complete absence of ascites account for this fact? Ascites may do harm in more ways than one. 1. By pressing upon the vena cava it may interfere with the venous circulation of the lower extremities, giving rise to oedema in these parts. 2. By pressing upon the renal vessels and kidneys. 3. By setting up a vicious circle by pressing upon the branches of the portal vein and thus interfering with the functions of the stomach and the intestines and also offering more obstruction to the portal system. 4. By pressing upon the diaphragm and interfering with respiration and cardiac action. 5. By abstracting from the blood a large quantity of albuminous fluid.

It remains for me to give a brief account of the collateral circulation which may be developed in cirrhosis so as to enable the blood of the portal system to reach the systemic veins. 1. Hæmorrhoidal branches of the inferior mesenteric anastomosing with those of the internal iliac. 2. Mesenteric veins anastomosing with those of the abdominal wall. 3. Coronary veins anastomosing with the œsophageal veins and thus communicating with the azygos veins. 4. Coronary veins and veins of Glisson's capsule on the one hand and the phrenic veins on the other. 5. One or more veins in the round ligament (the accessory portal vein or parumbilical vein or rudimentary umbilical vein of different authors) connecting the portal with the epigastric and other veins of the abdominal wall. 6. Veins of the pancreas, the duodenum, the colon, and the rectum communicating with the retroperitoneal branches. 7. Veins lying in the sub-peritoneal tissue, between the folds of the hepatic ligaments and the peritoneal folds round the liver communicating with the portal system on the one hand and the phrenic veins and azygos major on the other (the minor accessory portal veins

FIG. 2.

Cirrhosis of the liver without ascites. March, 1907.

of Sappey⁴). Many of these penetrate the capsule of the liver. 8. Left renal veins and the veins of the intestines, especially those of the colon and the duodenum. 9. Superficial branches of the portal veins of the liver and the

phrenic veins. 10. Very rarely communication between the parumbilical vein through an abdominal vein with the right iliac vein.⁵ Besides the foregoing there may be innumerable new vessels that may develop from adhesions.

I shall mention here another cause besides the collateral circulation mentioned above which may prevent the occurrence of ascites, namely, the increased exudation of fluid into the peritoneal cavity may be reabsorbed by the lymphatics of the diaphragm and the parietal peritoneum, which are independent of the portal system.⁶

Calcutta.

THE SYNCHRONOUS MOVEMENTS OF THE LOWER EYELIDS WITH THE TONGUE AND LOWER JAW OBSERVED IN CERTAIN DISEASES:

A SIGN OF DISEASE IN CONNEXION WITH THE LOWER EYELIDS.

BY HERBERT J. ROBSON, M.R.C.S. ENG., L.R.C.P. LOND.

ON Oct. 28th, 1905, at the Leeds and West Riding Medico-Chirurgical Society I reported eight cases in which a phenomenon connected with the lower eyelids had been observed; and since then it has been seen in several other cases, not only by myself, but by several other medical men. The phenomenon referred to is a slight eversion of the lower eyelids made evident upon protrusion of the tongue or depression of the lower jaw, the lids resuming their normal state when the tongue is retracted or the mouth shut—in other words, the lower eyelids become displaced from the eyeballs or are protruded from the eyeballs to the extent of one or two millimetres upon protrusion of the tongue or depression of the lower jaw. This phenomenon is apparently never present in health; furthermore, it apparently comes and goes with the onset and cure of disease, and therefore I think that it must be a sign of disease; and, since I can find no record of it in any published work or writing, I regard it as a new sign of disease with some distinct significance, and one worthy of further consideration. I do not think that it is a reflex act of disease. It is evidently produced by the contraction of the malaris fibres of the orbicularis palpebrarum muscle—the malaris muscle as described by Henle. From the fact that the facial nerve supplies the malaris muscle and the digastric and mylo-hyoid muscles, and the hypoglossal nerve supplies the genio-hyoid and the genio-hyoglossus muscles, and that the facial nerve communicates in the latter muscle with the hypoglossal nerve; and furthermore, from the fact that the nuclei of origin of the hypoglossal nerve and of the facial nerve are in close proximity in the medulla and the pons Varolii respectively, it is easy to see how the coördinate muscular acts of the simultaneous protrusion of the tongue and depression of the lower jaw with the eversion of the lower eyelids are produced.

