with moderate force, the compressions being made to imitate the systolic and diastolic action of the heart. In 31 cases, or 70%, life was restored. In chloroformed dogs under the same conditions, 76%, and in dogs shocked by the electric current, 14% were brought back to life. An attempt to try massage of the heart was made on the body of an alcoholic who had committed suicide by hanging, but without success, as might have been expected.

Statistics gleaned from various sources at home and abroad by Prof. Wm. W. Keen, show that of 28 cases of apparent death in the human being, during chloroform narcosis, 42 recovered by massage of the heart. But this treatment should not be relied upon alone. Artificial respiration should also be carried on and the patient should receive sufficient oxygen. For the purpose of restoring vasomotor tone adrenalin should be employed.⁶

In the great zeal to collect statistics on this interesting subject, doubtless many of them come from the same sources. Thus Lanermant has collected 25 cases of whom 4 were restored to life.⁷

Mauclair and Zezas report 28 cases with 6 successful results.⁸

Three methods are employed to do massage of the heart:

1. Incising the anterior wall of the chest so that the hand can grasp the heart.

2. Incising the diaphragm and then passing the hand up from the abdominal cavity.

3. Seizing the heart through the diaphragm without cutting it. In syncope the diaphragm is relaxed enough to render the last method easy. It has given the greatest percentage of recoveries (5 out of 9). It is the least mutilating and the only one that should be employed. Although the number of deaths seems large it should be remembered that all the cases saved would doubtless have died without the use of this method.

When babies are born, if their respiration and circulation are at fault, they are promptly rubbed and slapped without waiting for a diagnosis and usually with the result of bringing them around all right. So the poet of the future may have a chance to express himself with regard to massage somewhat as follows:

When this world you enter if you're gasping for breath,
'Tis the first thing they do to save you from death;
If too soon you would leave this terrestrial sphere
'Tis the last thing they do to keep you long here.

PULSE-PRESSURE ESTIMATION.

BY JAMES J. PUTNAM, M.D., OF BOSTON.

HAVING been interested for some time past in the measurement of pulse-pressure, and having striven to find the best method of estimating its degree by the finger, in the absence of instruments, I have decided upon the following plan as decidedly preferable to any other and as sus-

ceptible of being made, through practice, of much value.

The physician, placing himself opposite to his patient, should lay the pulp of his extended (right) forefinger over the patient's (right) radial artery, at the same time interlocking his forefinger and thumb with the forefinger and thumb of the patient's hand. With his disengaged (left) hand, the physician should then grasp the patient's relaxed arm, just above the elbow and just below the swell of the biceps, in such a way that with his thumb he may compress the patient's brachial artery against the underlying humerus, while with his fingers he may make counter-pressure on the outer portion of the arm. It becomes, then, very easy to estimate just the amount of muscular effort that is required to close the brachial artery so that the pulse is no longer to be felt by the finger at the wrist, and this effort measures the maximal pressure of the pulse. Even the minimal pressure, that is, the point at which the impulse in the two arteries becomes the same as the compressing thumb is raised, can be estimated better with the aid of the brachial artery, in this fashion, than with the radial alone, and fairly well, provided the physician has been accustomed to take such pressures accurately with an instrument suited for the purpose.

It is astonishing to find what a difference there is between the tension which the compressing thumb and fingers must overcome in the case of a compressible brachial artery and that in the case of an artery altered through hypertrophy. In well-marked arteriosclerosis the amount of pressure required for complete closure may be so great that the effort exerted in overcoming it must be considerable.

New Instrument.

A NEW DEVICE FOR ADJUSTING THE FOREHEAD MIRROR.

BY WILLIAM E. CHENERY, M.D., BOSTON.

IN operating on the nose and throat I have often desired some form of appliance by which the forehead mirror could be easily and aseptically adjusted. It has been customary to use pieces of aseptic gauze, but this has not been wholly satisfactory.

It occurred to me that a steel spring clamp might be made which could be boiled with the other instruments, and when needed slipped on to the side of the mirror and left there during the operation, thereby giving the operator an aseptic handle which he could use at will to move the mirror in or out of position.

I have had several made and perfected and now present this one which I have called the universal head mirror adjuster.

All users of the forehead mirror will appreciate it. It may be easily applied, fits large and small mirrors and will cling tightly so that the mirror

⁶ Ther. Gaz., Philadelphia, April 15, 1904.

⁷ Rev. de Chir., No. 3, 1906.

