has been extensively used by Dr. Reeves, of Chattanooga, but it has not been recommended in eye work, the celloidion having been considered the best. I have not succeeded with that method so well as I have with the one advised, and I believe that if you will follow the plan suggested in this paper, especially as regards the freezing and hardening process you will succeed by mounting some beautiful and valuable specimens.

CASE OF SARCOMA OF THE CHOROID —OPERATION—NO RECURRENCE IN NEARLY THREE YEARS.

Read in the Section of Ophthalmology at the Forty-first Annual Meeting of the American Medical Association, held at Nashville, Tenn., May, 1890.

BY A. G. SINCLAIR, M.D.,

PROFESSOR OF DISEASES OF THE EYE, EAR, AND THROAT IN THE MEMPHIS HOSPITAL MEDICAL COLLEGE; SURGEON IN CHARGE OF THE EYE AND EAR DEPARTMENT OF ST. JOSEPH'S HOSPITAL, MEMPHIS, TENN.

Malignant intra-ocular growths are of so much importance that every case of the kind should be placed on record, and especially the results of treatment, whether favorable or otherwise, in order that we may learn at what stage of development the disease passes beyond the control of remedial measures. I therefore beg to occupy your time briefly with a report of the following case:

In June, 1887, I was consulted by Mrs. K., 40 years of age, who reported that three years previously she had lost the sight of her right eye while suffering from symptoms which, according to her description, were very like those of acute glaucoma, and that the organ had continued more or less irritable up to the time of presentation. On examination I found vision extinct; conjunctiva moderately injected; pupil somewhat dilated, and motionless; iris discolored; lens cataractous; tension plus 1; pain in the eye, forehead and temple. Although suspecting the presence of an intra-ocular growth, I determined, as my patient was a lady, and cosmetic effects were therefore not to be ignored, before proceeding to enucleation to test the power of iridectomy to overcome the glaucomatous symptoms above enumerated—knowing that if an intra-ocular tumor were indeed present they would soon reappear and render positive the indication for removal of the eyeball.

I performed the operation accordingly, and relief of several weeks' duration followed. The symptoms then recurred in all their former intensity, and on August 14 I enucleated the eye under etherization. Entire relief from all symptoms followed; the patient made a good recovery from the operation, and soon regained her strength and spirits, previously much depressed by her sufferings.

I sent the eye, hardened in alcohol, to the laboratory of the College of Physicians and Sur-

geons, New York, for examination, whence I received in due time the following report:

NEW YORK, November 23, 1887.

Dr. Sinclair, Memphis, Tenn.

Dear Doctor:—The microscopical examination of the eye sent to the laboratory is as follows:

Cornea.—The cuboidal cells of the anterior epithelium are distorted and separated from each other by larger and smaller irregular shaped spaces (probably due to drying in the air). There are also a number of spindle-shaped cells among the cells of the anterior epithelium. At the sclero-corneal junction there are a few scattered pus cells. Lying against the posterior epithelium of the cornea is a layer of spheroidal cells.

Iveal Tract.—Iris is swollen and ciliary bodies flattened on both sides. The choroid just behind one of the ciliary bodies contains a mass of small spindle-shaped cells about 5-7 mm. in diameter.

Retina and Opticus.—Rods and cones absent from retina and there is an increased amount of interstitial tissue. In places the retina is changed to a connective tissue lamina. The optic disc shows a moderate degree of excavation.

Anatomical Diagnosis.—Small spindle-celled sarcoma of the choroid, interstitial retinitis, optic excavation, circumscribed purulent keratitis. Very respectfully yours,

IRA VAN GIESON.

Nearly three years have elapsed since the operation; the patient continues in vigorous health, and there is no sign of a recurrence of the disease.¹

54 Madison street.

A VEST POCKET OPHTHALMOSCOPE CASE.

Read in the Section of Ophthalmology at the Forty-first Annual Meeting of the American Medical Association, held at Nashville, Tenn., May, 1890.

BY FRANK TRESTER SMITH, A.M., M.D.,

OF CHATTANOOGA, TENN.

LATE ASSISTANT SURGEON, NEW YORK OPHTHALMIC AND AURAL INSTITUTE.

I present to the Section an ophthalmoscope case made for me by Meyrowitz Bros. in 1886, and which I have had in constant use ever since. It is made like a spectacle case, the open end being closed with a tightly fitting lid, or like a flattened pencil case such as is used by school-children. It is made of stiff pasteboard, or other light material, covered with morocco.

It presents the following advantages over the form in ordinary use:

1. Size. This is such that it can be carried in the vest pocket. The thickness is about half that of the wooden case.
2. Weight. Being smaller and made of lighter material, it is not as heavy as the ordinary form.
3. Shape. There are no corners and the edges are rounded off.

