to use with great satisfaction and profit the eye mirror, any more than to employ the laryngoscope, the endoscope, or the sphygmograph. Perhaps we all do not realize that the laity are learning the use of the ophthalmoscope simply as a scientific instrument. If you will visit the physical laboratory of the Institute of Technology in this city, you will see there a large hall filled with students at work at separate tables, each solving practically some physical problem with the instruments in his own hands. At one table you will find the ophthalmoscope, and the student's problem is to learn its theory and use, and finally draw a picture of what he observes through the instrument in the model of a human eye, the interior of which he can see in no other way than by means of the eye mirror he has before him. Now that student may hereafter be the engineer employed to survey and lay out a railroad through your town or village. Would it not be a little mortifying if he could look into the eye of your patient, one of his workmen, and tell you the piece of steel was still bedded in the globe, whilst you had promised the man his future sight because you judged the portion of metal had flown off from the eye and not penetrated it.

Finally, I would draw your attention to what may have escaped observation, namely, that the ophthalmoscope next to the microscope has done so much towards elevating and forwarding medical study and practice, by offering the means for and requiring better, closer and more truthful observation, more careful and more thoughtful deduction from such observation, and hence more intelligent and successful practice. We must all remember that the best distinction we can show the community between educated physicians and the hosts of quacks and pretenders is the wide gap between their ignorance and our striving for knowledge and truth. The wider and deeper we make this gap, the easier will it be for us to gain the confidence and retain the respect of our communities. The ophthalmoscope should be a powerful adjuvant in this.

Of the many books and various forms of instruments, as well as methods and means of study in ophthalmoscopy, I did not propose to speak, and therefore have said here nothing concerning them.

15 Chestnut Street.

CONGENITAL CYST OF THE NECK.

By W. C. B. FIFIELD, M.D., Dorchester.

IN reading recently a thesis of M. Paul Boucher, entitled "*Etude sur les Kystes Congénitaux du Cou*," my recollection reverted to a case of congenital cyst of the neck occurring in my own practice and published many years ago in the JOURNAL.

The case did not receive much attention at the time, but it seems to be unique among the cases recorded, and as it overthrows the differential diagnosis of M. Boucher I shall ask a republication of it.

M. Boucher divides congenital cysts of the neck into two classes, simple and composite. Of the simple, he gives the following description: "Simple congenital cyst of the neck presents the appearance of a tumor variable in size and extent. In some cases it does not exceed the size of a pullet's egg, in others it occupies the whole lateral part of the neck, and sometimes encroaches on the cheek. It is invariably found on the left side of the neck. (Why on the *left* is unknown. Let us recall here the statement of Malgaigne that the left half of the body presents defects of conformation or foetal lesions more often than the right.) More prominent and better defined when it is small, it spreads itself out, and seems to have its boundaries less clearly marked when it is more voluminous. We can, however, assign as extreme limits—upwards, the border of the lower jaw; downwards, the clavicle; inwards, the median line; outwards, the sterno-mastoid muscle. It is composed of a single sac, but this may be incompletely partitioned by trabeculae which radiate from its posterior wall. The walls are very thin and fluctuation is distinctly perceptible. It is invariably situated on the anterior part of the neck, *i. e.* in front of the sterno-mastoid muscle. It does not appear to affect the health and well-being of the child, and is unaccompanied by any other malformation. Any interference by operations, undertaken for its removal or for obliteration of the sac, by stimulant injections, is fraught with the greatest danger to the life of the patient.

