures, and as portions of the cut edges of the bowel were thus liberated, these edges were seized with Spencer Wells's clamp forceps to prevent

bleeding. The prolapsed recto-vesical pouch, being now free, was drawn gently downwards a little, and its neck tied with carbolised catgut just above the point where the ligatures had passed through it. The sac was then cut off and its pedicle allowed to slip back within the pelvis, secured by the catgut ligature. Those portions of the cut edges of the bowel which were held in the clamp forceps were again transfixed with ligatures, which, when drawn tight, completely occluded the orifice through which the process of peritoneum had been protruding. The ring of ligatured bowel was pushed within the anal orifice, the ends of the silk ligatures hanging out for facility of removal, a morphia suppository was inserted, and the man put to bed. The operation occupied about three-quarters of an hour.

There was considerable pain for two days. On the third day the bowels were moved naturally. From the first there was no difficulty in micturition. Two ligatures were found loose on the twelfth day. Two more ligatures came away two days later on. By this time the patient felt quite well, had little or no pain on defecation, and had complete control over the action of the bowels, from which it was presumed that some portion of the sphincter remained. The calibre of the bowel was almost normal, a ring being felt where the ligatured portion lay about an inch within the anus. Whether this ring disappeared subsequently by absorption, or whether it contracted to form a stricture, Mr. Raye is unable to say, as the man absconded on the twenty-first day, some of the ligatures being still *in situ*.

Medical Societies.

OPHTHALMOLOGICAL SOCIETY.

Monocular Iritis. — Interstitial Keratitis. — Pulsating Tumour of Orbit. — Double Chronic Glaucoma. — Corneal Changes in Acquired Syphilis. — Nævus involving Eye. — Paralysis of External Recti. — Mr. Hutchinson's Address.

THE last meeting of the session of this Society, which was also the annual general meeting, was held on the 2nd inst., Mr. Jonathan Hutchinson, President, in the chair.

The annual report of the Council, read by Dr. Seymour Sharkey, showed that the state of the Society was one of prosperity. The members number now 198. The library has been considerably developed, a complete set of Transactions of the Pathological Society, of "Brain," of the Ophthalmic Hospital Reports, and of the Archives de Neurologie having been added.

Dr. BRAILEY showed drawings from a case of Monocular Iritis in a child. The iris was discoloured, and projecting from it were several small greyish-white or pinkish-white nodules; it was adherent at three points to the lens. In the corneal substance were several small greyish opacities. He considered that the disease was tubercular, though the aspect of the patient somewhat suggested congenital syphilis.—Mr. HUTCHINSON said the sequel of the case might throw some light on its nature. The presence of enlarged cervical glands was in favour of a diagnosis of tubercle.

Dr. BRAILEY also exhibited a case of Interstitial Keratitis, in which the left cornea had a somewhat peculiar aspect, and the idea was that it was of tubercular origin. The right eye presented changes which were clearly of a syphilitic type. The left eye showed about a dozen small greyish-white fairly defined nodules.

Mr. A. Q. SILCOCK showed a man with a large Pulsating Tumour of the Orbit. The sight of both eyes had been destroyed by a charge of small shot some years ago. Within two or three days after the accident, he heard a hissing noise in his head. A tumour, occupying the inner angle of the left orbit and extending over the bridge of the nose, began to develop about twelve months after; pressure on the left carotid, which was enlarged, arrested the pulsation and bruit in the tumour, which was not growing rapidly in size. Mr. Silcock said he felt disposed to tie the carotid, but added that Mr. Hulke had advised the use of electrolysis.—Mr. ADAMS FROST was reminded of a case of arterio-venous aneurysm shown by himself to the Society in 1882 (Ophthal. Trans., p. 111). It was the case of a child in whom the signs pointed to fracture of the base of the skull.