

eye, behind the spectacle glass. He was now allowed to sit up. June 19 one drop of solution of atropin was instilled into each eye, and June 24 the instillation of the solution of atropin into the left eye was discontinued. June 27 the use of the 1 per cent. solution of atropin was discontinued in the right eye. July 4 I made a measurement of the cicatrix and of the leukoma with the curved strabismometer, and July 11 made a sketch of the eye (Fig. 1).

The cicatrix of the incision presents a beautiful linear scar bordered by two blood-vessels, and by the leukoma which at its widest part was then 2 mm. in diameter; the length of the corneal cicatrix was 5 mm. August 25, the boy not having come to see me previously during this month, I made an ophthalmoscopic examination of his right eye.

No details of the fundus were to be made out by either direct or indirect examination, but oblique focal illumination showed that, since the discontinuation of the atropin, the iris had been drawn in on all sides toward the cicatrix, completely covering the pupil, but presenting within its texture several apertures through which good vision was obtained (Fig. 2). There was no pain or inconvenience whatever, and no tendency to staphyloma.

September 22 the leukoma measured 1 mm. at its widest part. The eye, apart from the anterior synechia and the scar, is normal in appearance. Distant vision with the right eye is apparently perfect; the near vision is somewhat difficult to determine, as the patient is unacquainted with the alphabet, but he takes pleasure in looking at, and recognizes the objects in picture-books, though when interrogated he says that he sees "small" with his right eye.

A peculiar feature in connection with this case is the development of a vein, proceeding from the inner border of the upper eyelid, along the median portion of the lid towards the outer canthus. Possibly this communicated with the angular vein and so with the ophthalmic vein.

Taking into consideration the very successful results which have followed the treatment of the above case and the good vision which the patient possesses with his right eye, I do not propose to perform any operation on the iris at present. At present I am instilling three drops of a 1 per cent. solution of atropin into the eye daily.

There is an old and time-honored maxim which asserts that "meddlesome midwifery is bad." How much worse is unnecessary interference in the healing process of such a delicate organ as is the eye!

CEREBROSPINAL FLUID OF ANOMALOUS CHARACTER IN A CASE OF INTRASPINAL TUMOR

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Since the cerebrospinal fluid is frequently examined as an aid to the diagnosis of cerebrospinal disease it seems wise that any anomalous finding should be reported.

The fluid withdrawn under a pressure of 160 mm. of water, from a patient without fever, and with signs of a localized segmental lesion of the cord, had the following characters:

Macroscopically, it was clear and of a yellowish-brown color, looking like the clear serous fluid that is aspirated from pleural or peritoneal effusions. On standing a well-marked cobweb coagulum formed. The Noguchi and Nonne globulin tests were strongly positive, thick precipitates occurring. The Wassermann complement reaction was negative in the fluid as in the blood.

Microscopically, practically no cells were to be found either in the centrifugized fluid or in the coagulum. No bacteria could be detected.

Dr. Hyman, who later operated on the patient, and I came to the conclusion that we were dealing with a case of chronic compression of the cord, probably due to an intraspinal tumor,

but an explanation of the findings in the cerebrospinal fluid did not suggest itself. At operation a strongly marked edema of the membranes was found below the site of the tumor (an angiosarcoma). The transudate character of the fluid seems thus explained.

A similar finding, then, would suggest the presence of a compressing agent plus the probable concomitant occurrence of edema of the membranes, and would warn one to beware of the false localizing signs that may occur with such edemas.

SAPHENOUS VARIX SIMULATING FEMORAL HERNIA

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To the well-known saying, "The man who never makes mistakes in diagnosis never does autopsies," I would add "and never operates." Of all the surprises I have ever had, either in operations of my own or in those at which I assisted, the case I am about to describe was the greatest. The rarity of the condition found and the importance of differentiating it from femoral hernia are my reasons for publishing this case.

