suffered also from orchitis, so much so that this complication was rather the rule than the exception. In the case of a little boy about seven years old there was very severe deep-seated abdominal pain, which I could not avoid referring to some inflammation of the pancreas; it came and went very suddenly; there was no inflamed testicle here. But in one case the brain symptoms were so severe that I think a few notes about it will be considered worth recording.

Mr. M. S.—, aged thirty-five years, corn factor &c.; fair health except tendency to headaches and sluggish bowels. On Friday afternoon, Sept. 19th, he complained of a swollen neck and a feeling of slight malaise. I found the parotid gland of the left side very tender and enlarged. Ordered a mixture of citrate of potash, liquid diet, and local application of poultices. On Tuesday, the 23rd, I saw him again. He had treated the matter rather lightly, and, feeling better on Monday, he had attended a market about ten miles off, and had driven some distance in an open trap. He thought he had taken a chill, and had shivered. I found his right testicle swollen and tender, and the parotid swelling almost gone. He complained of thirst and very severe frontal headache. Temperature a little over 100°. I ordered him to rest in bed. The next day I found him restless and anxious, the headache most acute, "all over his head." He had not slept at all. Bowels not acted; urine scanty; temperature 103.5°; very thirsty. He complained of severe precordial pain, which was, however, relieved by a mustard poultice. At 9.45 P.M. the same evening, although a purgative had acted on the bowels once, he was much worse; the eyes were injected; pupils both contracted; headache intense; a little excitable, but not delirious; temperature 104.5°; pulse 120, hard and bounding. My friend, Mr. Charles Walls of Burgh, saw him with me about half-past eleven the same evening. We ordered fifteen grains of bromide of potassium to be added to each dose of the mixture he was taking. Cold-water cloths were continuously applied to the head. The next morning he was still suffering from acute pain all over the head. He had not slept; he showed some tendency to ramble. Temperature 105°. The cold cloths seemed to increase the pain; we therefore ordered hot sponges, wrung out in hot water, to be used instead, continually, and after an hour this greatly relieved the pain. No sickness, except after a dose of castor oil; another dose was retained. Soda-water and milk at intervals. On the evening of the 25th the temperature had fallen to 103.5°. Hot sponges still continued, with hardly any interval. Still feeling of nausea, but retains the soda-and-milk. The room was kept darkened, straw laid down thickly outside the house as the slightest noise troubled him. During the night he slept a little, and at my first morning visit on the 26th I found the temperature barely 102°. Hot sponging continued all day. Bowels open. Pulse 100, intermittent 1 in 13.—27th: Temperature 100.5°; pulse 84. Still headache.—28th: Temperature subnormal (97°). From this point he made a continuous but slow recovery. The headache continued, but was always relieved after the hot sponging.—Oct. 7th: Can walk a little about the room.—20th: Out of doors; says he feels quite well.

I have recorded this case at some length, as, although brain symptoms are alluded to in connexion with mumps in some text-books, I cannot find any detailed cases. In this case there was nothing more acute than usual when the parotid gland was first inflamed, but there was most certain evidence of a chill contracted while suffering from the slight feverishness which always occurs in mumps.

Wainfleet, Lincolnshire.

SYMPATHETIC OPHTHALMIA OCCURRING FOURTEEN YEARS AFTER RECEIPT OF THE ORIGINAL INJURY.

BY GEORGE F. HELM, F.R.C.S.,

OPHTHALMIC SURGEON TO THE ROYAL CORNWALL INFIRMARY.

J. Q.— came to me on Dec. 20th, 1886, complaining that the sight of his left eye was not so good as it used to be. The right eye was injured fourteen years ago by a portion of a bullet. He was marking at the time he received the injury at the rifle range where shooting was going on. This eye diverges, and is evidently the subject of traumatic cataract. The patient has never felt any pain in it, but it has always felt tender when pressed. A

