

gave considerable relief to the pain, but not much to the frequency of micturition.

"On Jan. 3rd, 1875, she was confined of a healthy child.

"April 14th, 1875. — No improvement had followed her confinement. There was occasional bleeding. She had to pass water every ten minutes, day and night, with pain and straining. If she tried to delay emptying the bladder, the pain was intense. She was emaciated and exhausted by suffering and want of sleep.

"Operation. — Mr. Jukes gave chloroform, and I dilated the urethra, so that I could introduce the finger freely into the bladder, which was very contracted, hardly being of the size of a walnut. Just at the point which had been noted as being painful in the previous examinations a slightly raised hard patch was felt (an ulcer?), but there was no stone nor polypus. The immediate result of the operation was that the urine dribbled away. Every two or three hours she tried to pass water, but this was done without pain. She rapidly gained in strength. I hoped that by degrees the bladder would increase in capacity. This, however, has not been the case, and the dribbling still continues. She has, however, no pain, and is in good health, eating and sleeping well, and looking after her children."

Mr. Smith further remarks, in a note written on Oct. 25th, accompanying the foregoing report of this case:—"She has unfortunately not got on so well as I had hoped. At the time of the operation the bladder was very much contracted, and it appears not to have expanded since, and thus the patient is on the horns of a dilemma. Either she must allow the urine to dribble away or she must pass it frequently. This, of course, is a result we must be prepared for, if the operation is done in a case with a rigid contracted bladder. It must not, however, be thought that this patient has gained nothing by the operation. *She has lost all pain and spasm.* She can take her choice whether to empty the bladder or allow it to empty itself, which she could not do before. She can sleep at night, can go about and get exercise, and she is in very good health; whereas before she had to pass water with pain and straining every few minutes day and night, and was a wretched invalid. The disease which is at the root of the mischief is still going on. There is still tenderness and occasional bleeding from the bladder, especially on defecation when the bowels are confined, showing that disease of the bladder is still there. I cannot help thinking that the continued existence of irritability of the bladder must tend to produce the same sort of mischief in the kidney which we find in old cases of stone, where there is no real obstruction, but only a constantly contracted state of bladder, and therefore that by the conversion of the case into one of constant dribbling a great danger to life is removed.—C. S. SMITH."

(To be continued.)

NOTES ON DR. BROADBENT'S LECTURES ON THE PULSE.

BY T. CLIFFORD ALLBUTT, M.A., M.D. CANTAB.

It is now some half-dozen years since, on one evening, I was talking with the late Dr. Anstie on the value of the sphygmograph as an instrument of clinical research, when he replied to my somewhat disheartened estimate of it, that its great value would not be in the detection of cardiac lesion, but in the better appreciation of constitutional states. This remark was a very fruitful one to me, and since that day I have more and more closely watched the quality of pulse and artery in various diseases. Perhaps little that Dr. Broadbent tells us is absolutely new to careful physicians, but, on the other hand, very little of it is popularly known even in the profession. My own experience tells me that the lecturer has put together very true and rather new things in a remarkably able way, and I trust henceforth they may form part of what lawyers call common learning. To one or two points I would refer.

First of all, I think that "worry" has far more to do with the production of high tension with impure blood than Dr. Broadbent quite admits. I believe it to

be a more potent cause than good living, and it will be seen that a large number of the author's cases occurred in abstemious people. Now, abstemiousness and worry often concur in the same person—in fidgety, industrious, anxious creatures, who fret in circumstances where other persons would be restful enough, or who, in selfish or unselfish sorrow, have more than their own weight of misery to bear. In my experience, high-pulse tension with imperfect excretion is less common in happy, genial, and more or less bibulous men than in the careworn. In past years I used to be more surprised than I have been of late to fail to find a tense pulse and all the concomitant perturbations which (the neuralgias and the intermittent diarrhoea excepted) Dr. Broadbent has so admirably set forth, in persons whose blood would seem, from their habits, to have been constantly embarrassed with sickness. I am sure abuse of alcohol alone has not an exceptionally strong tendency to produce the state in question. My patients in this class have more often been upright, self-denying parents, worn out by the misdeeds of their children; men whose hopes have sickened in long lawsuits or in protracted business anxieties; women bereaved of all that they have loved, and who have hidden themselves away in weariness and self-neglect; poor professional men harassed by overwork, little reward, and many claims. These are the people in whom I have found the kind of pulse-tension here spoken of, and in whom I have often watched the growing sallowness and leanness, the twisting and growing arteries, the vertigo, the pains in head, neck, shoulders, or elsewhere, as the world has grown too hard for them. And their cure or relief must lie in the reverse of all this—in sunshine within and without, a hard thing for most of us poor English men and women whose inner life is darkening generation after generation, till our hearts grow as gloomy as our skies. Two remedies, not mentioned by Dr. Broadbent, I could urge as being invaluable in my experience; the first of which is Carlsbad water. I find this water, and Marienbad in milder cases or stages, to be a stream of life for those whose blood is laden with the sort of impurities which overcharge the heart and arterial tree. It makes mercurials far less necessary, and its prolonged alterative action is of course more desirable. My other remedy is residence at a high elevation. I have repeatedly seen a two months' stay at Mürzen, Pontresnia, or the Eggischhorn, probably by accelerating respiration and skin action, cleanse blood which had been impure, and cleanse it in a way which kept it pure for long after-times. Finally, I think scarcely enough stress was laid upon the preservation of skin activity by bathing, rubbing, and warm clothing.

