hands produces the desired eversion. If the cilia are deficient, the ivory handle of the scalpel must be inserted beneath the lid; and pressure being made externally at the posterior edge of the tarsal cartilage with a finger of the other hand, as before, the eversion, though not without difficulty, may be completed. A certain number of light incisions of the conjunctiva are then to be made, parallel with the palpebral margin—of sufficient depth—and only sufficient depth—just to open the vessels and give vent to their contents, so affording the opportunity for their contraction. If the incisions be carried deeper, there arises the mischief of dividing the ducts of the meibomian follicles, and hence fresh complication and hindrance to the salutary progress of the case. The hæmorrhage should be encouraged by warm ablution; and, upon its cessation, an astringent should be applied. The best we have in these troublesome cases, is the undiluted liquor plumbi diacetatis; one or two drops of which should be painted over the freshly-scarified conjunctiva; diffusion of the fluid over the ocular portion of the membrane being prevented by a piece of linen or sponge. The application of sulphate of copper in substance may occasionally be substituted beneficially.

To the patient may be entrusted, for more frequent use, a solution of nitrate of silver, of the strength previously recommended; or of sulphate of copper or of zinc, from one to three grains to the ounce; or of alum, two, three, or four grains to the ounce.

Agglutination of the lids may be prevented by zinc ointment; and the milder nitrate of mercury ointment, or the nitric oxide ointment, diluted with four or five times the quantity of spermaceti, may be applied to the conjunctival margin, when the chronic inflammation involves the apertures of the meibomian follicles and the follicles of the cilia.

Occasionally, in these cases of inflamed and granular conjunctiva, much benefit is derived from dividing the external canthus for two or three lines, especially when the opening of the lids is naturally small. The good arises from the diminution of friction between the conjunctival surfaces which the operation causes, for it immediately lessens the pressure which the orbicular muscle has upon the lids and globe.

To sum up our main resources in chronic conjunctivitis, merging into the conditions of granular lid and vascular cornea, of ophthalmia tarsi and lippitudo;—restore, if defective, the general health, and keep regular but not profuse discharges from the intestinal canal. Locally, deplete by daily light scarification, while any morbid vascularity of moment, attended with thickening, remains apparent in the lining of the lids. Have recourse to astringent collyria for occasional use throughout the day. Regularly apply the most efficacious of all, the undiluted liquor plumbi diacetatis, after every scarification, as soon as the hæmorrhage has ceased, and while the remedial agent may yet find direct access to the very capillaries, the relaxed condition of which constitutes the essence of the disease. Finally, resort to the stimulating ointments mentioned, when the meibomian follicles, and those which secrete the cilia have become involved. Patients suffering from lippitudo, I should observe, must carefully remove all incrustations at the root of the cilia by warm ablution before applying ointments with any prospect of benefit. It is frequently desirable to draw out individual cilia when the corresponding follicles are the seats of abscess and ulceration, and especially when such complaints have imparted to the eyelashes a false direction, and caused them to turn in upon and irritate the globe.

Evulsion of the lashes may be practised as a palliative, also in cases of entropion arising from corrugation of the tarsal cartilage, the result of chronic ophthalmia. In these cases the conjunctival inflammation is in turn maintained by the inversion of the lid it has itself produced, and spasm of the orbicularis muscle, compressing the cilia against the globe, keeps the patient in continual distress and helplessness. To pluck out the offending cilia, however, affords only temporary relief; to extirpate the cartilage is to aim at a radical cure indeed, but by harsh means, of doubtful efficacy; to cut away the entire margin of the lid strikes at the root of the evil, but involves the abrupt division of the meibomian ducts, and subsequent confinement of their contents, while the bald palpebra is incapable ever after of properly protecting the conjunctiva. To pare away the outer palpebral margin, with its row of hair follicles, and leave the meibomian apertures untouched, is difficult, and though an improvement upon the operation last-named, is open to one of the same objections. The mode of treatment most eligible, because as effectual, and less severe than these, is to cut through the misshapen and thickened cartilage by a perpendicular incision with a fine sharp bistoury. The lid is to be everted for the purpose, and the division to be commenced at the posterior border of the cartilage, the whole breadth and thickness of which should be divided, while only the margin of the integument is incised. Upon cessation of the bleeding, it will be found that the entropion exists no longer; the effect of the orbicular spasm being counteracted. The patient consequently