⁸ Ibid., 111, i, 1906.

may be moved in any direction. During ordinary examinations it may also be used so as to

avoid finger prints on the mirror. This will be appreciated by many patients.

The instrument should be applied opposite the attachment to the headband.

Codman and Shurtleff have made the adjuster for me.

Clinical Department.

THE OCULAR AND GENERAL SYMPTOMS IN NASAL OBSTRUCTION. THE REPORT OF AN UNUSUAL CASE.

BY HARRY C. PARKER, M.D., BOSTON,

Clinical Assistant, Massachusetts Charitable Eye and Ear Infirmary; Instructor in Ophthalmology, Tufts College Medical School, etc.

AFTER reading Dr. Posey's exhaustive article presented before the Section on Ophthalmology of the American Medical Association in July, 1905, one feels there is little new to offer, showing the intimacy of the relation between the nose and its accessory sinuses and the eye. Although his article dealt with "The ocular symptoms of affections of the accessory sinuses of the nose," I wish he had given more space to those cases of simple nasal obstruction which give rise to ocular symptoms, as severe, and certainly as hard to combat without operative interference, as those of sinus troubles. I refer to the ocular symptoms caused by enlarged turbinates, spurs, deviations of the septum, etc.

There is rarely a day passes in the refraction room of the Massachusetts Charitable Eye and Ear Infirmary without the appearance of several cases which, from the character of their symptoms and the nature of their refractive errors, suggest the necessity of a nasal examination. In this connection I should like to state my hearty agreement with Dr. Edward Jackson in his dis-

cussion of Dr. Posey's paper as to the difficulty of recognizing sinus disease. I wish to call attention to the equal difficulty in recognizing cases of simple nasal obstruction, for many cases are reported back as negative by the rhinologist where, from the nature of the symptoms, you are sure a pathological condition exists in the nose, and which will usually be revealed at some subsequent examination.

The greater number of nasal cases have, at some time or another, definite eye symptoms, and the time has come when the oculist must insist, in order to get good results, on the intelligent co-operation of the rhinologist, or else be himself forced to treat the nasal conditions which give rise to ocular symptoms of greater or less severity. Few rhinologists recognize the fact that simple soft turbinate contact with the septum will, in many individuals, give rise to symptoms which will not be relieved at all, or only in part, by correcting errors of refraction or defects in the muscle balance.

The case I wish to report is of interest from the severity and the unusual character of the symptoms presented both ocular and general. My notes follow:

February, 1906. Mr. E. R. consulted me in regard to persistent diplopia and vertigo. His age, forty-one years, married, two healthy children. No history of wife having had a miscarriage. Had always been a hard worker. General health always excellent up to 1899. Denies gonorrhea or syphilis. Myopic as long as he could remember, and had worn glasses constantly from his early youth. His eyes had given him no trouble beyond the handicap of his myopia until 1899, when he developed diplopia. I wish to state here parenthetically that Mr. R. is a man of keen intelligence and not of the neurasthenic type. His diplopia at that time varied in amount for 20 to 60 prism degrees according to the notes of his oculist which he had with him. The diplopia was homonymous, *i.e.*, esophoria, which in itself is extremely unusual in as high a degree of myopia, and his binocular vision was always obtained readily with prisms. His myopia was at that time uncorrected. He was wearing O.D. — 13.00 S. — 2.00 cyl. x 180°. O.S. — 12.00 S. — 2.00 cyl. x 180°. — So full correction — 15.00 S. — 2.50 cyl. x 180°. out was given, combined with a 6 Δ° base out in both eyes. This produced a great discomfort increasing, if possible, diplopia and caused general symptoms, or at least general symptoms appeared at this time, such as numbness of the face, abdominal shooting pains, and the loss of muscle reflexes. He was allowed to wear his weaker lenses without prisms. His case progressed with little or no improvement, so he was taken to an alienist, who examined fully into his history as his oculist had done, and a constitutional cause of any sort could not be found. The slightest chance of syphilis denied except from possible innocent cause, about which the patient had no knowledge. He was told he had irregular tabes, advised to give up business and either rough it out West for a year or go abroad. He chose Europe and shortly after his arrival consulted a prominent oculist in Germany, who insisted he had syphilis and proceeded to give him a severe course of mercurialunctions, potassium iodide, which by the way he had had in teaspoonful doses three times a day before leaving this country, and quantities of Bland's pills. This heroic treatment succeeded simply in the