generally supposed. Such an inference, however, would be fallacious, inasmuch as every case of this remarkable phenomenon would almost certainly be placed on record.

The following comprises a brief record of cure brought about by the spontaneous, successive dislocation of each cataractous crystalline lens with the recovery of excellent sight.

A highly intelligent lady, 55 years of age, first consulted me on August 17th, 1892, with the statement that the sight had been imperfect for many years. There had been several attacks of ocular inflammation diagnosed as of a "gouty" nature. The eyes had become worse since the advent of the menopause three years before. The patient was wearing spectacles, —11 D. spherical, which she had obtained from an optician. Right vision: fingers at one metre and Jaeger No. 1 at eight centimetres; left vision: fingers at four metres and Jaeger No. 1 at four centimetres. The vision of the left eye was improved to $\frac{1}{2}$ normal with a -9 D. spherical lens. The tension of the eyeballs was normal. The right crystalline lens was opaque in its deeper parts, with a posterior polar opacity. The left lens exhibited opaque striæ and also a posterior polar opacity. "Floaters" were present in the vitreous humour of each eye.

Eight years later (August 9th, 1900) the patient came to me again. She stated that for several years she had been blind with her left eye and able to see print with the right eye only by holding the book or paper close to her face. On the afternoon of July 25th, 1900, whilst at tea, she found that with her left or blind eye she could see the teacups and the pattern of the tray. On the following day she saw, for the first time for several years, the cornice of her sitting-room. The sight of her left eye continued to clear at the top, but a crescentic mass remained at the bottom of the field. On July 29th with her left eye she could make out the clergyman in the pulpit at church. On August 2nd, whilst coming up stairs, the crescentic mass suddenly disappeared, and soon afterwards she found, to her delight, that she could distinguish the lettering on passing omnibuses. Upon examination, with the right eye vision was equal to counting fingers at 35 centimetres and No. 4 of Jaeger's type could be read at eight centimetres. The vision of the left eye with a +10 D. lens was $\frac{2}{3}$ normal and with a +14 D. lens the smallest type on Jaeger's card could be read. A nearly mature cataract existed in the right eye. In the left eye the anterior chamber was deep, the pupil clear and black, the iris sluggish and tremulous, and the tension normal. With the ophthalmoscope the dislocated lens was found to be lying in the lower part of the vitreous chamber.

On Jan. 18th, 1902, the patient came to me again. 12 days previously she had noticed that the sight of her right eye was so much clearer that she was able to distinguish her husband across the room. For the next few days the eye was somewhat uncomfortable, mainly because there was a sort of "wobbling," and prismatic colours were visible when the electric light was used at night. On Jan. 16th whilst at dinner she had suddenly discovered that the sight of her right eye had become quite clear. Upon examination the pupil of the right eye was found to be clear and black, the iris tremulous, the anterior chamber deep, and the crystalline lens dislocated into the lower part of the vitreous chamber. Tension was normal. Sight with a +9 D. lens was $\frac{2}{3}$ normal and with a +12 D. lens the smallest print could be read.

Welbeck-street, W.

A CASE OF PLACENTA PRÆVIA.

By A. W. LEMARCHAND, M.R.C.S. ENG.,
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I BELIEVE placenta prævia centrally situated to be rare. The notes of a case given below are interesting, I think, for the following points: (1) the patient was a young woman who had not had many previous pregnancies; (2) the character of the symptoms from the sixth month were typical and warned one to suspect placenta prævia; (3) the good fortune to get a strongly acting uterus and practically no unusual loss of blood when labour did set in; and (4) that non-interference was justified. I do not think that I should have

saved the child's life if I had turned and delivered, and from the central position of the placenta I am sure I should have had much hæmorrhage and risked the life of the mother.

