wire, which, after remaining a few days in a wound, stiffens into a metallic ring, horsehair, when cut just aside the knot, either retaining its original elasticity, springs open, or if it has been long soaked in the wound secretions, it becomes soft and pliable. I would recommend the use of this suture for wounds of the eyelid and other parts of the face, and to the loose integuments of the scrotum and penis; since to all these parts I have either applied the suture myself with good effect, or I have seen it used by others at my suggestion.

But I can imagine that there are other uses to which it might be extended, and especially to facilitate the union of wounds of the conjunctivæ. For the purposes of suture, long white tail hairs are the best. Before being used they should be soaked for a minute or two in water, or they may be drawn once or twice through the moistened finger-ends. The suture may be fastened off in a double knot, but if the hair is stiff, a third knot is often required. It may be removed in the ordinary manner, seizing the knot with the forceps, and dividing the suture just aside of it. It is scarcely necessary to remark, that horsehair, as a suture, is not suitable for wounds where there is much tension between the edges.

Bedford-row, 1862.

P.S.—Since writing the above I have been informed that the subject of horsehair sutures has been treated of by Gustav. Simon, but having failed to meet with the publication in question, I am unable to refer to it more particularly.

ON A CASE OF EMBOLISM.

By GEO. FRED. GILES, Esq., M.R.C.S.

G. K.—, aged fifty, a gentleman of delicate appearance, who never complained of ill-health, but in whom an arcus senilis had been noticed, since my first introduction to him—a period of about three years—was attacked in April last with intermittent fever, which resisted treatment by large doses of quinine and subsequently arsenic, but ultimately yielded to sea air; for after three weeks' absence at the sea-side he returned cured of ague, though complaining of excessive debility. I was consulted a few days after his return home in consequence of increasing debility, and some cough; his pulse was irregular; the stethoscope detected a very irregular action of the heart, with a loud prolonged first sound, heard more distinctly to the left of and a little below the left nipple. In Dr. Richardson's valuable work, "Asclepiad," article Cardiac Apnoea, page 247, is so exact a description of the irregular action in my patient's heart, and the cause, that I shall take the liberty of copying it:—

"Turning to the heart, he notices next, in a vast majority of cases, that there is no murmur, and no evidence of valvular obstruction. In place of indications of valvular mischief, there is, however, a sign which is specially symptomatic: this is irregularity of action. In instances where this irregularity admits of analysis, the hesitation observed is found to occur in the systole. There are a few strokes of perfect rhythm, lub—dup—pause; then lub—dup—dup—pause—dup—dup; and now again in rhythm, lub—dup—pause."

I am entirely indebted to Dr. Richardson's work for the correct diagnosis I was enabled to arrive at. The patient now nearly nightly was seized with the most alarming apnoea; his distress was agonizing. There was orthopnoea, and it was for ten minutes or so a fight for life; but a full dose of ether (which experience taught him always to keep at hand) shortened the paroxysm. These symptoms suddenly disappeared; he had no more apnoea; but the orthopnoea continued, and a new and most terrible train of symptoms set in: cedema and coldness of the feet came on; the coldness extended to the knees; a dark-blue line appeared around the toe-nails; vesicles formed on the insteps and up the legs; serum poured out in quantities sufficient to saturate everything placed to collect it; gangrene supervened, and death speedily terminated this wretched existence. It was evident a clot had been pushed on by the current of the circulation through the heart, and had plugged up the aorta in some part of its course.

Autopsy, twenty-four hours after death.—The body was attenuated apparently to the last degree. There was considerable rigor mortis. The head was not examined. The lungs were healthy; the left ventricle of the heart was much dis-

tended; the aortic valves were healthy, with the exception of one, which was a little thickened in the centre; tricuspid valves with numerous small vegetations upon them. The liver was somewhat enlarged; the gall-bladder greatly distended; the left kidney somewhat granular, with a fibrinous depressed patch on its under surface as large as a half-crown. This patch was supposed at first to be a cicatrix from a previous ulcer or carcinoma; but it was shown to Dr. Richardson, who decided that it was fibrinous exudation. On looking for the aorta at its bifurcation, a blue-looking vessel was discovered, supposed, in the first instance, to be a vein; but on dissecting it out, it proved to be the abdominal aorta, half an inch above the bifurcation. It was of the healthy appearance of an artery; but immediately below that point it was quite black. This colour extended down the right common and into the external and internal iliacs, and into the left common iliac, and was owing to a large fibrinous clot filling the vessels. The artery and kidneys were preserved.

The history and course of this case confirm with singular accuracy the recent advances of medical science in regard to fibrinous deposition. First, there is a disease marked by increase of fibrin; there is exudation of fibrin into the vascular organs; and there is deposit of fibrin in the left side of the heart. This deposit suddenly removed, the heart is set at liberty; but the coagulum carried into vessels becoming smaller in calibre, comes at length to a point where it blocks up the circulatory channel, and further deposition takes place, and the whole of the body below the seat of obstruction gradually dies. Finally, the whole body, worn out by the pain and the subsequent exhaustion, dies also. Could we but read a method of treatment as clearly and as successfully as we can decipher the morbid phenomena from their beginning to their end, how perfect in this diseased condition would be the triumph of our art! Let us hope that those who, in the midst of darkness, have cleared the way so far will continue their great work to its accomplishment.

Victoria-park-road, Hackney, Nov. 1862.

A Mirror OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla est alia pro certo noscendi via, nisi quam plurimas et morborum et dissectionum historias, tam aliorum proprias, collectas habere et inter se comparare.—MORGAGNI. *De Sed. et Caus. Morb.*, lib. 14. Proemium.

MIDDLESEX HOSPITAL.

CLINICAL REMARKS ON TWO CASES OF IRIDO-CHOROIDITIS;
IRIDECTOMY; RAPID RECOVERY.

(Under the care of Mr. SOELBERG WELLS.)

CASE I.—James C.—, aged eighteen, applied on August 11th. He was attacked by a severe inflammation in both eyes about two months ago. The left has quite recovered, but the right remains inflamed and its sight much impaired. It presents the following symptoms:—There is moderate conjunctival and sub-conjunctival injection; the cornea is clear; the aqueous humour very slightly clouded; the iris discoloured, and having a few beads of lymph scattered about on its surface, more particularly near the periphery. The pupil is irregular, almost inactive, and attached by several broad adhesions to the capsule of the lens. He does not see "blacks" floating about, but with the ophthalmoscope the vitreous humour is found to be diffusely clouded, so as to render the fundus somewhat indistinct and hazy. He experiences some pain in and around the eye, and considerable pain if the upper portion of the eye is touched in the region of the ciliary body. The tension of the eyeball is normal, and the field of vision good. The sight of this eye is considerably impaired, for he can only decipher the largest print (No. 20 of Jäger). He denies having ever had syphilis, or even gonorrhœa; but his penis is covered