ruptured bladder we cannot begin again, for if our selected means should fail, death will place the patient beyond the reach of surgical art.—Yours obediently,

WALTER RIVINGTON, M.S. Lond.

Finsbury-square, July 13th, 1883.

"ABDOMINAL HERNIA AND ITS CONSEQUENCES."

To the Editor of THE LANCET.

Sir,—With the notice that you were good enough to take, on July 21st, 1883, of my pamphlet on Hernia, I have not much fault to find, as it seems to me to be neither disingenuous nor unappreciative. Where your writer has clearly understood me he has, in the main, concurred with me, and I have no objection to the slightly disparaging tone of his last paragraph, which justifiably points out what I admit to be a veracious inaccuracy of style. I am glad to receive, however, that even this fault of mine has not concealed my meaning from the reviewer. I omit allusion here to the subject of so-called "omental strangulation," on which his views are expressed in merely hypothetical terms. But there are two points on which he entirely misrepresents, if he do not actually misunderstand, me. I take the second first. Reference is made to the supposed occlusion of the hernial channel by food and its relation to the presence or absence of collapse, his language is here, though probably right grammatically, not logically quite so clear as it might be. But as I understand him, he charges me with ignoring the fact, or with the presence of intussusception, yet to which hopeful medical treatment was promptly and continuously applied, with the most rigid abstemion from milk and all solids, and in which the symptoms were sudden and most acute; great and portentous facts involved in the physiology of abortion by which the intestinal functions are obstructed, and which, not merely by the inconvenience, however great, of a mere passing and passive constipation, but the active indication that such "obstruction" has commenced. I care not for the immediate purposes of treatment in the most interesting cases of "intestinal obstruction" as I understand and employ it. The whole of this section was written by me for the express purpose of noticing what he erroneously charges me with ignoring the collapse resulting from peritoneal infiltration of feces. The idea originally conveyed by me is that there is no such thing as "the collapse of perforation per se"; but that when perforation permits the large escape of feces into the peritoneum, the collapse which undoubtedly follows is the "collapse of septicaemia," due, of course, to the absorption of the putrid matter. Our writer is expected to be so corrected as to remind one's readers that rapid septicaemia is one of the acknowledged but various and different promoting causes of the general condition termed "collapse." For due consideration of "collapse" from every point of view, however, reference may be made to an address by Professor von Nussbaum, published in 1877,1 abstracted in English on May 15th of the same year in the London Medical Record.

The other, and last point of which I wish to notice, is the utter misrepresentation by the reviewer of the term "intestinal obstruction" as I understand and employ it. In this he merely follows the too prevalent practice of attempting the hopeless task of separating the cases caused by mechanical causes from those caused by non-mechanical occlusion. The essential symptoms are alike in all, I care not what the variety, though the degrees of acuteness truly differ; but that does not help the diagnosis, or alter the immediate indications as to treatment.

Cases illustrating my view are continually being published, and I need not multiply them, but I may add that I have known a case of intussusception, discovered by post-mortem examination, in which there never was complete constipation from first to last, and in which we felt certain during life that, whatever the form of intestinal obstruction, we might safely exclude intussusception. I have also known a case in which the intussusception was sudden and severe, with pain, temperature of 103°, quickened pulse, belly distended and uncertainty as to the existence of a circumscribed tumour, everything noticed at the first visit consistent with the presence of intussusception, yet to which hopeful medical treatment was promptly and continuously applied, with immediate benefit, but undergoing daily remission, followed by daily ameliorations, under the assiduous enforcement of the most rigid abstention from milk and all solids, and under the repeated obstructions as to treatment. Even here, it took the patient a month to recover entirely, under the most exactly appropriate treatment; though within the first two days it appeared extremely probable that the obstruction was of some "functional" kind, perhaps permitting the impaction of food in the first instance. Such cases are those which, when treated with the finger, with enema, or with milk and other improper ingesta, often eventually die, and reveal post-mortem what some are pleased to call "no signs of obstruction." Why, the whole thing is "obstruction" throughout, from the last stool preceding the seizure to the first puff of wind per anum after improvement. By "intestinal obstruction" I do not mean solely one of the mere anatomical causes of obstruction, be it strangulation of a hernia (internal or external), invagination, volvulus, band, constriction of any kind, pressure, &c., but I mean the great and portentous facts involved in the physiological abortion by which the intestinal functions are obstructed; that not merely by the inconvenience, however great, of a mere passing and passive constipation, but the active indication that such "obstruction" has commenced. I care not for the immediate purposes of treatment in cases of "intestinal obstruction" as I understand and employ it.

So surely as cases are not promptly treated tenderly in this way, so surely will some of them continue to develop from a comparatively harmless "bellyache" to a formidable or fatal disease. It is impossible, in a communication that should be confined within limits that I must have exceeded, to do more than touch upon the points immediately concerned, but I desire to correct obvious misinterpretations.

I am, Sir, yours truly,

ROUSTON PARKER, B.S., F.R.C.S.,

Professor of Surgery in University College, Liverpool.

* * * We regret that Mr. Parker has omitted to give in his pamphlet evidence that the collapse of perforation is merely collapse of septicaemia; he appears to us to have overlooked the other explanations of that state. The concluding paragraphs of Mr. Parker's letter appear to us to justify in every particular the remarks to which he takes exception.—Ed. L.

ON THE CHINESE ORIGIN OF SYPHILIS.

To the Editor of THE LANCET.

Sir,—An annotation in THE LANCET of March 31st, 1883, on the "Antiquity of Syphilis," moves me to select from my unfinished essay on "Syphilis in China," a contribution to the history of this much-debated question.

Chinese writers on syphilis state that that malady was unknown in their country, meaning thereby the Valley of the Yangtse and regions northward, until about the middle of the ninth century of our era, and that it was introduced from Canton and spread gradually over the empire. It extended to Japan also, as stated in the work by Dr. Schulze in Yercher's Archive. Of hardly less interest is the fact that the Chinese were the first to employ mercury in the treatment of syphilis, its use being synchronous with the advent of the new contagion. If I might quit the realm of fact for the region of speculation, I should say that Arab traders conveyed the poison, as well also as its mercurial antidote, from Canton to the West, and that its appearance in Southern Europe, late in the fifteenth century, was due to that agency. It appears to be much less virulent now than when first described.

I am, Sir, yours faithfully,

June, 1883.

D. J. MACgowan, M.D.

LIVERPOOL.

(From our own Correspondent.)

THE EYE AND EAR INFECTION.

MR. EDGAR BROWNE has had a very interesting series of cases of detachment of the retina, treated by paracentesis and by subcutaneous injections of picrocarpine. The immediate results have been sometimes brilliant, but Mr. Browne points out that in the great proportion of cases a relapse will occur. Very satisfactory results have been obtained in cataract cases with a preliminary iridectomy performed six