The patient had some slight elevation of temperature during the first three or four days after the operation, but otherwise progressed without a bad symptom. The sutures were all removed at the first dressing on the tenth day, when the wound was found perfectly healed, and she left the hospital on the twentieth day.

The details of the operation leave no doubt as to the truly extra-peritoneal nature of the cyst, inasmuch as all attempts made to open into the general peritoneal cavity, either by passing the hand upwards over the upper margin of the tumour, or by endeavouring to effect an opening through the base of the cyst into Douglas' pouch, failed entirely in effecting their object. When attempting the former procedure, Mr. Thornton came upon the cæcum and vermiform appendix completely enclosed in loose vascular connective tissue, and closely applied to the cyst wall. This condition of things was evidently due to the adhesive inflammatory action set up in its immediate neighbourhood by the rapidly growing cyst.

With regard to the question of the mode of development of this tumour, I believe the following to be the true explanation of its origin:—The cystic disease commencing in the outer end of the ovary (whether from a distended Graafian follicle or as the result of an epithelial ingrowth, it is not at present my intention to discuss), probably gave rise to the formation of a true ovarian cyst, lying at first encapsuled in the cellular tissue between the layers of the broad ligament. In the subsequent course of its growth this cyst, distending the layers of the broad ligament, continued to develop in the direction of the least resistance—viz., more or less directly outward—until having reached the seat of reflection of the parietal peritoneum, it gradually opened up the layer of subperitoneal cellular tissue which lies beneath the transversalis fascia lining the abdominal wall, and thus came to constitute a truly extra-peritoneal tumour.

ON SCLEROTOMY.

By C. BADER,

OPHTHALMIC SURGEON TO GUY'S HOSPITAL.

CONTINENTAL oculists, especially De Wecker of Paris, restrict sclerotomy to certain forms of glaucoma. In course of time the operation will, I believe, be adopted in every case of glaucoma. Already von Graefe has been struck by the favourable course of iridectomised glaucomatous eyes with a cystoid cicatrix.

When iridesis was the fashion, leakage of the aqueous chamber beneath the conjunctiva and decrease of tension was one of its undesired consequences. Many sclerotomised patients state that excitement, sleepless nights, grief, &c., which before the operation produced hardness of the eyeball and obscuration of sight, since the existence of staphyloma of the conjunctiva (leakage after sclerotomy) gives rise to a sensible increase of staphyloma, but no more to obscuration of sight.

If, a considerable time after the operation, a vascular zone surrounds the base of the staphyloma the prognosis is not so favourable. De Wecker and others do not make a sub-conjunctival sclerotic flap. It seems to me that the more we secure a staphyloma of the conjunctiva, and through it a leakage of the aqueous chamber, the better. No repetition of the operation will be required if leakage exists.

The incision through the sclerotic should be made close in front of the insertion of the iris, whether the iris be in contact with or adherent to the cornea, or in its normal position, or displaced backwards. Our knife should be guided by our knowledge of the place of insertion of the iris in health; whether the iris be cut through or be displaced beneath the conjunctiva, no heed need be taken, provided the sclerotic be divided in front of the insertion of the iris.

Cases in which the iris had been perforated during sclerotomy seem to recover more rapidly than others; cutting too far backwards through the ciliary region may lead to shrinking of the eyeball.

An important point in the after-treatment is to explain to the patient the necessity for binding up the eyes without exercising pressure upon the eyeball. A soft, black silk

bandage suffices, it gives the patient a sense of security, and excludes light.

Case of Dr. Henry Pain of Cardiff (published with his permission).—Dr. Pain, aged sixty-three, consulted me on Oct. 6th, 1879, for glaucoma in both eyes. He had previously been seen by other oculists. Right eye: tension + 1; bare perception of light with nasal portion of retina; optic disc whitish, apparently swollen; the retinal veins full in the disc and retina; cornea clear; good aqueous chamber; pupil somewhat dilated; fixed media slightly turbid.

Left eye: tension + 2; retina sensitive to light throughout; optic disc deeply cupped, pink; retinal vessels very thin in the disc and displaced; spontaneous pulsation; remainder like right eye.

The patient, highly myopic, had suffered five years ago from albuminuria. I advised sclerotomy at once. On Oct. 10th the doctor consented, and both eyes were operated on under the anæsthetic. The eyes were kept shaded without pressure upon eyelids. He left London Nov. 13th, with good leakage and tension below par.

April 19th, 1880: Tension below par; corneæ clear; pupils drawn upwards; left iris well pushed into the bulging conjunctiva; media clear; optic discs pale-pink, flat; no trace of cupping—i.e., no trace of displacement of retinal blood-vessels in their course across the disc. Perception has returned to the entire right retina, and even large objects can be recognised.

