body is not always clean and to extract it by a method which makes a new path through the vitreous increases the liability of infection, and is not, therefore, a scientific procedure. It should be extracted by the shortest possible path, and after localization we know just which path to choose. The incision should be made with a sharp knife and the conical tip of the magnet should be placed against the lip of the wound and patiently held there until the foreign body presents itself. He regards this as the ideal method since it causes a minimum of traumatism at the hands of the surgeon. We should hold as an aphorism that it is bad surgery to introduce instruments of any kind into the vitreous when it can be avoided. To insert the long strip of magnet deeply into the vitreous is, to his mind, an illogical and certainly a most dangerous procedure, and one which in his experience in the majority of instances has been unnecessary. He mentioned a case seen in consultation in which the foreign body had been located by Dr. Sweet. The surgeon asked Dr. Risley's advice as to the locality for incision and he suggested a point nearest the foreign body as shown by the localization chart, but he disagreed and made the incision on the opposite side of the globe and inserted a long tip so that the foreign body was pulled entirely across the vitreous chamber. As to the question of polarity, Dr. Risley has seen a foreign body, a sliver of bright metal 8 mm. in length, reverse itself, end for end, and then approach the magnet, emerging at the original wound of entrance. It was in the anterior segment of the eye and could be readily seen through the widely dilated pupil.

DR. WM. H. WILDER, Chicago, emphasized the matter of radiographs in these cases. He thinks that many of us are prone, as soon as we suspect the presence of a foreign body in the eye, to apply the magnet at once, and it may be in some cases with disastrous results. It is often used in this way to make a diagnosis. He feels sure from experience that this should not be done, and he has seen one or two striking instances in which he was unable to demonstrate the presence of a foreign body. In one case there was a piece of steel as large as the end of a lead pencil. It had penetrated with a remarkably small wound and had pierced the posterior coat of the eye and lodged against the optic nerve. The patient experienced no sensation whatever when the most powerful current was applied. The eye subsequently had to be enucleated. He thinks that in many cases if the surgeons were more careful to obtain a radiograph, and especially by means of some apparatus for localizing the foreign body, there would be less injury to the eye than by at once applying the magnet. He agreed with Dr. Risley that the shortest course that we can have the foreign body pass through is preferable to the method of removing it through the anterior chamber.

DR. EDWARD JACKSON, Denver, recently saw a case with Dr. Stevens, in which a splinter of steel was seen hanging back of the lens, with a wound of entrance showing in the cornea, anterior capsule and posterior capsule. We extracted the splinter with the Johnson magnet through the sclera and the lens has cleared up completely.

DR. T. J. MCCOY, Los Angeles, stated that during the last ten years he has had charge of five different roads and has had to do with a great many foreign body cases. Because of unprincipled attorneys they have to be extremely careful in the location of foreign bodies and have instituted a system; first the *x*-ray is used; second, the written consent of the patient for removing the body is obtained, because disastrous results may sometimes occur. Without that they will not have anything to do with it. Experience points to the fact that the best results are obtained by making the incision nearest to the location of the foreign body. In one case the accident was due to the explosion of a cartridge at twenty feet distant and the patient was struck in the eye. It was impossible to tell whether the foreign body was there because of the hemorrhage. It was located with the *x*-ray and was removed. In another case in the last three weeks a miner was struck with a stone; it was located with the *x*-ray and removed. In dealing with these cases among these miners, mostly foreigners, the physician must be very careful to secure consent first before operating.