History.—On Oct. 11, 1910, I was called to see Mrs. K., a woman of 37, mother of seven children, the youngest being 3 years old, who had always been in good health and had worked hard all her life. She complained of crampy pains all over her

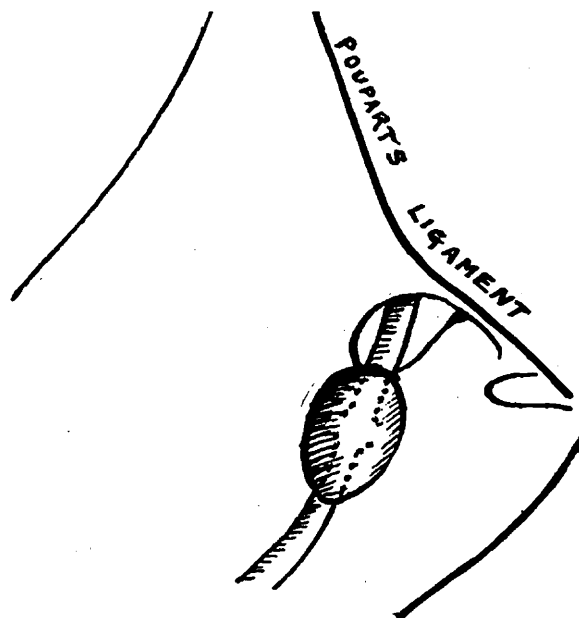


Diagram of saphenous varix simulating femoral hernia.

abdomen, but most severe on the lower left side, together with continual rumbling of gas. As she had been constipated for a few days, she had taken several doses of castor oil. These increased the pain, although they brought on a fairly good bowel movement. There were no other complaints.

Examination.—Temperature was 98 F.; pulse, 112. The abdomen was not tender, was soft, there were no masses felt or swelling noticed. Just below the saphenous opening on the left side, however, was a swelling about as large as a walnut. It was not tender, was easily reducible, especially when the patient lay down, and gave a most decided impulse on coughing. The patient said she had noticed this swelling ever since the birth of her last child and that it had never given her any trouble. I made a diagnosis of femoral hernia and told the patient it would be well to have it operated on, telling her of the danger of strangulation, etc. Her abdominal cramps I attributed to the cathartic and treated her accordingly.

Three days later I was called again. The abdominal pains had grown worse, especially on the lower left side, and radiated down the left thigh. She had frequent soft stools and the rumbling of gas was marked. Temperature was 100 F.; pulse, 124. Peristaltic waves could be seen over the lower left abdomen, where there was also tenderness and more resistance than on the right side. The hernial mass was a little larger, was tender, and was no longer reducible. Operation was now most urgently advised, but absolutely refused. During the day, the temperature rose to 102.6 F. and an indistinct mass could be felt in the lower left quadrant of the abdomen. On the evening of the next day, the bowels moved, but with much difficulty and straining. There was considerable resistance in the lower left side of the abdomen and the entire abdomen was moderately swollen and tympanitic, especially over the course of the colon. The patient felt nauseated and vomited a little bile. The hernial mass was tense, tender, and flat to percussion. Temperature was 102.2 F.; pulse, 124. Operation was now insisted on. The patient was taken to the German Deaconess Hospital at once, where I operated that same evening.

Operation.—An incision was made over the supposed hernial swelling and large enough to do a radical operation for the cure of femoral hernia. Imagine my surprise on dissecting out the mass to find that it did not emanate from the saphenous opening at all, but was continuous on either end with the internal saphenous vein just below its emergence from the saphenous opening. It formed a sacculated pouch springing from the anterior wall of the vein. The vein was tied off above and below the tumor and the latter removed. On opening, it was found to contain a fairly fresh unorganized blood-clot and the wall of the pouch was a dilatation of the wall of the vein. There was no hernial sac visible, neither was the femoral ring abnormally large; nevertheless I sutured Poupart's ligament to the pectineal fascia with one catgut stitch, thus preventing the possibility of a future hernia or the recurrence of one that might have slipped back into the abdomen. The wound was closed with interrupted silkworm-gut sutures. Examination under anesthesia now revealed a large infiltrating mass occupying the pouch of Douglas and extending upward into the left side of the abdomen. I decided to terminate the operation at this point and await developments.

Subsequent History.—The patient ran an irregular temperature ranging from 99 to 103 F. for ten days, after which it suddenly came to normal, where it stayed during the remaining eight days that she was in the hospital. During this time, the pelvic mass became gradually smaller and on her discharge could barely be felt. As it gave no symptoms and seemed to be gradually disappearing, the patient was tentatively discharged from the hospital.