In acute cases I am inclined to think that the presence of the sign may be caused by the circulation in the blood of some toxin, or that at other times it may be some nervous impulse acting directly upon the common nuclei of origin of the hypoglossal nerve and of those fibres of the facial nerve supplying the orbicularis palpebrarum and its offshoot the malaris muscle. In chronic cases it is obviously caused by some change in the deeper structures of the skin.

Probably if the phenomenon or sign is regularly looked out for it will be often found present in acute cases as quite a transitory sign and as indicating a severely ill condition; for instance, in a case of influenza complicated with acute laryngitis, in which the patient was extremely ill, the lower eyelid sign was present one night, but it had disappeared the next day when the urgent symptoms had been relieved, and it was not afterwards observed in that case. Of course, a healthy eyelid is referred to, and not the condition of eversion of the lower eyelid sometimes seen in old people with or without granular lids and with marked epiphora, and who, like their lower lids, their figure, and their faculties generally are gradually dropping down in response to gravity and other laws of nature.

Some general conclusions.—1. The phenomenon cannot be detected unless it is specially looked out for, because the

⁴ Sappey: Centralblatt für Chirurgie, 1901.

⁵ Drummond: Brit. Med. Jour., February, 1888.

⁶ Quincke: Ascites, Deutsches Archiv für Klinische Medizin, 1882.

tongue and eyes are not inspected at one and the same time unless the observer is on the *qui vive* for this movement of the eyelids; and this, I think, is one of the main reasons why it has hitherto not received any notice. 2. I think that it should always put the medical man on his guard, whether, for instance, he is treating an acute case for some urgent symptoms, or, on the other hand, examining a case for life insurance; as whenever the phenomenon is present in chronic cases—judging from my own experience—some severe asthenic condition will be always found to exist, or it will be found that the patient has been a martyr to pain for many years. 3. From observations made on a few of the cases I have noticed that the phenomenon for a time almost disappears after the tongue has been protruded several times and also after stroking the forehead or touching the lower eyelid. 4. In all the cases observed except one it was present in both eyes. 5. In three of the cases the phenomenon disappeared as the patients convalesced from their various maladies. 6. In two of the cases, though formerly the phenomenon was present in a very marked degree, it is now nearly absent and the patients are both much better in health than when I at first saw them. 7. In two acute cases in which the phenomenon was observed it disappeared when the urgent symptoms had passed off. 8. As regards chronic cases, the patients who have presented this phenomenon in my own practice have been affected with various cardiac and abdominal diseases, and two of them had suffered from very severe headaches for many years in consequence of uncorrected astigmatism. 9. The phenomenon is never present in health. It comes and goes with the onset and cure of disease, as proved in five of my cases, and therefore I think that it is a clear index or sign of disease.

Leeds.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF DISLOCATION OF THE OUTER END OF THE CLAVICLE.

By H. M. JOSEPH, M.B., B.C. CANTAB.

DISLOCATION of the outer end of the clavicle is not common, probably less than 3 per cent. of all cases of dislocation. Owing to the difficulty in keeping the bones in position this accident having once occurred is always liable to recur, and hence the prognosis is in every case doubtful. Bergmann says that the prognosis is unfavourable as regards complete restoration of form, but functional impairment is slight although the carrying of heavy burdens is difficult. Free abduction is considered the only movement endangered. It is in athletes that one usually meets with this dislocation, and to them it gives a serious handicap in their sport; football, whether Rugby or Association, has to be given up, and often tennis. One player I know of was able to continue football after having the bones wired, but the limitation of movement caused by the wiring of the acromio-clavicular joint prevented his playing tennis. Two others, although unable to play football again, or tennis with the right arm, took up left-handed tennis. Others have never taken the field again in either sport. One of the first questions therefore that arises in these cases is, "Will it be necessary to give up games?" and it is in this connexion that the following case may be of interest.