DR. WILLIAM M. SWEET, Philadelphia, believes that there is

a class of old injuries in which the metal may be allowed to remain so long as it is not causing any symptoms, and the patient understands the importance of prompt treatment in the event of trouble. Patients frequently seek advice for the removal of a traumatic cataract, and are surprised to learn after *x*-ray examination that a foreign body is in the eyeball. An attempt may be made to remove the body with the magnet point placed at the lips of a small incision in the sclera, and in the event of failure the body may be allowed to remain if all reaction following the operation subsides. Numerous insertions of the magnet point into the vitreous in the hope of securing the body from the firm exudate in which it is possibly imbedded may ultimately succeed in removing the metal. Dr. Sweet would rather leave a piece of steel in the eyeball than a piece of copper. He thinks that the tabular statement of the eyeballs least worthy of study, as it indicates in each instance the cause of failure to preserve the globe. A certain number of eyes had to be removed because of the severe traumatism from a large-sized foreign body, but the larger proportion were lost from delay on the part of the attending physician in recognizing the possibility of a foreign body having lodged in the ball. If these cases were seen earlier the results of operation would be more favorable. In compiling the summary of the tabular statements no figures were presented of the results achieved by other operators, since it is practically impossible to draw satisfactory conclusions in comparing groups of cases which involve so many factors that affect the ultimate saving of the eyeball or the preservation of sight. Apart from the fact that the cases summarized cover the experience of many different operators, some of whom adhere to the plan of inserting the magnet point into the vitreous in recent cases, the ultimate results of operation are further influenced by the size of the foreign body, its position in the eye, and time elapsing between the injury and extraction. If we compare the 182 cases in this report in which extraction was attempted with the 165 cases reported by Haab, Dr. Sweet said, we have the following: Extraction successful, Haab, 141 cases, or 85.5 per cent.; this report, 164 cases, or 90.1 per cent. Extraction failed, Haab, 24 cases, or 14.5 per cent.; this report, 18 cases, or 9.9 per cent. Eyeballs requiring enucleation, including only cases in which extraction was attempted, and was successful or failed, Haab, 39 eyes, or 23.5 per cent.; this report, 44 eyes, or 24.2 per cent. Good sight, Haab, 51 cases, or 30.9 per cent.; this report, 44 cases, or 24.2 per cent. Light perception or projection, which could probably be improved to serviceable vision in a large proportion of the cases by the removal of the existing cataract, Haab, 20 cases, or 12.1 per cent.; this report, 70 cases, or 38.4 per cent. Sightless eyeballs, Haab, 19, or 11.5 per cent.; this report, 16 cases, or 8.8 per cent. Extraction failed, but eyeballs not removed, Haab, 12 cases, or 7.5 per cent.; this report, 8 cases, or 4.4 per cent. In de Schweinitz's report of 26 cases, the results were as follows: Good sight, 10 cases, or 38 per cent.; eyeballs lost, 8, or 39.8 per cent.; eyeballs saved, which probably could have been improved by subsequent operation, 6, or 23 per cent.; eyeballs saved, but ball somewhat shrunken, 2 cases, or 7.7 per cent.

Clinical Notes, New Instruments, Etc.

A NEW SHIELD FOR USE IN NOSE AND THROAT EXAMINATIONS.

I. J. KERR, B.S., M.D.

Physician to the Tuberculosis Dispensary.
CLEVELAND, OHIO.

One of the greatest dangers to the physician handling patients suffering from tuberculosis lies in having masses of muco-pus thrown into his face by the patient sneezing or coughing while the nose, pharynx or larynx is being examined. The greatest danger exists in the public clinics where the patients are not over-particular to restrain a desire to cough while being examined. These patients are also apt to have very irritable throats

which render them more liable to cough while the tongue depressor or the laryngoscope is being used.

So far as I know, a glass in metal frame suspended on a movable arm between the face of the patient and the face of the physician is the only device which has been used to protect the physician up to this time. This is certainly a great protection, but it has many obvious disadvantages, among which are the clouding of the glass by the breath of the patient and physician, and its size and position.

During a recent visit to the New York Municipal Clinic for Tuberculosis, Dr. Waters, chief of the clinic, showed me a celluloid shield which had been made for him, but which was not satisfactory and did not seem to me practical. It was simply a sheet of celluloid, with temples similar to those used on spectacles, fastened to the sides, the idea being to wear this shield under the head mirror.

DESCRIPTION OF SHIELD.

I have thought out and had made for me the following device which seems to me satisfactory in most particulars:

It is of celluloid, which, of course, is inflammable if held too close to a flame or very hot surface. I have protected it partly from this by binding its surface with thin strips of aluminum.

In this form if it is not held within four inches of the top of the gas or oil lamp, directly over the flame, the danger is very slight, as I have proved by tests. Even if the shield is brought directly in contact with the metal condenser on the lamp after it has been burning for some time it does not ignite. If by chance it does ignite it does not burn rapidly enough to expose the wearer to great danger.

I have considered the possibility of making a shield of mica, but in sheets large enough to make such a shield it would be very expensive. Then, too, it is very easily cracked or splintered, so that it would not be durable. If expense were no object this shield could be made of mica in the same way I have my celluloid shield.