experiences immediate relief, which may be rendered permanent by preventing reunion of the cartilage until its morbid change has, in some degree, subsided, and the irritability and inflammation of the surface of the globe have, under the use of appropriate and now efficacious means, passed away.

The vascular condition of the cornea, produced by a granular state of the eyelid, or that arising from entropion, does not require the adoption of any special measures, beyond those calculated to restore the conjunctiva and the lid to health. It depends, indeed, so entirely upon the morbid change in the last-named part, that we always find it subside and disappear as the palpebra regains its normal condition under the remedies above enumerated.

In conclusion, do not expect a rapid cure in these chronic cases. It is only from a steadily continued course of treatment, and by patient adherence to a regimen calculated to guard against re-awakened inflammatory action in the part, or renewed constitutional disturbance, that ultimate convalescence can be obtained. For sudden and most vexatious relapses, threatening to undo in a few hours the work of weeks, are apt to occur from a seemingly trifling imprudence or exposure. The practitioner must be prepared for these, and not be disheartened at their occurrence; but, as occasion shall require, must bring all available resources successively to his assistance, deeming a cure under such circumstance, contrasted with one in cases of acute disease, at once more creditable and more gratifying, because more difficult of attainment.

CASE IN MIDWIFERY—A MEDICO-LEGAL POINT.

By HENRY DERMOTT, Esq., M.R.C.S.E.

THE subjoined report of a case which lately came under my notice is perhaps useful in a medico-legal point of view.

I was called, on Sunday morning, the 17th of January, 1853, to see Mrs. W—, a young married woman, aged twenty-three, pregnant of her first child, and who did not expect to be confined until the end of the month. When I arrived, I found the child born, and lying on the floor, the cord broken off within about three inches of the umbilicus; there was no hæmorrhage from that portion, but from the placental about a pint of blood had been lost, and was still trickling away. On raising the child, I was surprised to find it strong and healthy, and nothing the worse for its quick transit into the world, other than a large contusion, about as big as an orange, on the front part of the head. The cord was separated as cleanly as if it had been done by an accoucheur. The mother was leaning on a table in the centre of the room. Having placed her into bed, the placenta was expelled after about half an hour. She stated that having been awake from sleep by a pinching in her inside, she got up, and directly on doing so, one pain came on, which expelled the child on to the floor.

I examined the vagina and abdomen, in order to satisfy myself as to its being the first child, and was quite convinced of its being so. The vagina was narrow and muscular, and the external opening small. The child was full-grown, and had evidently reached the natural period.

Now, had this woman reached the water-closet, as was her intention, the child must have been suffocated, and before a coroner's jury the mother would be placed in a very awkward dilemma; and my sole object in reporting this case is for the benefit of medico-legal inquiries, where a point resembling the particulars of this case may be brought into question hereafter.

Charlwood-street, Pimlico, 1853.

OBITUARY. — That distinguished member of the profession, Samuel McCulloch, Esq., M.R.C.S., died recently at his residence, in Duke-street, Liverpool. He had served in Spain, under the Duke of Wellington, as Staff Assistant-surgeon, and afterwards with the army on the Canadian frontier. After the close of the war he practised as surgeon in Liverpool, where his honourable and amiable character, and his professional skill secured to him the regard and respect of all who knew him. He died, after a few days' illness, of a disease of the lungs, produced by exposure to the weather in the course of his professional duties. He was in his sixty-first year, and his father, who is in his ninety-second year, survives him.—At Commercial-street, Newport, J. W. Jones, surgeon, of fever, caught in the discharge of his duties, at the Whitworth Hospital, North Brunswick.