present it does not look at all inflamed, and he says it is in no way different from its ordinary condition. The left eye was quite well ten days ago, but since then he has noticed a fog or smoke to be always present before his eye. There is no pain in it now, nor has he ever had any pain. The eyeball is prominent, and the conjunctiva red; but it was not so yesterday. The pupil acts, but sluggishly, and is somewhat oval. There is some slight ciliary injection. He has been compelled to give up his work—that of a carpenter. Right eye: Vision is totally destroyed. Left eye: Vision = $\frac{1}{2}$; reads J. 2 at twelve inches. There is no improvement with any lens for distant vision. Tension in each eye is below the normal. The ophthalmoscope shows some keratitis punctata. I told him that his left eye was suffering from sympathetic ophthalmia, and advised that its fellow should be removed. This he declined. In April, 1887, he found his sight failing so fast that he went up to Moorfields, where his eyeball was removed the next morning, I believe from Tenon's capsule, and a glass globe inserted. V = $\frac{1}{2}$. To continue to use atropine as ordered, and to wear dark glasses. He continued on and off to use atropine for a couple of years or more, during which time his vision has declined to $\frac{3}{8}$, and to all appearance the vision will continue to get worse. He now, in June, 1890, complains of great discomfort in each eyeball, so I admitted him into the Royal Cornwall Infirmary, in order to remove the glass globe from the right eye. I found that this was no easy matter to accomplish, for the globe was sunk so deeply in the orbit that I could hardly reach and hold such a slippery glass globe. Moreover, it was so tightly and closely enveloped by very tough tissue that it was only after great difficulty that I was able to slip it out of its capsule. A few days later he expressed himself as feeling quite relieved from the uncomfortable feeling which he had complained of in each eye. His vision, however, remains now (November, 1890) at $\frac{3}{8}$. Pupil is insensible to atropine; anterior chamber is shallow and iris dotted over with deposits of lymph. The eyeball, when examined after removal, contained some osseous deposit in the choroid, as well as a piece of lead—the cause of all his subsequent trouble. The moral of this case is one which has been so often preached to unwilling ears—viz., the necessity for insisting on an early removal of the injured eye; but the uneducated are slow to listen to advice the exact *rationale* of which they cannot understand. And, moreover, this case shows that hardly any lapse of time gives security against a liability to sympathetic ophthalmia. The glass globe had probably nothing to do with keeping up the destructive process which had already begun when it was inserted, but its presence added much to his discomfort, for he has been quite free from any pain ever since I removed it.

Marazion, Cornwall.

LOCAL DEPLETION OF THE CERVIX UTERI.

BY ALEXANDER DUKE, F.R.C.P.I., &c.,

EX-ASSISTANT MASTER, ROTUNDA HOSPITAL; GYNÆCOLOGIST, STEEVENS'S HOSPITAL, DUBLIN.

TAKING blood from the cervix uteri, though not so much practised as formerly, is still a valuable aid in some gynæcological cases. I now never puncture the cervix, as the same advantages can be gained by scarification—viz., merely drawing the end of a rounded sharp knife across the os and cervix, which gives rise to no pain, and has the great advantage of safety, as I have seen severe hæmorrhage follow puncture. When the part looks congested and blue, instead of the ordinary light pink, or mother of pearl, as some describe it, I make it a rule to take a little blood by scarification; and I use nothing to check bleeding, as this always ceases when enough blood has flown, as shown by the altered colour of the part. In cases of stenosis and flexion, when there is any considerable difficulty in passing the sound, I scarify the part, and when bleeding ceases I have never failed to introduce the sound or point of my dilator. I learned this proceeding from noticing how relaxed the uterus and cervical canal become after hæmorrhage from that organ. If more blood is wanted when the bleeding has ceased after scarifying, I fit a sponge into a holder large enough, when moist, to tightly fill the cylindrical speculum, and by moving it up and down, I, in the speculum, produce a vacuum, and thus cup the cervix. I have found this a useful proceeding in cases of amenorrhœa

from congestion, and hope that gynecologists will give the plan a trial. I also found it useful during the menopause when the patient complained of intense headache, more especially of the vertex, and by drawing blood at regular intervals, and so imitating nature, I have been able to give more relief, and in a far shorter time, than by the use of drugs.

Dublin.

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.

KING'S COLLEGE HOSPITAL.

A CASE OF ILEO-CÆCAL INTUSSUSCEPTION IN AN ADULT;
ABDOMINAL SECTION; RECOVERY; REMARKS.

(Under the care of Dr. NORMAN DALTON and Mr. WATSON
CHEYNE.)

INTUSSUSCEPTION is such a rare disease in the adult that the record of a case successfully treated by any method would be of interest, and much more so is the account of a case in which recovery followed reduction of the intussusception after abdominal section. We have in a previous number of THE LANCET¹ considered the question of treatment of this disease, and cannot do more than refer to the method employed by those in charge of this patient. From statistics collected at that time,² the operation of laparotomy had been performed sixty-three times. In thirty-four, when the invagination was reduced (twenty-three of which were children), five recovered; and out of eleven adults, seven recovered.³ In the children the ages varied from six months to four years; the duration of symptoms before operation from seventeen hours to a month. Of the cases where success followed in the adult, the ages varied from twenty to fifty, and the duration of the symptoms from some hours to several months. To these we added other successful cases: one by Mr. Carver,⁴ a boy aged two years and nine months, in whom abdominal section was successful seven weeks after the commencement of symptoms; and a second by Mr. Workman,⁵ that of a child aged eight months and a half. Operation was performed on the failure of insufflation, combined with massage; the symptoms had existed for only twenty-four hours. Since our previous publications on this subject, few cases have been recorded, but Mr. Annandale⁶ operated successfully on a child three years old for acute obstruction, the symptoms of which had commenced two days before. Attempts to afford relief before operation by opium given in small doses, the administration of enemata, and the use of rectal bougies, were unsuccessful. Still more recently, Dr. F. Kammerer⁷ has operated on a child of six months for acute obstruction, and obtained success. There have doubtless been many instances of recovery after operation, the details of which have not yet been published; for instance, at one hospital—the Royal Free⁸—there have been two successful operations on children during the past two years for intussusception, and although one child died some weeks later from pneumonia, the fatal disease apparently bore no relationship to the operation. Although the question as to the advisability of performing abdominal section in these cases has been to a certain extent unsettled, there is an increasingly strong feeling in favour of it, should the intussusception not be relieved in the early stages by the methods—insufflation, &c.—usually employed. In commenting on his case, Mr. Annandale laid great stress on the importance of early operation.