"Composite congenital cysts are distinguished from the simple, first, by their situation. Simple congenital cysts, always superficial, are *never* situated elsewhere than on the anterior lateral part of the neck. Composite cysts, on the contrary, lie deeply and show themselves both on the anterior and posterior part of the neck. Between these, also, a great difference exists. Pos-

terior cysts are commonly found upon infants born before term, and are accompanied by some defect of conformation, while those of the anterior part are found upon children born at full term, of good health, and without bodily deformity. Anterior cysts are often large, and most frequently occupy both the anterior (meaning by anterior the middle line from the chin to the sternum) and bi-lateral portions of the neck. Posterior cysts occupy by preference the median line, extending on each side of the vertebral column. In some cases, however, they proceed from one side of this line and reach even to the acromion. Not fairly fluctuating, composite congenital cysts present irregularities to the touch, being apparently solid in some parts and soft in others. They are irremediable by any operation. The diagnosis must lie between adult hydrocele of the neck, for the simple cyst; between ranula, cysts of various contents below the chin, congenital goitre, cystic goitre, and congenital cysts of the thyroid, for the anterior composite cysts, and between spina-bifida and encephalocele for the posterior composite cyst."

M. Boucher gives no record of either simple or composite cyst extending into the axilla.

Cæsar Hawkins, in his article on "A Peculiar Form of Congenital Tumor of the Neck," alluding, probably, to the composite cyst which so resembles ranula, says that he was at first inclined to believe that these cysts resulted from the obstruction of the conduits of the parotid and sub-maxillary glands, but he rejected this opinion when he saw a congenital tumor of many cysts occupying the axilla.

The case reported by me in 1860, entitled "Congenital Cyst," not only presents some points that invalidate M. Boucher's plan of diagnosis, but is unique in the extension of the cyst to the axilla. It is interesting to remark that, at the time of publication, a correct plan of treatment was given, that of expectancy, combined, if necessary, with capillary punctures; notwithstanding the success claimed at that time by M. Roux, of Toulon, for injections of iodine, but which are shown by M. Boucher to have been obtained only after repeated attempts, great suffering and most serious risk of life. Simple hydrocele of the neck in adults is another matter.

An ambrotype of the patient is still in my possession and is worthy of being photographed.

On the 7th of April, 1859, I was requested to see a new-born child in Braintree.

The child presented, in the *left posterior* cervical region known as the left posterior mastoid triangle, a tumor more than equaling the size of the two closed fists. It was tense, fluctuating, seemed entirely subcutaneous and overhung the shoulder of that side, rolling and swaying about with the motions imparted to the child. Within the axilla of the same side was another tumor of the same appearance as the first, but much smaller, evidently containing fluid. By pressure on the cervical tumor, the axillary tumor could be distended, while the first became flaccid, and *vice versa*. The liquid did not flow through any subcutaneous channel, but seemed to pass directly through the shoulder, in the space between the scapula and clavicle, by a narrow neck like that connecting the two globes of an hour-glass. My interest in the case was so much excited that I invited my friends Drs. J. B. S. Jackson and Calvin Ellis to see the child. They kindly consented, and came to Braintree. I understood Dr. Jackson to say that he had not met with a parallel case. The tumors were then much more flaccid than at birth. Day by day they decreased in size until they were scarcely visible. Thus they remained until January, 1860, nine months, when they again began to enlarge, until having almost reached their original size, I was requested to see them. The superior was now, as it had been before, the largest. They were quite hard and gave to the touch a feeling as if the finger was passing over the foetal surface of a placenta. They were tender, and the child cried with pain when they were handled. On Wednesday, last, I again saw the child. The superior cyst had suppurated and was discharging a rusty-colored pus. The child had no bodily deformity. The tumor disappeared and the patient is now (1872) a well grown boy. At the time of the report of the case, I remarked that it might be appropriately called congenital hydrocele of the neck. In M. Boucher's thesis, published in 1868, I find that Wernher had given the name of "congenital hygroma of the neck" to these cysts, not making the division of simple and composite. Under the title *Cou* in the *Dictionnaire de Médecine*, M. Maunoir gives cases of hydrocele of the neck, but makes no mention of congenital cysts. At the time of this case, I was unable to find any allusion to cysts of the neck in new-born children. The *London Lancet* of Dec. 10th, 1859, contained the following paragraph:—
"Injection of Congenital Cysts of the Neck with Iodine.—At the last meeting of

the Société de Chirurgie, M. Boinet related the particulars of the success of M. Roux, of Toulon, in treating multilocular cysts of the neck by puncture and injections of iodine. The patients were newly-born children, and the success highly encouraging." I then added, "Since, however, children may readily attain the age of three or four years without suffering, there are many reasons for postponing the operation. If the tumor gives inconvenience, occasional capillary punctures will give relief."

