

by iron-grey induration. A cavity the size of a Tangerine orange was found in the apex of this lung; and another about the size of an egg in the upper part of the lower lobe, on its outer aspect. A number of bronchial tubes, filled with muco-purulent fluid, were visible on section of the lung. No true grey tubercles were found in either lung. A few atheromatous patches were found at the commencement of the aorta. The valves were healthy. The liver was in the first stage of cirrhosis.

Remarks—There is strong reason to believe that in this case no pulmonary disease existed before the first attack of hæmoptysis, beyond a morbid delicacy of the walls of the bloodvessels of the lungs, probably induced by the patient's intemperate habits. The man's health, he several times assured me, was perfect up to the time of the first attack of bleeding. I have been unable to ascertain what was the state of his chest during the period he was in the hospital under the care of another physician; but at the time of his discharge the only evidence of pulmonary mischief consisted in some slight consolidation of a very limited portion of the upper lobe of the left lung, probably corresponding to the small cavities found after death, which had resulted from the softening of cheesy nodules. These nodules were in all probability the results of changes set up by the hæmoptysis. The further progress of the case is interesting. Every subsequent attack of hæmoptysis was followed by inflammatory changes in the lungs, especially the right. There was also a decided tendency for the first series of these changes to terminate in resolution, but another attack of bleeding unfortunately prevented this. There was a peculiarity in this case which is worth noticing—viz., the rise of temperature for a day or two before each series of attacks of hæmorrhage occurred. If this temperature elevation should be found to occur in other cases it will be an important guide to treatment, for as soon as the increase is noticed remedies should be administered with a view of preventing the supervention of an attack of bleeding. There are a few other points connected with the treatment of hæmoptysis in which this case is instructive. Acetate of lead checked the first attack of hæmoptysis the man had after coming under my care, when gallic acid, which has been recently so highly extolled, failed. In my experience, acetate of lead is the best remedy in pulmonary hæmorrhage, except in those cases in which the hæmorrhage is very persistent, when an emetic of ipecacuanha, as recommended by Trousseau, has no equal. The Dover's powder in the above case produced vomiting, and thereby checked the hæmorrhage, which had proved rebellious to acetate of lead and a mixture containing gallic and sulphuric acids. From the record of the case there can be no doubt of the advisability of checking the bleeding at once in cases of pulmonary hæmorrhage. I am inclined to doubt whether this symptom is ever a salutary one in the progress of phthisis. In a great many instances no ill effects may arise from an attack of bleeding, but in others it may have a most injurious influence; and in my opinion the temperature of a patient should be carefully observed for some days after an attack of hæmoptysis, with a view of ascertaining whether such attack has been followed by inflammatory action in the lungs or not.

Cambridge, September, 1871.

TREATMENT OF GRANULAR OPHTHALMIA BY THE LOCAL USE OF QUININE (QUININÆ BISULPHAS).

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THE unsatisfactory results of the treatment of granular ophthalmia, especially if combined with pannus (vascular cornea), will, I hope, justify the publication of the following remarks. Experiments were made, with various substances, on patients suffering from granular ophthalmia with pannus. The idea which led to the selection of the substances experimented with was, that granular ophthalmia is the result of some extraneous substance becoming lodged in the conjunctiva, and giving rise to what have been called granulations. Experiments made elsewhere with antiseptics

on organic matter have shown quinine to be one of the most effective antiseptics.

The substances experimented with on granular ophthalmia were the scrapings and juice of the root of bryonia nigra, the nitric oxide of mercury ointment (hydrarg. nitrico-oxidi, gr. iii., adipis ʒi.) and the bisulphate of quinine in powder. The remedies were applied morning and evening; of the quinine about as much as would go on the point of a pen-knife was placed, with a dry camel's-hair brush, on the inner surface of each lower eyelid. No other treatment, such as exclusion from light, use of lotions, &c., was made use of. The hypothesis that quinine acts specifically upon granulations, as mercury, for instance, does on lice, may be erroneous; the effect may merely be that of an irritant, causing moderate suppuration, and, with it, removal of the granulations.