¹ There is still (Dec., 1890) no sign of a relapse.

4. As a result of the shape we have another advantage: It is dust-proof. The lenses are consequently more easily kept clean.

5. As a further result of the shape we have the advantage of greater durability. The hinges of the ordinary case are soon worn out.

6. It is never necessary to remove the handle from the instrument.

7. The ophthalmoscope can be kept in the case at all times except when in actual use. During office hours it takes too much time to be continually taking the instrument from the case with a lid. By removing the lid the ophthalmoscope can be placed in the case and taken from it more easily than from the vest pocket. The weight of the ophthalmoscope will prevent its falling out of the pocket in stooping.

I use the Knapp ophthalmoscope. The instrument with a tilting mirror would require a thicker case. There is no place in this case for an accessory lens. I find it more convenient to carry this in an eye-glass case in my vest pocket.

THE TORSION OF ARTERIES FOR THE ARREST OF HÆMORRHAGE.

Read at the Sixteenth Annual Meeting of the Mississippi Valley Medical Association, at Louisville, Oct. 9, 1890.

BY J. B. MURDOCH, M.D.,
OF PITTSBURGH, PA.

There is no subject of greater interest to the practical surgeon than the arrest of hæmorrhage. This remark is equally true whether the hæmorrhage comes from a wound accidentally inflicted, or one made intentionally, by the surgeon's knife.

Without the means of stopping the flow of blood from bleeding vessels, the surgeon's art would be greatly crippled, and surgical operations, where blood-vessels must be divided, would be impossible.

There is no sight so appalling as a formidable hæmorrhage. When a large artery is opened, the blood gushes out in an angry stream, the face becomes pale, the color leaves the lips, the respiration becomes sighing, the heart fails to beat, and death closes the scene. Without any knowledge of the circulation or nature of the blood, or of the means by which its flow from a wound could be arrested, what a terrible and mysterious sight it must have been to the early races of men to see one of their number perish from hæmorrhage. What, for instance, must have been the sensation of our first parent Adam, as he looked upon the wounds of his dead son Abel, with the stain of his blood upon the ground. Surgeons from the earliest ages have shared this dread of hæmorrhage, and have ever been striving for the best means of its control.

Upon no subject has our profession been more conservative than upon this one—the arrest of

arterial hæmorrhage. Since the time of Celsus, notwithstanding the numerous methods which have been proposed for this purpose, but two, viz.: the actual cautery and the ligature, have received the endorsement of the profession. But, if the profession has been slow to endorse new methods, its confidence once gained has been most unwillingly surrendered.

From the time of Archigenes, who practiced in Rome shortly after the time of Celsus, up to the time of Richard Wiseman, Sergeant-Surgeon to King Charles II, the red-hot iron was the sole method employed. Thus this method of checking hæmorrhage after amputation not two centuries ago, was the same as that used for fifteen hundred years previous. The pertinacity with which surgeons adhered to the use of the actual cautery after Paré's great discovery of the ligature, well illustrates the fear in which surgeons stood of hæmorrhage. They had used, and had seen their fathers use, the red-hot iron, and, notwithstanding the pain it caused and the interference with primary union, they were unwilling to discard the agent which long usage had taught them was successful.

In 1564, Ambrose Paré published his new discovery, which, to use his own language, "was taught him by the special favor of the sacred Deity." In this publication, as is well known, Paré demonstrated the value of the ligature as a hæmostatic. But, owing to the extreme fear of hæmorrhage, and the criminal neglect of surgeons, it was two hundred years before it was adopted by the profession, and then it came into favor through the influence of Sharpe, one of the surgeons of Guy's Hospital, London, who boldly championed the claims of the ligature to popular confidence.

Since this time nothing has dislodged the position which the ligature has held as a hæmostatic in the opinion of the profession.

The efforts made by Sir James Y. Simpson, of Edinburgh, to substitute acupressure, and the still more recent endeavor of Dr. S. F. Spier, of Brooklyn, to substitute constriction for ligation have most signally failed. The same statement may be made also in regard to torsion as a means of arresting arterial hæmorrhage. It has not received the support of the profession to any great extent, but unlike the other rivals of the ligature, it has had champions for hundreds of years, and still holds a place as a valuable means of arresting hæmorrhage. This subject has received but little attention by modern surgeons. The twisting of an artery to arrest bleeding is of ancient origin. It is spoken of by Celsus. A fact often observed that an arm or leg may be torn from the body with the loss of only a few drops of blood, no doubt suggested the method. It has been advocated by such surgeons as Amussat, Dieffenbach, Schroeder and Syme. But the credit of