I was called on Dec. 21st, 1901, to see the patient, aged 30 years, who had just about completed her sixth month of her third pregnancy. Without any very apparent reason she had had a sharp hæmorrhage but no labour pains. A little opium and absolute rest in bed were ordered. During the next two months there were two more sharp bursts of bleeding but no pains. Through these two months she wore generally one diaper a day which, with the two exceptions noted, were only just soiled. The patient's mother, a midwife, was constantly with her and she was warned that probably the "afterbirth was in front of the head" and she was told, as soon as any pains set in, to send for me. On March 19th I received a message and at once went to the patient. I found that there had been slight hæmorrhage, three diapers being considerably soiled but not saturated. Per vaginam the os was of the size of a two-shilling piece, the vertex was presenting, a pad was felt in front of the head, and there was a cord-like feeling on the pad suggestive of placental vascular trunks. I could feel no edge to the pad. This was at 5.20 P.M. The pains were coming fairly strongly and quickly. I walked to my house about a quarter of a mile, got some chloroform, and telephoned to my partner, Mr. W. Cooper, to come and lend a hand, as I meant to turn. At 5.45, on my return, I found the head advancing; the bag in front of it, which I took to be membranes, felt decidedly thick. Round the presenting part of the head, but more especially in the right lateral quarter of the pelvis, the bag of membranes seemed to be heaped up and I thought that here was the edge of the placenta and that the head was slipping past it. The pains were now very strong and as there was no hæmorrhage and the head would soon be born I decided not to interfere. At about 6.20 Mr. Cooper came in. The sutures in the head could be distinctly felt but the "membranes" seemed to be thicker than normal. At 6.45, no attempt having been made to break the membranes, the whole ovum was expelled and the placenta was found to be spread over the head and shoulders of the child, the centre of the vertex corresponding to the centre of the placenta. The placenta was thin and spread out, covering about half the inner surface of the membranes. The child was dead and efforts to make it breathe were of no avail; it was of fair size and had nails almost to the end of the fingers but none on the toes. About one and a half pints of liquor amnii and blood followed the child; the uterus contracted nicely and after half an hour a 1 in 3000 biniodide douche was given. The patient was cleaned, bound, and made comfortable and at 8.5 P.M. I left the house.

Barnstaple.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF NEARLY FATAL INTRALARYNGEAL HÆMORRHAGE FROM PAPILLOMATA OF THE LARYNX.

By ADOLPH BRONNER, M.D.,

SENIOR SURGEON TO THE BRADFORD EYE AND EAR HOSPITAL;
LARYNGOLOGIST TO BRADFORD ROYAL INFIRMARY.

CASES of dangerous hæmorrhage from laryngeal papillomata are extremely rare. The notes of the following case may therefore be of some interest.

A strong, healthy man, aged 48 years, saw me in June, 1896. He had been hoarse off and on for nearly two years and was getting worse. I found a large number of papillomata growing from the vocal cords (edges and upper surface) and the ventricular bands. These were removed at intervals of from two to three months by Frænkel's forceps. On Dec. 18th, 1897, the patient was running to catch a train when he began to cough and to feel choky

and had to walk slowly. He spat up small quantities of bright blood. In the train he gradually became worse, the cough was more violent and he was continually spitting up small lumps of blood and he felt as if he were going to suffocate. He had a distinct recollection of being asked for his ticket but he did not remember seeing the collector. When he arrived at Bradford, 20 minutes after entering the train and five minutes after having given up the ticket, he had to be lifted out of the carriage and was unconscious for from 15 to 20 minutes. During this time he was violently shaken and brandy was poured down his throat. He coughed up lumps and threads of coagulated blood and froth. He gradually came round and was taken to a private hospital. I saw him in about half an hour. He was breathing rapidly and perspiring freely and was coughing up frothy mucus and small lumps and threads of coagulated blood; some of the latter were ramified and evidently came from the smaller bronchi. The pulse was 125. There was slight dulness of the base of the left lung and numerous rales and sonorous rhonchi were heard over the bases of both lungs. The upper parts of the lungs were normal. The symptoms gradually cleared up in two days. There were not, and never had been, any symptoms of tuberculosis of the lungs. He said that both lungs felt heavy, especially the left, as though a large piece of lead were pressing on them. For the next three or four weeks the patient coughed up small lumps of red blood. He says that for some months before the attack he expectorated very small pieces of blood now and then. I saw him in June, 1898, and could see distinctly a small blood-clot in one of the papillomata of the vocal cords and there was local hæmorrhage after the removal of the clot. The patient used a formalin spray for some months and the papillomata then practically disappeared and there has been no recurrence up to the present time.

The case is a very peculiar one. Of course, the hæmorrhage may have been of pulmonary or intertracheal origin. But the facts that there have been frequent attacks of very slight hæmorrhage without very violent cough, and that I could distinctly see a small blood clot on the papillomata seem to prove that the growths on the edge of the vocal cord were the cause of the hæmorrhage. The violent exertion and excitement in catching the train probably brought on a more severe hæmorrhage than usual and also induced a violent spasm of the glottis which, combined with the blood entering the smaller bronchi, nearly proved fatal.

Bradford.

A CASE OF RELAPSING PYREXIA CONTINUING FOR 14 MONTHS UNABATED.

By SHEFFIELD H. M. NEAVE, M.R.C.P. LOND.

