exists to their escape from the bladder when they first appear. To be more explicit; a patient may continue to pass easily and freely all the phosphatic salts precipitated in the bladder for a long period of time, and this, too, even in the presence of some chronic cystitis. There appears to be no risk of aggregation and concretion of the deposit for a considerable time, nor perhaps will there ever be if proper precautions are taken at the outset and continued. The following are the conclusions I have arrived at in relation to this subject:—

1. That, in its healthy condition, the bladder rarely, if ever, retains, but on the contrary expels, all phosphatic deposits.

2. That when the bladder is not healthy, but affected by chronic inflammation, provided it is not considerable nor very prolonged in duration, the power of expulsion is still almost as great as in the healthy organ.

3. That there is a diseased condition of the inner coat of the bladder, in which its ability to expel phosphatic deposit is almost lost, and in which the formation of concretions—and if these are neglected, of stone—is certain to occur. It by no means infrequently happens after cystitis that the mucous coat acquires a morbid condition, which is not so much one of actual inflammation as the result of long continuance of that action. The membrane loses its polish, usually in one or more circumscribed spots, and becomes abraded, roughened, even flocculent, and exudation of lymph sometimes takes place on the surface. This matter, which is extremely tenacious, and to which phosphatic salts strongly adhere, is wholly different, it need hardly be said, from the ordinary and well-known viscid mucus of the bladder. The latter has often been regarded, not without apparent reason, as a mechanical agent for gluing together crystalline particles to form concretions, although I doubt that it acts thus to any considerable extent. The lymph exuded from an abraded spot becomes loaded with phosphates, attaching them to the surface beneath, from which the tenacious mixture is not easily removed.

Let me illustrate the action which takes place thus. Every hospital student knows that if a new gum-elastic catheter be fastened into the bladder and left there, the urine being healthy, no phosphatic deposit will occur during the first day or so, on the small portion of the instrument which protrudes within the cavity of the organ. If, however, the catheter remains for a considerable period, whitish granules will appear on its surface at different points, and these in time coalesce and form an enveloping crust. What is the *rationale* of the action? Simply this: while the surface of the catheter was smooth and polished, no phosphates appeared, but after the urine had partially dissolved and abraded the varnished surface, making it slightly rough, and beginning to expose the fibrous basis of the instrument (a process which takes place much more rapidly in ammoniacal than in healthy urine), the roughened surface determines the precipitation of the salts upon it. The same thing occurs on the surface of the bladder, the urates or oxalates being deposited while inflammation is absent, phosphatic salts when that change has taken place. And thus it is that in the rings of a cut calculus may be seen the history of a patient's troubled life during the period of its formation, quiet intervals showing one form and character of deposit, attacks of inflammation marked by a white phosphatic ring, and so on. Another illustration is furnished by the absence of deposit on a well-made india-rubber catheter, although retained for a long period. Its surface resists the action of urine; if, therefore, the instrument was smooth at first, no precipitate takes place. I have left, in very exceptional circumstances, such a catheter for six weeks without removing it, and then found it as free from deposit as when introduced.

Now, these phenomena explain the reason why cysto-phosphatic deposits in some cases obstinately persist and recur. So long as the mucous lining of the bladder retains its polish, so long as no serious denudation of epithelium takes place, no precipitated phosphates, as a rule, will be detained in the interior, provided the organ can empty itself, or can be emptied artificially. No adhesion of phosphatic material to the wall will result at any point, and consequently the appearance of deposit is not in these circumstances a very serious matter. But—and we shall see hereafter how closely this subject bears on the operation of lithotripsy—the moment the mucous coat of the bladder has notably lost in any one spot its natural polish, has become denuded or roughened, so soon there is danger that phos-

phatic salts will be attached to that spot, and become the fertile and continuous source of concretion-formation in the bladder. If degradation of the tissues has gone far enough to permit the exudation of lymph, the condition approximates to that of ulceration, which, however, is rare in the bladder, and only present in very severe or long-continued disease. An illustration of the action which takes place in such circumstances may occasionally be observed after lithotomy, when the urine deposits on the surface of the wound a phosphatic coating, which adheres sometimes with great tenacity to the exuded lymph there, while no deposit whatever occurs in the bladder itself. In those somewhat rare instances of calculus partially encysted in a sac of the bladder, the small rough surface which is exposed in the cavity acts in a similar manner. Phosphates are deposited upon it, and when the aggregation has assumed a certain size, it is detached, falls into the bladder as a concretion; the process goes on at the original spot, and may be repeated again and again.