Left eye reads well without glasses No. 2½ of Snellen's type at four inches.

Finsbury-circus, E.C.

A CASE OF

FATAL ULCERATION OF THE DUODENUM, PRODUCED THROUGH SCALDING BY HOT WATER USED AS A HÆMOSTATIC.

By J. R. GREENWOOD, M.R.C.S.

IN February, 1880, I was consulted by J. H—, aged forty, a commercial traveller, relative to an epitheliomatous growth on the penis, which he stated had first made its appearance some two years before, since then he had suffered considerable pain. The glans and prepuce were now completely lost in a large mass of ulcerated warty granulations, which constantly discharged a thin sanious fluid, having a most offensive odour. There was very slight glandular enlargement, and the patient experienced little, if any, difficulty in passing his water; he stoutly denied ever having had syphilis, but owing to the presence of some very suspicious scars on his legs and thighs, I felt much inclined to doubt his statement. I strongly advised him to let me amputate the penis before the growth should have invaded any more of its substance, but it was some weeks before I could obtain his consent.

On the 29th of March, the patient being brought fully under the influence of bichloride of methylene, administered by my father, I amputated the penis about an inch beyond the pubes in the usual manner, leaving the urethra projecting slightly beyond the dorsum. The patient passed a good night after the operation, and when I saw him the next morning was in a very satisfactory condition. During the morning, however, I was suddenly summoned to him, and when I arrived found him bleeding profusely from the wound; as he was rapidly becoming collapsed, I despatched a messenger to my surgery for some perchloride of iron, and in the meantime endeavoured to check the hæmorrhage *secundum artem* by cold water and vigorous pressure. When the perchloride of iron arrived I found—as has usually been my experience with this much-vaunted styptic—that it was of absolutely no avail in checking the hæmorrhage. Matters had now reached a crisis when it suddenly occurred to me to employ the method advocated by Mr. Keetley, of St. Bartholomew's Hospital, of sponging the bleeding surface with hot water; I did so, and in a very short space of time had the satisfaction of seeing the bleeding entirely cease.

My pleasure at this fortunate result was destined to soon change into a feeling of anxiety, for when I visited

my patient at night he complained of great pain and uneasiness in the part, which decidedly wore a very unhealthy appearance. The next day I found that he had passed a very bad night, a hypodermic injection of morphia which I had administered the previous evening having afforded him very little relief, whilst one or two small sloughs had made their appearance on the surface of the wound. When I dressed the parts again at night the prognosis was still more grave, for the sloughs had greatly extended, and now threatened to involve the remains of the penis. Early next morning I was sent for in a great hurry, as he had been suddenly seized with acute pain in the abdomen with vomiting. I found him with feeble pulse, cold extremities, anxious countenance, and temperature 101° F. The bowels were also confined. As the vomiting was persistent I gave him an effervescing mixture with hydrocyanic acid and ammonia, also castor oil to relieve the bowels. When I called again towards the evening peritonitis was evidently present, although there was complete absence of the characteristic drawing up of the knees. The bowels were still confined, and I twice used turpentine enemata to relieve a distressing tympanites which, from its amount, evidently interfered with respiration. The sloughs had now extended to the scrotum and skin over the pubes. Temperature 102.5° ; pulse 130. The next morning I found that he had had no sleep owing to the intense pain, vomiting still continued, and the peritonitis was well marked. Temperature 105.8° ; pulse 148. I now began to suspect some intestinal lesion (probably obstruction), and consulted with my father as to the best course to take; we eventually decided to operate for the relief of the supposed obstruction without delay, as the patient was now (3.30 P.M.) in a very precarious condition, the temperature having steadily risen to 106.3° . On returning to the patient's house half an hour afterwards to perform the operation we found that he was just dead. It appeared that he had suddenly started up in bed a few minutes before, gave a kind of gasping shriek and fell back dead.

