erated by a knife or needle thrust through the sclera between the external and inferior recti muscles, just in front of the equatorial region, parallel to the plane of the iris, and behind the lens. In many cases no fixation forceps were employed to rotate or steady the eyeball, and no loss of vitreous occurred through the small opening in the conjunctiva. Little or no reaction followed, save in exceptional cases; and the application of a protective bandage, and the instillation of atropia, were needed but for a few days.

The facility and thoroughness with which laceration may be done, depend largely upon the position of the membrane in the vitreous. If the membrane is far back, it is more easily reached in the proposed operation.

In regard to the improvement of vision, our author states that laceration of a membrane in the middle or posterior parts of the vitreous always, or nearly always, promises improvement of the sight, if no serious lesion of the fundus is present. If the membrane runs fore and aft in the vitreous, and especially if it is attached anteriorly to the posterior lens capsule, the chances of improving the vision are comparatively slight, though even in such cases, the writer has seen decided improvement in vision following the operation, especially in eccentric vision.

EVISCERATION OF THE EYEBALL.

Prince,¹¹ in an article upon "Evisceration of the Contents of the Globe," states that he early found that the pain was more prolonged and severe than in enucleation, and that the healing was more protracted. He thought the pain due to the effects of pressure and inflammatory irritation on the long ciliary nerves left exposed by the operation, as they run forward in grooves on the concave surface of the sclera. He, therefore, was led, at the completion of the operation, to cauterize the whole interior of the sclera with pure carbolic acid. The use of carbolic, in this way, seems indicated both for its antiseptic and anæsthetic powers.

It closes the tissues subjected to it against the admission of micro-organisms; and it destroys the power of the sensory nerves to give rise to pain.

He advocates packing the scleral cavity with powdered iodoform. After some weeks the mass of iodoform is expelled; but there seems to be some gain in the final stump. In none of the cases packed with iodoform was there subsequent suppuration.

THE ANILINE VIOLETS AS ANTISEPTICS.

Stilling¹² reports several cases of hypopyon-keratitis with deep marginal ulceration of the cornea, in which the healing took place under methyl-violet and auramine so rapidly that he predicts that this treatment will soon replace actual cautery in these affections. He saw immediate improvement in a case of sympathetic ophthalmitis in a boy when the aniline solution (1 to 1000) was dropped in the eye.

Stilling explains the powerlessness of the antiseptics hitherto in use to arrest suppuration which has once begun by the fact that they readily form precipitates, and are not diffusible. Some aniline colors, and particularly the violets, possess, according to Stilling, all the properties of a good antiseptic, as they not only readily kill micro-organisms, but quickly permeate the tissues in which suppuration has taken place. The result of bacteriological experiments, made in conjunc-

tion with Wortmann, was to show that aniline violets retard the development of bacteria, even in such feeble solutions as 1 to 64000. More concentrated solutions (1 to 1000 and 1 to 2000) were found to kill at once the bacteria which might be present, and altogether prevent their further appearance.

Berry¹³ says, in reviewing the above paper: "A therapeutic agent which is brought to one's notice with such a flourish of trumpets must, one would imagine, possess some of the advantages claimed for it. It is hardly likely that others will be able to confirm Professor Stilling's report in all particulars, even although they should hold the same views as to the micro-organismal character of the various inflammations met with in the eye. From some personal experiences of methyl-violet in the solution of 1 to 2000, I can confirm its non-irritating nature and its diffusibility; but I have not seen that it has any power in checking suppuration at all, and, indeed, its antiseptic properties seem to me to be but slight."

Clinical Department.

SUDDEN DEATH PROBABLY FROM OEDEMA OF THE GLOTTIS.¹

BY FRANCIS MINOT, M.D.

THE patient was a lad, seventeen years old, who had always enjoyed good health.

On Monday, October 20th, he complained of pain in swallowing, and was first seen by Dr. Minot on Tuesday afternoon. He was in bed; pulse, 100; breathing perfectly quiet and natural. His only complaint was difficulty in swallowing, from pain. The voice was thick, as if from inflammation of the tonsil. In fact, the left tonsil was swollen, and could be felt from the outside. The palate and fauces were somewhat redder than usual. There was no deposit or membrane to be seen on either tonsil, or on any other part of the mouth or fauces. The temperature at 6 P. M. was 101.8°.

On Wednesday morning, October 22d, the pulse was 84, temperature 100.6°. His sleep had been disturbed by the pain in swallowing, but he felt much better. No exudation could be seen. A puncture was made in the swollen tonsil, but no pus was reached. There was moderate bleeding from the incision, which appeared to afford relief. No fetor of the breath could be perceived. The breathing was perfectly free. He continued to improve in his general condition during the day, and towards evening he got up, of his own accord, dressed, and went down to dinner with the family. He was able to swallow two tumblers of milk, and was in the best of spirits. After dinner, went up to his bed-room without the least difficulty. When seen afterwards by Dr. Minot his pulse was 76, temperature 100.8°. He was very cheerful, and said he felt much better. After going to bed he slept quietly for an hour and a half, and then awoke suddenly with a feeling of suffocation. He went to the bath-room, adjoining, gargled his throat, and returned to bed. He had hardly lain down before he expired.

A digital examination of the mouth and fauces was made soon after death, but nothing abnormal was dis-

¹ Read before the Boston Society for Medical Improvement, October 27, 1890.