In looking over the literature, I find a saphenous varix in this location a very rare occurrence. I could find no case reported in the last three years. Although varicosities are common enough in the long saphenous vein, they are uncommon in this situation. According to MacCready's statistics quoted in von Bergman's and Keen's text-books on surgery, a saphenous varix was mistaken for femoral hernia nine times as against forty-seven times that abscess and one hundred and fifteen times that enlarged lymphatic glands were the cause of a mistaken diagnosis.

So much for a simple varix. But to find such a tumor, with impulse on coughing and easily reducible, after three days no longer reducible and tender in a patient with rising temperature, abdominal cramps, swollen tympanitic abdomen, and the other symptoms I have mentioned, was an unusual coincidence.

The explanation was simple enough after the operation. The varix had become thrombosed during the three days and the temperature and abdominal symptoms were due to the pelvic exudate.

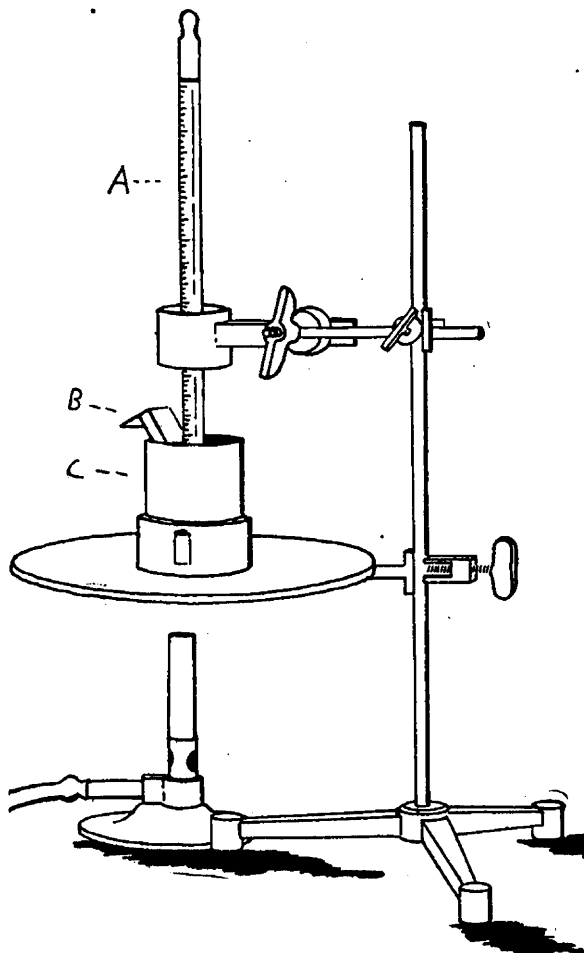
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A SIMPLE APPARATUS FOR ACCURATELY FIXING BLOOD-SLIDES BY HEAT

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In fixing blood-slides by heat, one finds that the results of the copperplate method are so inconstant that it is difficult to get a good specimen unless one keeps in constant practice. There is no way of determining the exact amount of heat used or of keeping the heat regular. I have devised the following simple apparatus for office and laboratory use:

As shown in the illustration, an ordinary laboratory stand and supports an iron dish, C, resting on an asbestos plate, under which is a gas burner. This iron dish is easily made by screwing a two-inch nipple into a pipe cap. This dish is filled with petrolatum, into which is sunk a small, thin copper cup so that the end sticks out as shown at B. This cup is



Apparatus for fixing blood-slides by heat. A, thermometer for registering amount of heat; B, copper cup for holding blood-slide; C, dish containing petrolatum in which cup with blood-slide is immersed.

just large enough to admit with ease the glass slide. In the petrolatum is sunk the bulb of a thermometer, A. The exact temperature is registered by the thermometer. The slide may be introduced by using a small copper strip bent at an angle at the ends; and when the blood is sufficiently heated the slide and copper strip are withdrawn. With Ehrlich's stain I have obtained the best results by heating to 280 F. for seven minutes.

The disadvantages of this apparatus are that it requires constant attention. The advantages are that the slide may be accurately heated, and this may be done by one's untrained office assistant, whereas by the copperplate method one can hardly get constantly good results no matter how well one is trained.