The case was that of a married woman aged twenty-six, and the symptoms came on suddenly on the morning of July 8th, 1890. At about 6 A.M. she felt a sharp pain in the lower part of the abdomen, which lasted from five to ten minutes, and then ceased. In about a quarter of an hour the pain returned, and after that she had about two attacks every hour. Each pain was of the same character, was felt at the same spot, and lasted the same time, and with most attacks she vomited a greenish material. She compared the pain to being tied in a knot. During the day the bowels were opened freely.

In the evening she was admitted into a medical ward of King's College Hospital under the care of Dr. Dalton. She was then rather collapsed, but soon rallied; and when examined a slightly tender, sausage-like mass was felt in the right iliac fossa. When seen during the visit on the afternoon of the 9th she was better, the attacks of pain and vomiting having occurred less frequently, and having been less severe. This was due to the opium which she had been given. She had, however, passed two large pultaceous motions, which consisted chiefly of blood, partly darkened and partly bright red, as if recent. When not in pain she looked quite well; there was no fever, and the urine was normal in quantity and quality. The tumour was now very evident. It was cylindrical, about as thick as a German sausage, and about three inches long. It lay in the right iliac fossa, with its long axis directed upwards and to the right, but it was freely movable, and could be shifted into the right lumbar region and also into the umbilical region. It was slightly tender; but, except when the tumour was touched, palpation was painless over every part of the abdomen, and there was no abnormal distension. During the night the attacks of pain continued to be infrequent, but in the morning the tumour seemed larger, and as the symptoms pointed clearly to intussusception Mr. Cheyne was asked to see the case. He concurred in the diagnosis, and it was agreed that abdominal section should be done. The patient having been anaesthetised, and the front of the abdomen thoroughly purified, an incision about three inches long was made in the middle line from a little below the umbilicus downwards. The peritoneal cavity being opened, the tumour (which was very freely movable) was found to be an ileo-cæcal invagination, and a cautious attempt was made to pull out the invaginated portion. As this was not successful, the incision was enlarged sufficiently to enable the hand to grasp the tumour, and the invagination was then squeezed out without any special difficulty. The wall of the affected part of the bowel, especially that of the cæcum, was much thickened by inflammatory exudation; but though the peritoneal surface was dull there was very little lymph on it. The peritoneal cavity was not washed out. The wound in the peritoneum was closed by a continuous catgut suture and the muscles and skin brought together by interrupted sutures, and the usual antiseptic dressings were applied. The patient passed a good night, and from the time of the operation she had no further pain or vomiting. There was no fever. She was kept on milk diet for two or three days, and was given one grain of opium every four hours. The opium was then stopped and the diet gradually increased. The bowels were moved freely after an enema on July 18th, and on that day the wound was dressed for the first time and found to be healed. The patient was discharged on Aug. 1st quite well.

Remarks by Dr. DALTON.—As regards the etiology, the patient was inclined to attribute her illness to great nervous excitement and depression produced by a domestic quarrel during the night; and she said that she felt an internal trembling just before the pain occurred. She had, however, recently eaten some stale stew. This may have been indigestible, but it still remains probable that the emotion may have effected the abdominal sympathetics in such a way as to cause the irregular intestinal contractions which produce intussusception. The frequency of intussusception in children (who are obviously emotional subjects) and its rarity in adults (when not due to polypi) would tend to strengthen this supposition. The extreme mobility of the tumour was very remarkable, and it was found at the operation to depend on the presence of a long meso-cæcum. The tumour was usually felt in the right iliac fossa, but while the anaesthetic was being administered it disappeared, and was only found (after some search) under the lower margin of the liver. Another point worth noting is that, after the wound was sewn up, the tumour could still be felt through the abdo-

¹ Mirror of Hospital Practice, vol. i. 1889, pp. 170, 171.

² Barker: THE LANCET, vol. ii. 1888, p. 263.

³ Operators: Nuck, 1692; Fuschsius, 1824; Wilson, 1831; Howse, 1874; Bellamy, 1879; Kleberg, 1879; Burckhardt, 1883.

⁴ THE LANCET, vol. i. 1889, p. 171.

⁵ Ibid., vol. ii. 1888, p. 888.

⁶ Transactions of the Medico-Chir. Soc., Ed., 1888-9, New Series viii., p. 74-78.

⁷ Med. Record, New York, 1890, xxxvi., p. 113.

⁸ Operators: Messrs. Barrow and Berry.