¹³ Ophthalmic Review, July, 1890.

¹¹ Journal of the American Medical Association, October 12, 1889.

¹² Revue Générale d'Ophthalmologie, ix, 4, April, 1890.

covered beyond the swollen condition of the left tonsil. There was no autopsy.

The death was evidently caused by some sudden obstruction to the breathing at or near the glottis. It is possible that the case was one of diphtheria, in which the exudation was confined to the larynx, a fragment of the membrane having become detached and arrested at the glottis; but there had been no special symptom of diphtheria, and not the slightest difficulty of breathing until just before death.

A more probable explanation of the sudden death would be œdema of the glottis, the result of extension of the pharyngitis to its immediate neighborhood.

Reports of Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.

G. G. SEARS, M.D., SECRETARY.

REGULAR Meeting, Monday, October 27, 1890,
Dr. W. L. RICHARDSON in the chair.

ANATOMICAL SPECIMENS.

Dr. A. T. CABOT showed a calculus removed from the ureter of a woman through the vagina, and also read a paper on

THE NON-OPERATIVE TREATMENT OF ENLARGED PROSTATE.¹

Dr. F. S. WATSON: There are several things which I would like to speak of in this connection. The large majority of cases which come under one's observation require the non-operative, rather than the operative, treatment, and they form far the more important class of the two. The question as to when to use the catheter, to institute catheter life, is one which I think comes most prominently as the first and most important question. As a rule one has not the choice, for the reason that the patient generally does not seek relief until the symptoms have become very decidedly annoying, and then interference is almost always required. I do not know that an absolute rule can be laid down as to the amount of residual urine which should determine the use of the catheter. The plan which I think a fair one to act upon is that when the residual urine exceeds two ounces, and the patient is suffering from more than one or two calls during the night to urinate, that the catheter should be used, and, if it works well, continued. The quality of the urine is another factor in deciding whether the catheter should be used. Where the urine is clear, and there is no special irritability, and the amount does not exceed more than two or three ounces, then it is safe, with occasional testing to see that it is not increasing, to leave that bladder alone, as a rule, as far as the catheter is concerned. Where, however, there is pus or mucus or blood, the necessity of catheterization is much greater. In regard to the passage of the catheter, there is one little point which is often noticed by the surgeon, and that is that the patient will frequently be able to pass the catheter in one position more easily than in another. One patient passes it more easily lying down, another sitting on the edge of a chair, another standing up; and sometimes the difficulty may be entirely overcome, if there is a slight obstruction to the

passage of the catheter, by change of position. I am very glad Dr. Cabot accentuated the precaution in regard to the beginning of catheter life, with reference to the care with which it should be surrounded, because in spite of all the warnings uttered on this subject, I do not think that that is borne in mind sufficiently. I cannot help thinking that it is a frequent practice, especially away from large medical centres, for the practitioner to keep a silver catheter knocking about in his case, and when a patient comes in with retention, in the most dangerous stage of prostatic enlargement, he takes it out of the drawer, pushes it into the bladder, and empties the whole bladder at once. That I do not think can be too strongly condemned. As Dr. Cabot says, the soft rubber catheter, when possible to use it, should be used. The cleanliness of instruments is another problem which is very difficult, and one very often neglected. The plan I have adopted is to keep the red rubber catheters in carbolic acid, in which they can be kept for years without becoming brittle. I instruct the patient to get one of these tubes in which to keep the catheter. The catheter is washed with warm water before and after using, in order that the carbolic acid may not be too irritating. The form of catheter, which is the one that I think, as a general rule, will pass in more cases where there is a difficulty than any other, is the *coudé* catheter of Mercier. The elbow of this instrument can be made longer than it is by using the stylet of Guyon, which can also be introduced into the catheter in such a way as to make it into a *bicoudé* or double-elbowed catheter. These two forms of catheters, the *coudé* and *bicoudé*, I think will pass in the difficult cases, as no other forms of catheters will. I have never had to use the silver instrument, and I don't believe I ever shall use one. Except in trained hands they are exceedingly dangerous, and are responsible for many false passages. As to the frequency of the use of the catheter once its use has been begun. That, of course, must be determined by circumstances. If the patient has a very irritable bladder, in spite of the daily passage of the instrument, there is no harm in the nature of things in passing the catheter more often. Where no urine can be passed spontaneously, it is well to imitate the frequency of the natural calls to urinate, using the catheter once in three or four hours. It may prove to be harmful, and if it does, other means must be considered, as, for example, drainage of the bladder, cystotomies, etc., that is if the case goes on from bad to worse. The character of the urine as indicating renal incompetence is of the utmost importance, and it is the danger signal in these cases. Low specific gravity and the neutrality of the urine are pretty sure indications that the person with enlarged prostate has damaged kidneys, and that you are going to have trouble ahead. The dangerous class of cases are those that come with overflowing bladders, where there is incompetence of the bladder, the patient coming in that way to the surgeon for the first time. He is almost sure to have damaged kidneys, and whether you catheterize or don't, he is probably going to die. If you catheterize, catheterization gets the blame. A suggestion which Mr. Harrison made is valuable in this connection, and that is aspiration of the bladder over the pubes with a fine needle, which obviates the introduction of air or dirt into the bladder, a thing which is likely to occur, and his suggestion is well worth considering. He has met with marked success in treating these large overdistended bladders

¹ See page 529 of the Journal.