With some considerable difficulty I obtained permission to make a post-mortem examination, and on opening the body forty-eight hours after death the appearances were as follows: Heart hypertrophied, weight 18 oz., valves healthy; firmly adherent pale clots in all the cavities and extending into the great vessels. Lungs much congested and oedematous. Bronchial mucous membrane red and thickened. On opening the abdomen a large quantity of opaque greenish stinking fluid escaped; a large pale clot was seen lying near the duodenum, on pulling which aside a rent through the peritoneum was discovered, near the head of the pancreas. On opening the duodenum a deeply-indented elongated ulcer with a well-defined margin, about an inch long and half an inch broad, was seen. It commenced half an inch from the pylorus, the gastro-intestinal mucous membrane being otherwise healthy. All the coats of the intestine were destroyed, so that the pancreas formed the base of the ulcer, whilst the pancreaticoduodenal artery, from which the clot proceeded, was distinctly seen crossing it. The visceral layer of the peritoneum was everywhere vascular and opaque, the parietal layer being coated with soft lymph. The rent into the peritoneal cavity was close to the margin of the ulcer, and doubtless took place when the patient shrieked out immediately before death, since none of the contents of the duodenum had escaped. The liver weighed over five pounds, and was gorged with bile. Spleen large and soft. Extensive granular degeneration of both kidneys was present. From the condition of the penis and scrotum it was evident that had the patient survived a short time longer they would have entirely sloughed away, leaving the pubes completely denuded.

The patient's wife was positive that up to the time of seizure he had never complained of any abdominal uneasiness, and the question therefore arises, To what was the duodenal complication attributable? From some hitherto unexplained cause *burns* often occasion duodenal ulcers: now I am of opinion that my patient received as great a shock to the system as a burn would have occasioned from the *scalding* produced by the application of the hot water to such a recent wound; the general condition of his internal organs being, moreover, in a most unsatisfactory state to resist such a strain at the time. In the absence of all proof to the contrary, it appears to me I have good ground for assuming that scalding by the hæmostatic itself—which undoubtedly caused the sloughing of the wound—was also the cause of the ulceration of the duodenum.

Canonbury-square, N.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

GUY'S HOSPITAL.

RUPTURED HÆMATOCELE OF THE TUNICA VAGINALIS;
INCISION; CASTRATION; RECOVERY: REMARKS.

(Under the care of Mr. R. CLEMENT LUCAS.)

THE following report is from notes taken by Mr. C. J. Griffiths. The case was dressed by Mr. Marsh.

J. R—, aged sixty-three, was admitted on Dec. 9th, 1879. He was a labourer employed in gas-works, and had been a free drinker. He said that forty years ago he had a hernia on the left side, which became strangulated, and was operated upon. Since then he had worn a truss continuously. He gave a somewhat indefinite account of the previous condition of his scrotum, but it would appear from what he said that it was generally large, that it swelled at night time, and was larger on the right side than on the left. He had never been tapped.

On Friday, Dec. 5th, he felt ill and giddy, and was troubled with flatulence. On the 6th, when at his employment he perceived that his scrotum began suddenly to swell, and he was compelled to leave off work. The scrotum continued to increase in size during the whole of the next day, and on the evening of the 9th he was conveyed in a cab to the hospital, not being able to walk.

When admitted the scrotum was enormously distended, tense, and of a dark, purplish-red colour. The swelling was about the size of a man's head. Mr. Clement Lucas, who was called to see him, determined to operate at once, as there was evident danger that the scrotum might slough. Chloroform having been administered, an incision six or eight inches in length was made from the neck to the base of the scrotum. A large quantity of blood was found extravasated into the cellular tissue of the scrotum, after which the tunica vaginalis remaining distended behind was carefully incised. The vaginal sac was found greatly thickened, in parts atheromatous, and contained calcareous plates. Its cavity was distended by old and recent blood-clot. An attempt was then made to dissect away the thickened and degenerated tunica vaginalis, but this being found impossible, the testicle with its coverings was removed after a stout ligature had been applied. The operation was performed under carbolic spray, and antiseptic dressings were afterwards employed.

The patient suffered very little from the effects of the operation. His temperature remained normal until the 12th, when it rose in the afternoon to 101° F., but soon fell again to normal.

He went on satisfactorily with the exception of a little constipation, and on the 22nd the wound had a healthy granulating surface, with slight discharge.

On Jan. 7th the patient was allowed to get up for a short time. His general health was good. He ate and slept well, and his bowels were regular.

By Feb. 4th the wound had healed, and the patient left the hospital.

Remarks by Mr. LUCAS.—This case was exceptional, and difficult to unravel clinically, but the operation served to clear up its pathology. The patient's history was scarcely trustworthy, for he at first said there was no previous swelling, then admitted that there might have been. The result of the operation proved conclusively that an old hæmatocele had long existed, and it was by the giving way of this that the enormous extravasation occurred. The original cause might have been a long-forgotten blow, or possibly it might have commenced insidiously from the rupture of a degenerate vessel. However this may be, the immediate cause of his seeking advice was more evident. A new outflow had taken place into the cavity of the tunica vaginalis, and the walls of this being degenerated, yielded to the increased