The shield is 7x9 inches and is attached to the posterior surface of the head mirror by four clamps fastened to its surface. A hole is made in the shield in the proper place for the shank of the mirror, and this can be at either side of the center line, according to which side of the light the patient is placed. If the examiner wears glasses a hole may be cut in the shield corresponding to the aperture of the head mirror. The shield may be easily detached from the mirror to be cleaned or disinfected in formalin, or in case the mirror is to be used without the shield.

With good sharp illumination I have no trouble in being able to make the ordinary nose and throat examination while using this shield.

Keenan Building.

A CASE OF POISONING FROM OPIUM OR MORPHIN IN A 7-WEEKS-OLD BABY.

EDWIN OLANDER, M.D.
ST. PAUL, MINN.

On July 6, 1906, I was hastily summoned to see a seven-weeks-old baby whom the mother said was getting blue in the face at times, as if in the last throes of death.

When looking at the child I observed that when it became cyanosed the cyanosis was not caused by a typical convulsion,

but rather by embarrassment of respiration. I immediately examined the eyes and found typical pin-point pupils, not reacting to the light. I questioned the mother as to any medicine which had been given, and she brought me a bottle of Jadaway's Elixir for Infants, manufactured by the C. W. Wilson company. The directions read:

A child less than 2 weeks.....	5-8 M.
A child 2 to 4 weeks.....	8-12 M.
A child 4 to 8 weeks.....	12-18 M.
A child 2 to 4 months.....	20-30 M.

The mother stated that she had purchased the bottle at a neighboring drugstore, and on the evening of July 5 had given the child five drops for colic. I believe that she had really given this small dose. I knew that I was dealing with a case of opium or morphin poisoning, and told the mother so.

Emetics, high enemas, massage and stimulants were administered, and on the morning of July 7 the child was fully recovered.

The pure food bill which has passed Congress, from a physician's point of view, is many years behind time. We must now see that it is strictly enforced, as it will aid in the prevention of such cases of poisoning as this.

Here a child had been give one-third the dose which the bottle stated could be given and yet suffered severe poisoning from this dangerous preparation.

A CASE OF INTESTINAL OBSTRUCTION.*

FRANK S. HOUGH, M.D.
SIBLEY, IOWA.

I have made no extensive examination of the literature of intestinal obstruction, but from the nature of this case I believe that it is a rare one.

History.—Mrs. A., aged 30, married one year, was operated on by me two years ago for destructive disease of the appendages. Nine years ago she suffered from pus tubes and general pelvic inflammation. Both ovaries were mere sacs filled with soft necrotic material, and all the other evidences of long-continued inflammations were present. She was a physical wreck. For about a year she suffered severely from the artificially-induced menopause; after that she commenced to put on flesh and became, apparently, the picture of health.

Present Illness.—On the evening of May 9, she partook liberally of sauerkraut. She returned home and retired with a feeling of well being. Some hours later, after midnight, her husband saw that she seemed ill, as she was groaning and rolling about though still asleep. He aroused her and she said that she had great abdominal pain; the abdomen was found to be swollen. Soon she commenced to vomit and the pain increased in severity. I was summoned some time later and was loth to diagnose obstruction because one classical symptom, the element of shock (as registered by pulse, temperature and skin) was wanting. The patient vomited incessantly for sixteen hours.

Treatment.—I made many unsuccessful attempts to pass a long colon tube, but at last my efforts were rewarded by such an immense discharge of gas and feces that I thought, and told the family, that things were now all right. The pain and vomiting stopped for an hour and then the same symptoms returned and I found that I had only emptied the colon and that the small intestine was still enormously distended. I suspected volvulus near the lower end of the cecum.

Operation.—An eight-inch incision was made through the right rectus and was followed by evisceration of practically all the ileum, which was greatly distended and cyanotic. Not having a Paul's tube or other similar contrivance, multiple incisions were made in the bowel which allowed of evacuation of contents. The emptied bowel was sutured and returned. The cecum was located and an effort was made to elevate it and the adjacent ileum but it could not be done. The constriction could be felt, however, and a distended black loop of bowel was fished

* Abbreviated from a paper read before the Upper Des Moines Medical Association, Spirit Lake, Iowa, July 11, 1906.