The patient, aged 26 years, received his injury while playing Association football, and he presented the usual signs of dislocation of the outer end of the right clavicle above the acromion. He complained of pain and "a feeling as if something were loose in the shoulder," and he could not raise the arm. Examination revealed the outer end of the clavicle lying just above the acromion process and causing an elevation of the outer extremity of the trapezius muscle. By pressing on this swelling and at the same time supporting the arm the dislocation was easily reduced, but it recurred at once on releasing the support of the arm. The shoulder was attended to immediately after the injury. The clavicle was kept in place by means of stout strapping tightly bound and running over the acromio-clavicular joint and under the

elbow; a pad of cotton-wool was placed in the axilla while the elbow was fixed well forward and close to the side by a broad calico bandage. The patient was told that he would probably be unable to play football again. The clavicle and acromion were kept in place in this way for six weeks, after which time gradually increasing movements were allowed—first passive and then active. The treatment thus presented no new features. The result, however, was extremely satisfactory. The patient was able to play football again four months after the injury and he has since played in county matches. He has also been able to take part in first-class tennis tournaments. There is now no deformity and all the movements of the arm are perfectly free. The only inconvenience the patient now suffers is an occasional pain felt when pressure is applied over the acromio-clavicular joint.

Oxford-gardens, W.

NOTE ON A CASE OF EXTENSIVE SURGICAL EMPHYSEMA.

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THE following is a case of very extensive surgical emphysema which came under my care some time ago. A man, aged 66 years, fell, striking his chest against the corner of a table and fracturing his seventh and eighth ribs on the left side rather towards the back. About three hours afterwards he noticed that his scrotum was becoming swollen and uncomfortable and this swelling advanced rapidly over the whole body. 24 hours after the injury the body was found to be swollen and puffy all over and the air could be felt crackling under the fingers; it was evidently immediately beneath the skin, which was lifted up in a large soft mass producing the appearance of general dropsy. The entire surface of the body was affected with the following exceptions: the scalp, defined by a line running round the head more or less coronally at the level of the external occipital protuberance, the temporal ridge, and the upper and outer angle of the orbit, and this area of immunity was continued downwards to the malar bones, and thence over the nose as far down as the tip, the eyes and eyelids thus escaping; the point of the chin; the auricles; the hands, back and front, from a line just above the wrist-joint; the region immediately over the patella; and the feet, dorsum, and sole from a line at the ankle-joint. There was no sign of pneumothorax. For the first day or two there was a little dyspnoea, with slight cyanosis of the face and lips, and rather rapid respiration, but this soon passed off. There was no pain anywhere except at the site of the fracture, though the swelling of the scrotum and penis gave rise to considerable discomfort. Treatment consisted in restricting the movements of the chest by strapping and the administration of sedatives for the cough. The emphysema gradually subsided and in a fortnight it had quite disappeared.

The chief interest in this case is the widespread extension of the emphysema and though such cases no doubt often occur I have not been able to find any record in recent writings of a similar one to this. The area of immunity over the nose and eyelids also is notable, since it is recognised that there is a fairly free communication between the subcutaneous tissue of these parts; this has been noticed during the injection of paraffin for nasal deformities, where some of the material has overflowed if not checked by pressure at the sides of the nose. The definite limiting line at the wrists is remarkable, seeing how easily cedema continues up the back of the forearm from inflammation of the hand.

Glasgow.

ROYAL NATIONAL ORTHOPÆDIC HOSPITAL.—The erection of the new building in Great Portland-street for the combined three London orthopædic hospitals is proceeding rapidly. It will accommodate over 200 beds and in addition it will have a detached out-patients' department and nurses' home in Bolsover-street connected to the hospital by means of a subway. Mr. Rowland Plumbe, F.R.I.B.A., is the architect and Messrs. Holloway Brothers are the builders.