has been extensively used by Dr. Reeves, of Chattanooga, but it has not been recommended in eye work, the celloidion having been considered the best. I have not succeeded with that method so well as I have with the one advised, and I believe that if you will follow the plan suggested in this paper, especially as regards the freezing and hardening process you will succeed by mounting some beautiful and valuable specimens.

CASE OF SARCOMA OF THE CHOROID —OPERATION—NO RECURRENCE IN NEARLY THREE YEARS.

Read in the Section of Ophthalmology at the Forty-first Annual Meeting of the American Medical Association, held at Nashville, Tenn., May, 1890.

BY A. G. SINCLAIR, M.D.,

PROFESSOR OF DISEASES OF THE EYE, EAR, AND THROAT IN THE
MEMPHIS HOSPITAL MEDICAL COLLEGE; SURGEON IN CHARGE
OF THE EYE AND EAR DEPARTMENT OF ST. JOSEPH'S
HOSPITAL, MEMPHIS, TENN.

Malignant intra-ocular growths are of so much importance that every case of the kind should be placed on record, and especially the results of treatment, whether favorable or otherwise, in order that we may learn at what stage of development the disease passes beyond the control of remedial measures. I therefore beg to occupy your time briefly with a report of the following case:

In June, 1887, I was consulted by Mrs. K., 40 years of age, who reported that three years previously she had lost the sight of her right eye while suffering from symptoms which, according to her description, were very like those of acute glaucoma, and that the organ had continued more or less irritable up to the time of presentation. On examination I found vision extinct; conjunctiva moderately injected; pupil somewhat dilated, and motionless; iris discolored; lens cataractous; tension plus 1; pain in the eye, forehead and temple. Although suspecting the presence of an intra-ocular growth, I determined, as my patient was a lady, and cosmetic effects were therefore not to be ignored, before proceeding to enucleation to test the power of iridectomy to overcome the glaucomatous symptoms above enumerated—knowing that if an intra-ocular tumor were indeed present they would soon reappear and render positive the indication for removal of the eyeball.

I performed the operation accordingly, and relief of several weeks' duration followed. The symptoms then recurred in all their former intensity, and on August 14 I enucleated the eye under etherization. Entire relief from all symptoms followed; the patient made a good recovery from the operation, and soon regained her strength and spirits, previously much depressed by her sufferings.

I sent the eye, hardened in alcohol, to the laboratory of the College of Physicians and Sur-

geons, New York, for examination, whence I received in due time the following report:

NEW YORK, November 23, 1887.

Dr. Sinclair, Memphis, Tenn.

Dear Doctor:—The microscopical examination of the eye sent to the laboratory is as follows:

Cornea.—The cuboidal cells of the anterior epithelium are distorted and separated from each other by larger and smaller irregular shaped spaces (probably due to drying in the air). There are also a number of spindle-shaped cells among the cells of the anterior epithelium. At the sclero-corneal junction there are a few scattered pus cells. Lying against the posterior epithelium of the cornea is a layer of spheroidal cells.

Iveal Tract.—Iris is swollen and ciliary bodies flattened on both sides. The choroid just behind one of the ciliary bodies contains a mass of small spindle-shaped cells about 5-7 mm. in diameter.

Retina and Opticus.—Rods and cones absent from retina and there is an increased amount of interstitial tissue. In places the retina is changed to a connective tissue lamina. The optic disc shows a moderate degree of excavation.

Anatomical Diagnosis.—Small spindle-celled sarcoma of the choroid, interstitial retinitis, optic excavation, circumscribed purulent keratitis. Very respectfully yours,

IRA VAN GIESON.

Nearly three years have elapsed since the operation; the patient continues in vigorous health, and there is no sign of a recurrence of the disease.¹

54 Madison street.

A VEST POCKET OPHTHALMOSCOPE CASE.

Read in the Section of Ophthalmology at the Forty-first Annual Meeting of the American Medical Association, held at Nashville, Tenn., May, 1890.

BY FRANK TRESTER SMITH, A.M., M.D.,

OF CHATTANOOGA, TENN.

LATE ASSISTANT SURGEON, NEW YORK OPHTHALMIC AND
AURAL INSTITUTE.

I present to the Section an ophthalmoscope case made for me by Meyrowitz Bros. in 1886, and which I have had in constant use ever since. It is made like a spectacle case, the open end being closed with a tightly fitting lid, or like a flattened pencil case such as is used by school-children. It is made of stiff pasteboard, or other light material, covered with morocco.

It presents the following advantages over the form in ordinary use:

1. Size. This is such that it can be carried in the vest pocket. The thickness is about half that of the wooden case.
2. Weight. Being smaller and made of lighter material, it is not as heavy as the ordinary form.
3. Shape. There are no corners and the edges are rounded off.

¹ There is still (Dec., 1890) no sign of a relapse.