This seems to be the opinion of M. Boucher, both for simple and composite cysts, that any operation is inadvisable.

My case conflicts with the diagnosis of M. Boucher in several particulars. 1st. Simple congenital cysts may appear in the posterior region of the neck, 2d. They may exceed the boundaries given by M. Boucher, and appear in the axilla. 3d. Contrary to the proposition of M. Boucher and Herr Wernher, a posterior cyst may be found in a child born at term and presenting no deformity of body. Lastly, the result shows the good effects of an expectant mode of treatment.

ABSORPTION OF RETAINED PLACENTA.

By A. D. ROBINSON, M.D., Island Pond, Vt.

Mrs. T., multipara, aged 37, became pregnant about the middle of October, 1871. On the first of March following I was consulted by her husband, who informed me that his wife had symptoms of threatened miscarriage. I did not see the case, but the usual advice and remedies touching cases of like character were prescribed. Four weeks subsequently I was summoned to visit Mrs. T.; found her suffering from quite a profuse uterine hæmorrhage, attended with considerable gastric disturbance and vomiting, but no uterine pain.

My suspicions having partially framed a diagnosis in advance, I was not a little surprised to receive the following history from both the lady and her husband. I was informed that on the evening following the day on which Mr. T. called on me for the prescription for his wife, soon after retiring to bed, she was delivered of a four months' foetus, with—to use her own language—very little pain or inconvenience, but that no afterbirth followed the discharge of the foetus. Mrs. T. also informed me that her confinement to the bed was comparatively brief from the moment of her miscarriage, and that she had enjoyed a good degree of health, so that she had attended

to her own household duties up to the time of her attack four weeks subsequently.

Suspecting that the undischarged placenta might have been thrown off through decomposition, in a fluid form, questions bearing on such a result were asked, but with positive assurance that less discharge existed than at a birth of full term, and attended with no unusual amount of foetus.

On examination of the uterus, I found a shortened neck and unnaturally large fundus, furnishing almost indubitable evidence of its having recently contained a foetus, and that it still held within its walls some foreign body, which I had good reason to believe was a placenta, or some portion of one. But, suffice it to say, our patient was relieved of the vomiting by a laxative enema, which brought away a considerable quantity of hardened fecal matter; and of the uterine hæmorrhage by opiates and rest.

From this hour Mrs. T. gradually recovered; and, if we may accept her evidence to verify the fact, no placenta has been thrown off, either entire or in part, and she still continues in the enjoyment—so far as I know—of perfect health. I may add still further with propriety, that she is a person of unusual intelligence and reliability, and in every respect irreproachable character, which goes very far to strengthen her observation of the case.

I have thus furnished to the profession a brief history of one of those freaks in obstetric practice which would seem quite incredible were it not that cases of similar import have been long since met with. As the question of absorption of a retained placenta is still *sub judice*, an accumulation of evidence may still be necessary to clear up this among other anomalous cases of obstetric surgery.

September 20, 1872.

In the treatment of erysipelas, Professor Broca recommends the application of collodion upon the skin above the part attacked. The layer of collodion, which is to be on sound skin, should be from six to eight centimetres wide, and forming a complete circle, separating the healthy skin from that attacked. A slight circular compression is thus produced, and it is rare for the disease to cross this barrier, behind which it speedily fades. The part should be examined once or twice a day, in order at once to repair any fissures, and the collodion should be quite pure, without any oil, which is sometimes added to it.