Dr. Broadbent's generalisation of cases in which a low blood tension is a leading feature was, I think, a very striking part of his lectures. Bromide of potassium with bromide of iron and strychnine has proved very valuable in my experience, as in that of the lecturer. But he does not seem to have tried ergot in these cases. For some time it has been my favourite drug for the relief of persons thus afflicted, and it may be given for months continuously without the least injury to the patient.

Leeds.

RARE CASES OF IRITIS IN CHILDREN NEAR THE AGE OF PUBERTY.

WITH REMARKS.

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THE two following cases, illustrating a very rare event, the occurrence of uncomplicated iritis at, or rather below, the age of puberty, and without apparent cause, seem deserving of record; since simple iritis, unaccompanied by disease of either the cornea or the deeper structures, is scarcely ever seen below the age of puberty, excepting in infants suffering from inherited syphilis.

CASE 1. A mild attack of iritis in one eye in a girl aged fourteen years; no complications; no cause assigned.—Louisa P—, aged fourteen, came to the South London Ophthalmic Hospital on Aug. 18th, 1875, with slight inflammation of four days' duration in the right eye. There were all the

symptoms of commencing iritis: ciliary congestion, slight muddiness of the aqueous, and loss of brilliancy of the iris; but the pupil was still active. A two-grain solution of atropine was ordered. On the 21st the congestion had increased, the aqueous was duller, and the pupil, although showing no synechia nor any pigment spots on the lens-capsule, would not dilate fully with atropine, and remained oval after its use. Ordered to continue atropine drops and to take three-grain doses of iodide of potassium with ammonia. On the 25th the pupil had dilated more fully, and a single tag of adhesion was found at its upper part, the part which had hitherto responded least to the atropine. There was still moderate ciliary congestion, but no pain. At the next visit (28th) the eye was much better and the congestion had almost disappeared, and a week later (Sept. 4th) it was quite pale. Atropine was now discontinued, and a bitter mixture substituted for the iodide, which was depressing her. On the 11th the eye was still quite quiet, and I have not seen her since. The attack, although quite well-marked, was mild throughout, and showed no tendency to relapse. There were no opacities in the vitreous nor any disease of the fundus.

No clue was found as to the cause of the eye affection. Careful inquiry, both of the patient and her mother, threw no light on it. Neither rheumatism nor gout was known in the family; there was neither evidence of, nor any reason for suspecting, syphilis, acquired either in the ordinary way, by vaccination, or otherwise. There was no history of injury. She was a pale, rather thin girl, and her mother thought she had been losing flesh lately. She had not yet menstruated. She showed no signs of inherited syphilis.

CASE 2. *Iritis, acute and well marked, in one eye of a healthy boy aged fifteen; a thin membrane formed over pupil; no cause found.*—Henry P—, * aged fifteen, a healthy-looking boy, well nourished, and of good colour, came under care on December 23rd, 1874, for iritis of his right eye. At the first visit there was slight general haze of cornea, muddy aqueous, and great congestion, but no iritic adhesions. The congestion was chiefly conjunctival. I was quite unable at this or at any subsequent visits to find a cause for the iritis; the most careful examination of his person failed to detect any evidence of primary or secondary syphilis, and he denied, I think truthfully, ever having been exposed to risk of venereal disease. From the state of the genitals it is probable that he had not arrived at puberty. He was not subject to any arthritic symptoms, nor could he learn from his relatives that there were any such complaints in the family. I made special inquiry as to gout. He showed no evidence of hereditary syphilis.

At his next visit the signs of iritis were much more pronounced, and eventually the pupil became covered by a thin greyish-white membrane, and its edge considerably adherent to the lens-capsule. The fundus was examined repeatedly, and no disease of the vitreous was found. There was no ulceration of cornea whatever.