THE following case now under the care of Dr. Harrington Sainsbury at the Royal Free Hospital is so unusual and so defies treatment that I think it cannot fail to be of general interest.

The patient, a male, 17 years old, was in his usual health till February, 1901. He had spent the whole of his life in a house close to the London Docks. In that month he began to have attacks of pyrexia at regular intervals. The predominant symptom from his own point of view was his intense desire to sleep by day as well as by night. In the intervals of his attacks he felt quite well and used to go to work. He has now been in the Royal Free Hospital for nearly six months and during that period has passed through nine cycles of pyrexia and remissions of fever in 172 days, making an average of 19 days apiece. The actual number of days of remission (*r*) and days of pyrexia (*p*) for each of the nine cycles was as follows: (*r*) 11, (*p*) 7; (*r*) 12, (*p*) 7; (*r*) 12, (*p*) 6; (*r*) 14, (*p*) 5; (*r*) 14, (*p*) 6; (*r*) 13, (*p*) 6; (*r*) 14, (*p*) 6; (*r*) 12, (*p*) 7; (*r*) 14, (*p*) 6.

The only physical signs that are in any way permanent are a slight increase of splenic dulness upwards and an enlarged gland in the left axilla. The temperature during an attack rises to a maximum of 105° F. in the third or fourth day and during the last day it comes down by crisis to 96° or 97° with some collapse. The patient has very little discomfort, but is drowsy and has some bronchitis, his tongue is furred, vomiting occurs at the highest point of temperature, there is some tenderness over the spleen, and the blood count shows a leucocytosis of 16,000. The blood has been examined by various pathologists for malaria

parasite, spirillum Obermayeri, and reaction of Malta fever, all with a negative result. During the remissions the patient appears to be fairly robust though somewhat anæmic—the blood showing a deficiency of hæmoglobin—without much wasting, and he feels quite well. Over the period of six months, however, he has lost weight.

Every chance of a collection of pus has been well considered and investigated; *imprimis*, cholecystitis with hepatic intermittent fever has been kept well in view and there is never any sign of jaundice. The cerebro-spinal fluid is sterile. There are no renal symptoms and the urine is normal. A negative result has likewise followed the exploration of the nose, the naso-pharynx, the larynx, and the rectum. There is no affection of the special senses and the fundus oculi and the ear are normal.

Royal Free Hospital, W.C.

A MINUTE PERITONEAL HERNIA THROUGH A CLEFT IN THE XIPHOID CARTILAGE.

By WILLIAM BRAMWELL, M.D., B.CH. DUB.

WHILE making a routine examination of a man, aged 36 years, of not very good muscular development, I noticed what looked like a small fatty tumour over the xiphoid cartilage in the middle line and midway between its attachment to the gladiolus and its lower extremity. The tumour was rather less than half an inch in diameter and was about a quarter of an inch in thickness. On palpation I was surprised to find it become gradually smaller and finally disappear. It also disappeared whenever the patient lay down and there was a slight impulse on coughing. The aperture was a cleft-like perforation in the cartilage with perfectly smooth and symmetrical edges which could be distinctly felt through the skin. It was about half an inch long and a little more than a sixteenth of an inch in width. The patient, who was under treatment for dyspepsia, said that he had noticed the tumour as far back as he could remember but that it had never caused him any pain or inconvenience.

A cleft or perforation in the xiphoid is not an uncommon occurrence but I have never heard or read of a hernia in this situation. This, I judge, was a hernia of a small portion of the parietal peritoneum—that is, a hernia consisting of sac only—and if so is an instructive example of the closeness of apposition of the intestinal contents and of the completeness with which even the smallest crevice is filled in.

Liverpool.

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.

WESTMINSTER HOSPITAL.

A CASE OF ACUTE BANTI'S DISEASE.

(Under the care of Dr. W. MURRELL.)

THE obscurity which prevails as to the exact nature of the various forms of splenic anæmia can only be dissipated by the careful record of many cases. It is not improbable that the term "Banti's disease" includes more than one variety of disease, but undoubtedly the following case is rightly included under that designation. Dr. Murrell's very full bibliography of the subject is of great value.

A married woman, aged 31 years, residing in Lambeth, was admitted into Westminster Hospital on Jan. 16th, 1902, with a history of hæmatemesis. Mr. A. Mackenzie Hickley, under whose care she had been, reported that she was perfectly well until three days previously when without apparent cause and without premonitory symptoms she vomited three pints of clotted blood. Her previous history was unimportant and there was nothing pointing to hæmophilia in any