parenchyma is hardly, I think, sufficiently appreciated by the profession at large; but unless attended to may involve the practitioner in some disrepute.

The first case was that of a woman aged forty-eight, married, with two children, who was admitted to hospital in October, 1894, with an induration at the root of the right nipple of one year's duration. She complained of some lancinating pain. There had been no injury, but chronic ill-health, and latterly she had been unfortunate in business. The tumour appeared as large as a hazel-nut. The patient thought there had been discharge from the nipple. There was no gland enlargement. Upon removal it was found to be one large cyst, with the remaining parenchyma pervaded by minute cysts; there were no vegetations and no malignant indications. The patient has just (October, 1895) had the left breast removed for an exactly similar condition, the right side remaining, of course, healthy. The second case was that of a woman aged thirty-five, single, sent by Dr. Garry Simpson of Acton in August, 1892. She was a spare, neurotic woman with a fluctuating tumour in the left breast, which had been noticed six weeks, as large as a pigeon's egg. On removal one large cyst filled with turbid fluid was found; the whole breast tissue was full of tiny cysts. In July, 1893, the remaining organ was found to be slightly lumpy. In August, 1895, a distinct cyst the size of a bean was apparent in the lower segment, and removal was advised. The third case was that of a widow aged forty-six, who had three children; she was seen in November, 1893. In the right breast was a large prominent globular tumour the size of a hen's egg, freely movable, hard, and solid to the touch. The patient was neurotic through much worry. On removal a multilocular cyst with solid round fibroma as large as a marble was found. There was no malignant tissue. The patient reappeared in July, 1895, with a tumour the size of a walnut, rounded and hard, in the left mamma. It quickly increased in size from augmentation of the fluid contents, and has just been removed, proving wholly cystic.

Gloucester-place, W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

SYMPATHETIC OPHTHALMIA WITHOUT EVIDENCE OF MICRO-ORGANISMS.

BY W. J. COLLINS, M.D., M.S. LOND., F.R.C.S. ENG.,
FELLOW OF THE UNIVERSITY OF LONDON.

A WOMAN aged sixty-five years was admitted on Aug. 20th, 1894, into the London Temperance Hospital. There was a history of failing vision for two years, for which she had been treated at another hospital, where an operation for cataract had been performed on the right eye in April, 1894. The operation was unsuccessful, and the eye had remained painful and almost blind. Three weeks prior to admission the sight of the left eye suddenly became dim, and there was much ocular pain. She was seen for the first time as an out-patient on Aug. 16th, and was told to go in at once, but unfortunately she did not present herself until Aug. 20th. On admission the right eye was painful and red, and the media were not clear. The site of the old coloboma was occupied by a reddish-yellow mass, and the remainder of the iris was fixed by a dirty bloodstained effusion. There was only perception of light. The left eye was red, watery, and painful; the cornea was clear, but the pupil did not act to light. Owing to the presence of a nearly mature cataract the vision was only perception of light and hand reflex. The right eye was at once excised and belladonna fomentations applied to the left. Subsequently she developed a smart attack of iritis in the left eye, with swelling of the eyelids, which, however, yielded slowly to treatment. She was discharged with the left eye in a quiet condition, but with some posterior synechiæ. Owing to the cataract the vision could not be further tested. The excised eye was placed in Müller's fluid and handed over to Mr. Cargill, surgical registrar at King's College Hospital, who made a careful search for micro-organisms by various methods, and mounted several sections of the eye. The sections show

the coloboma blocked with leucocytes; the lens, or remains of the lens, is present; the deeper layers of the ciliary body and choroid are crowded with small, round lymph cells, and the sheath of the optic nerve, especially in the neighbourhood of the porus opticus, exhibits similar infiltration. Mr. Cargill assures me that elaborate searches for micro-organisms yielded absolutely negative results. Here, then, was a case of sympathetic iritis in which the exciting eye, excised *flagrante delicto*, yielded no evidence whatever of particulate infection by the most thorough methods of investigation. The mystery of sympathetic ophthalmia is not yet solved. During the height of the neurotic school of thought we were directed to the ciliary nerves for some kind of reflex causation; the humoralists, however, looked to the lymphatic sheath of the optic nerve as the path of infection. In obedience to the germ theory domination the ciliary nerves have of late been less accused, and the lymphatic sheath has been regarded as merely providing a path along which bacteria might proceed. The case I now record will serve to indicate that this explanation may not be all-sufficient. The reflection that sympathetic ophthalmia is in some way merely corollary to the law of symmetry and the recollection of the selective powers exerted by similar tissues may supply a more fruitful working hypothesis.

Albert-terrace, N.W.

NOTES ON A CASE OF APYREXIAL ENTERIC FEVER.

BY W. RUSSELL, M.B. ABERD., D.P.H. LOND.,
RESIDENT MEDICAL OFFICER, NORTH CITY FEVER HOSPITAL, LIVERPOOL.

A BOY aged thirteen years was admitted to hospital as suffering from enteric fever. His parents said that he had been ailing for over a week. On admission he presented a typical typhoid look of prostration, lying on his back with his arms lying loosely by his side. The pupils were dilated and he had a circumscribed flush on each cheek; his tongue was covered with a dirty-white fur. The abdomen was slightly tympanitic, and there were two rose-coloured spots disappearing on pressure. There were no lung complications, and all that the patient complained of was a feeling of being tired. There was no diarrhoea at any time during his illness. He was fed solely on milk. The temperature on admission was 100° F.; it fell to normal next day, and remained so for ten days, during which time his tongue was still heavily coated and the typhoid appearance was well marked, when the temperature rose to 103.2°, and he passed about three ounces of blood, his temperature falling in twenty-four hours to normal. Next day there was another rise to 101.4°, and he passed about four ounces of blood, his temperature subsiding to subnormal and continuing so for eighteen days. He was then allowed to sit up in bed, but kept strictly on a milk diet, as his tongue, notwithstanding stomachic medicines, had not perfectly cleared up. Two days later the temperature rose to 101°, and then a typical typhoid temperature continued, with numerous typhoid spots and very foul tongue. Gradually his tongue began to clean, and he was discharged from the hospital four weeks later. The point of interest in the above case was the fact of the patient presenting typhoid symptoms, tongue, spots, hæmorrhage, &c., notwithstanding that his temperature remained normal or subnormal, except before the hæmorrhage occurred, and after being allowed to sit up in bed.

Liverpool.

RADICAL CURE OF HYDROCELE BY INJECTION OF PERCHLORIDE OF MERCURY.

BY N. WHEATCROFT HOLMES, L.R.C.P., L.R.C.S.,
L.M. EDIN.

LATE GOVERNMENT MEDICAL OFFICER IN WEST AND SOUTH AUSTRALIA,
AND HOUSE SURGEON TO THE MANCHESTER SOUTHERN HOSPITAL
FOR DISEASES OF WOMEN AND CHILDREN.

THE result of the following case proved very satisfactory. A man aged sixty-eight years, suffering from diabetes, had a large fluctuating swelling of five years' duration in the scrotum on the right side, pyriform in shape, with a smooth regular outline. There was no impulse on coughing, and it was non-translucent by transmitted light. On Sept. 22nd I first made an exploratory puncture with a hypodermic needle and