I need hardly say that these statements are based on several observations of my own, made from time to time not only on the living but also on the recent subject. Numerous examples in the museum of the Royal College of Surgeons may be referred to as illustrating very clearly the action described and the presence of calculous incrustation on portions of the inner coat of the bladder. Preparation No. 2025 shows its origin in prostatic disease, and is a very good example. Among others I will refer to the following: Nos. 1986–88–89, 2023, 2045, and 2557, the determining causes being stricture, prostatic disease, and calculus.

The relation of this subject to lithotripsy and to specific treatment of the condition will follow in the next paper.

ON THE TREATMENT OF ACNE.

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COMMON ACNE is a disease of the skin which is generally cured without much difficulty, but the severe and inveterate varieties are admitted by all to be both troublesome and obstinate. It is to the treatment of these latter that I wish especially to direct attention.

The foundation of all successful treatment depends on the promotion of a healthy action of the sebaceous glands, and the consequent prevention of comedones; therefore, all very soothing remedies, while they produce a temporary relief to the inflammatory symptoms, do not strike at the root of the malady. The basis of all treatment should be vigorous rubbing with soap and flannel, for friction with soap, more than anything else, prevents the formation of comedones, and consequently of the acne pimple. The following plan of treatment succeeds in a large number of cases:— (1) The face should be steamed every night by holding it over a basin of hot water for a few minutes. (2) The skin should then be well rubbed for five or ten minutes with soap and flannel, or a soft nail-brush may be used with advantage when the skin will bear it; the soap should then be sponged off with warm water. (3) When the face has been dried, a lotion, composed of half an ounce of precipitated sulphur, two drachms of glycerine, one ounce of spirits of wine, three ounces each of lime-water and rose-water, should be thoroughly applied and allowed to dry, and remain on all night. If the skin is greasy the addition of some ether to the lotion is an advantage. Sometimes an ointment is more effective than a lotion; in that case one drachm and a half of hypochloride of sulphur, ten grains of carbonate of potash, ten drops of oil of bitter almonds, and an ounce of lard may be used; or three drachms of sulphur ointment and five drachms of vaseline will be found to be a very useful unguent. Whatever is used should be allowed to remain on all night, and washed off in the morning with warm oatmeal and water or weak gruel. If the skin becomes very tender under this treatment, it may be discontinued for one or two nights and then resumed. The most common cause of failure is want of perseverance or timidity on the part of the patient or doctor, for a temporary increase in the redness and irritability of the skin often prevents the continuance of the most efficacious remedies.

The treatment I have here indicated will be generally successful in dealing with ordinary acne, but will fail in a certain proportion of inveterate cases. In these I find nothing so effectual as the application of potash soap in the form of a lotion well rubbed on the skin every night. One ounce of soft soap, one ounce of rectified spirits of wine, and six ounces of rose water will generally be found of sufficient strength. The lotion should be applied with a piece of flannel, and vigorously rubbed on the skin for as long a time as is convenient, the longer the better, short of making the skin really sore. Then the lotion should be washed off, and one of the sulphur lotions applied and allowed to dry on. Sometimes, after the vigorous use of soft soap, sulphur is not easily borne; in that case the following lotion may be used instead:—Prepared calamine powder and oxychloride of bismuth powder two drachms of each, rectified spirits of wine half an ounce, glycerine one drachm, perchloride of mercury three grains, and rose water to eight ounces. The quantity of perchloride of mercury may be increased if necessary. The worst cases of acne will in time yield to the soft soap treatment.

With regard to general treatment of acne no rule can be laid down that shall be applicable to all cases. Any symptoms of dyspepsia or irregular menstruation may point to a rational plan of treatment, but in the absence of any indications of this kind we may hope to succeed by local means alone. It is not uncommon to find that people who suffer from acne are anæmic, or otherwise below the normal standard of health; in all such cases, iron, either alone or combined with arsenic, will be found useful. In severe cases of acne, associated with chronic dyspepsia, the oxide of silver (one grain in a pill) given twice or three times a day is often beneficial. I find empirically that small doses (ten to fifteen minims) of the solution of perchloride of mercury, in combination with the tincture of the perchloride of iron, or with tincture of chinchona, has a very good effect on many obstinate forms of the disease, even where there is not a possibility of syphilitic taint.

In nearly all cases the local treatment of acne must for a long time be more or less continuous, inasmuch as when left to itself the disease is apt to return, but instead of using the remedies every night it will be sufficient if they are applied once or twice a week.

NOTES ON MIGRAINE OF THE EYE.

By DR. X. GALEZOWSKI.

Translated by A. STANFORD MORTON, M.B.

THERE exist a certain number of ocular affections in which no lesions are to be found, and which might lead one to suspect the existence of some serious malady.