For the first week the case was treated with iodide of potassium, atropine and blisters; but finding on December 30th that he was decidedly worse, I ordered grey powder in two-grain doses twice daily, with the same of Dover's powder, omitting the iodide. This treatment, together with atropine, was continued for six weeks. The eye improved rapidly under it, and was quite quiet at the end of that time. All treatment was omitted for a month (February 17th to March 17th); at the latter date "relapse of ciliary congestion, no pain," is noted; treatment resumed for three weeks. On April 7th the eye was again quiet, and he has not been seen since the 14th. Not the slightest salivation or inconvenience occurred throughout the treatment, nor was his health apparently affected for better or worse.

It would not seem that these cases can fairly be placed in any one of the groups into which it is customary to divide the subject of iritis. The iritis of hereditary syphilis, occurring as it does in the secondary stage of the disease, and a few months after birth, could not include such cases as the above; while in neither of them was there any reason whatever for suspecting acquired syphilis. The large group variously known as "rheumatic," "arthritic," and "recurrent" iritis would not, I think, be commonly understood to include such cases as the above. Rheumatic iritis seldom

if ever occurs under twenty years of age, and in a large majority of its subjects there is a history of some rheumatic affection; in men the rheumatic affection being often found to have begun as gonorrhœal rheumatism. Neither would the smaller group, first differentiated, I believe, by Mr. Hutchinson, consisting of iritis in adolescents who inherit the gouty diathesis, appear to admit cases resembling those above given. In the cases described by that author* the disease was characterised by its extremely insidious onset, and an almost entire freedom from the ordinary signs of inflammation, by the occurrence of opacities in the vitreous, and by the tendency to progress to closure of the pupil and secondary changes in spite of treatment. In the two cases narrated in the present paper not one of these leading characteristics of the heredito-gouty iritis was present, for the disease was acute, of comparatively short duration, and not accompanied by any visible change in the vitreous. Moreover there was no history of gout in the parents or ancestors of either patient—a negative fact which must be allowed some weight, although it cannot be taken as conclusive. It is scarcely needful to distinguish between the cases forming the subject of these notes and those groups in which iritis occurs as a complication of certain diseases of the cornea; particularly of interstitial (syphilitic) keratitis, and of certain forms of cyclitis with marginal ulceration of the cornea.†

A case, not at first sight comparable with those here described, but possibly illustrating an extremely severe result of a similar form of disease, I have recorded in the Ophthalmic Hospital Reports (vol. vii., p. 360.) In this case a healthy-looking boy, eleven years of age, lost his right eye from acute irido-cyclitis leading to inflammation of the vitreous and retina, without any adequate cause being discoverable.

A detailed record of all cases of uncomplicated iritis in children below puberty (excluding, of course, the infantile syphilitic cases) would probably throw much light on the causation of these rare forms of disease, and perhaps result in placing them within one of the already recognised groups of iritis.

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ON THE OCCIPITO-POSTERIOR POSITIONS IN MIDWIFERY.

By JAMES MORE, M.D.

THE mechanism of labour is to a great extent a question of fine adjustment and adaptation between the foetal head and maternal passages; and a labour, to be natural, must proceed so that the longest diameter of the foetal ovoid adapts itself to the longest diameter of the pelvis, and this we know to be the right oblique.

Are, then, all presentations of the head occurring in other than the right oblique, and with the occiput looking to the left groin, unnatural? This has been answered in the negative by the younger Naegele, Simpson, and others, who maintain that the third position, occurring as it does so often, must rank as a natural presentation.

We know that when the forehead is primarily situated behind either the left or right foramen ovale, nature, as if aware the position is not the most satisfactory, attempts by a rotatory movement to bring the head into a position more favourable for delivery—viz., the occipito-anterior. Unfortunately, this rotation is not always accomplished, and thus it is we have so many cases of tedious labour when the presentation is either in the third or fourth position. I do not look upon occipito-posterior positions as always causing delay, but what I maintain is that in a large proportion of these delay does take place, and chiefly in those cases where nature cannot of herself change the position from the occipito-posterior to the occipito-anterior. The very fact that nature does attempt to rotate, coupled with the fact that most of our cases occur in the first position, leads me

* See Clinical Lecture published in THE LANCET, Jan. 1873.

† For some very suggestive and valuable remarks on the latter disease by Mr. Hutchinson, see Ophthalmic Hospital Reports, vol. viii., pt. i., p. 5, under the title of "Mackenzie's Scrofulous Sclerodermatitis."

* Though the surname of each begins with P, the names are quite different, and the patients not related.