Migraine of the eye, or periodic hemiopia, is marked by very characteristic visual derangements, which it is of great importance to recognise, so that they may not be confounded with serious cerebral or other affections. Migraine of the eye is not so rare as one might suppose, and I have collected observations on twenty-one cases of this complaint.

The symptoms which characterise this affection are as follows:—

1. The complaint generally attacks those who have for several years been subject to ordinary migraine; this latter ceases and is replaced by visual nervous symptoms, which, however, may come on without being preceded by any other nervous symptoms.

2. Migraine of the eye is more frequent in females than males, and occurs at all ages, but I have only twice seen it in individuals as young as thirteen or fourteen.

3. The onset of the attack is not always the same. In some cases the ocular migraine is preceded by headache; while in others, and these are more frequent, the visual trouble comes on quite suddenly, and is characterised either by hemiopia or central scotoma.

4. The hemiopia is either monocular or binocular. The former is sometimes lateral, and at other times it occupies the upper half of the visual field. In the binocular form the field of vision is obscured laterally, either in the right or left half of both eyes; the sight is completely lost in the half of the field of vision; nevertheless the acuity of vision remains almost normal. This hemiopia is only temporary, lasting

from twenty to fifty minutes, and then disappearing completely. Sometimes, however, I have seen it pass into complete blindness, lasting for a brief period; or, again, in other cases it is followed by a slight indistinctness of vision for the remainder of the day.

5. Central scotoma is more rarely the chief symptom of the malady, which maintains this form throughout; but three times I have seen it transformed into hemiopia.

6. Flashes of light, and rainbow colours in zigzag forms, generally accompany ocular migraine. These phenomena are perceived by the patient in the obscured part of the visual field, becoming gradually more and more indistinct, and finally disappearing altogether. Three of my patients said they observed thousands of luminous muscæ and silvery spangles darting about in the darkened field of vision.

7. There may be more or less violent attacks of vomiting preceding or accompanying the migraine of the eye, but these are frequently altogether absent.

8. After the disappearance of all the ocular symptoms, giddiness, more or less intense, comes on, and continues some hours or even days.

9. The scintillating hemiopia is almost always followed by a headache, which continues all the rest of the day, either in one half or over the whole of the head.

10. The eyeball is often painful and tender, the patient experiencing a sensation of weight and tension at the back of the orbit, and occasionally the eye is red and watery.

11. Periodic hemiopia generally recurs at long intervals, once or twice a year only; but in certain cases it is more frequent, and may recur as often as once a month, once a week, or even sometimes twice or thrice a week. In these latter cases there supervenes a disturbance of sight and a sort of asthenopia, which is almost permanent, and renders all work impossible.

12. Ocular migraine is often observed in those troubled with dyspepsia, but this last symptom is not constant; when it exists it almost always indicates the presence of gout, which, as Trousseau and Charcot have well demonstrated, often predisposes to migraine.

13. Periodic hemiopia is observed sometimes in pregnant women, but then it is accompanied neither by scintillations nor by headache. On the contrary, in pregnant women one sees cerebral troubles characterised by a sort of aphasia and by encephalopathy, which may continue for half an hour or longer.

14. Analogous cerebral derangements may also be found in migraine of the eye, but they are relatively rarer and of shorter duration than in the preceding case.

15. Ocular migraine does not present any gravity, and disappears of itself under the influence of a tonic strengthening regimen. The sulphate and bromhydrate of quinine have seemed to me speedily to relieve the symptoms. The employment of ferruginous preparations, the cold douche, and avoidance of all exciting aliments, such as coffee, liqueurs, spices, and such like, may also act efficaciously in accelerating the cure of migraine of the eye.

Paris.

CASE OF OBSTRUCTED LABOUR.

By A. B. MUNRO, M.D. & C.M.

LABOUR may be obstructed by various displacements of the uterus, frequently accompanied by faulty position of the child in addition. One of the most common is found especially in multiparous of relaxed habit, constituting "pendulous abdomen," a malposition usually remedied without difficulty by abdominal support in the supine position during the periods of uterine action. But these means may fail entirely, and in the presence of strong uterine effort, serious results must follow if prompt assistance be not rendered. The following is an illustrative case:—

Mrs. R—, aged forty-four, has borne twelve children; confinements of very short duration (seldom more than twenty minutes), and has frequently got up the following day. During thirteenth pregnancy has had indifferent health, slightly jaundiced, and altogether "had a poor time of it." Began to have pains on Oct. 25th, and called in a midwife. On the afternoon of the 27th I was sent for, as "something was wrong." Pains had recurred more or less all the time, and now there was a discharge of matter resembling me-