The effects on granular conjunctiva of bryonia nigra and of the nitric oxide of mercury ointment, though curious in other respects, are of little interest here. Suffice it to state those of quinine. In some cases its application was followed by severe smarting, which continued for ten or fifteen minutes; in other cases no pain whatever was felt; in all cases appeared increased purulent discharge from the conjunctiva, with shrinking of the granulations, and clearing of the surface of the cornea. The intolerance of light ceased rapidly in all cases; the dilatation of the pupils appeared in from twelve to twenty-four hours after the first application of quinine. The pupils, though dilated in ordinary light, contracted well on exposure to strong light.

CASE 1.—A. B., aged fourteen. Granular ophthalmia for six years; at present vascular cornea (pannus) in both eyes; pupils barely visible; granular conjunctiva; extreme intolerance of light. The application of bryonia nigra was followed by symptoms of purulent ophthalmia (chemosis, swollen lids, &c.), which, with slight improvement of sight, subsided within ten days; the intolerance of light persisted. Quinine was used and the bryonia discontinued. The eyes improved rapidly; the granulations became smaller, and the intolerance of light disappeared completely within four days.

CASE 2.—C. D., aged ten. Granular ophthalmia with pannus for two years, with intolerance of light. The use of the nitric oxide of mercury ointment (for fourteen days) was followed by slight improvement. It was discontinued and quinine substituted. Within ten days all intolerance of light had ceased, the cornea became much clearer, &c.

CASE 3.—E. F., aged ten. Granular ophthalmia for one year. The intolerance of light persisted for three weeks while the nitric oxide of mercury ointment was used; it disappeared on the second day after the quinine had been applied.

CASE 4.—G. H., aged thirty-four. Granular ophthalmia for one year, with pannus and intolerance of light. Quinine was used for ten days; on the third day the pupils became dilated, and on the fourth all intolerance of light had ceased.

CASE 5.—I. J., aged eleven. Granular ophthalmia for four months, with slight pannus and intolerance of light. Quinine treatment for three weeks. All intolerance ceased; cornea much clearer; granulations red, much smaller; slight purulent discharge.

Case 6, aged fourteen, bad for three months; Case 7, aged fifteen, bad for four years; Case 8, aged ten, bad for two years, improved equally rapidly under the quinine treatment; in all did the intolerance of light disappear within from five to ten days, with marked improvement in the state of conjunctiva and cornea.

SOURCE OF FALLACY IN ESTIMATING THE MORTALITY FROM CHLOROFORM.

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DEATH from chloroform inhalation is a subject worthy the attention of all practical surgeons, and the particulars of each case deserve the strictest investigation. Yet the most accurate attention to details very often leaves us wholly ignorant of the conditions which accompany or cause the fatal result. The object of this communication is

to show that one of the sources of fallacy which have been suggested is *not* an ideal one, but must be taken into account in any statistical enumeration which may at any time be drawn up. It has often been stated by writers on this subject that a certain number of deaths which have occurred while persons have been under the influence of chloroform must be set down to natural causes, wholly independent of the anæsthetic. To some, this has seemed so unlikely as not to be worthy of consideration; but when we compare the number of sudden deaths which happen in any community with the very rare occurrence of death under chloroform, it will not seem so unlikely that the coincidence may occasionally occur. A remarkable case of sudden death bearing on this question happened lately in my practice, which has made such an impression on my mind as to induce me to record it.

A patient from the country, recommended to my care by Professor Allen Thomson, came to town in July last to have a small epithelial tumour removed from his lower lip. He and his wife took a lodging in the neighbourhood of my house, and a day was fixed for the operation. A more urgent case requiring my services happening on the morning appointed, I sent a message that I would postpone the operation till the following morning. Next morning I got a message from the lodging-house landlady, that my patient had gone out the previous day to execute some commissions, and had not returned. Shortly after this I received the startling announcement that, soon after my patient had left his lodgings, he had dropped down dead in the street! There is little doubt that if I had proceeded with the operation on the morning appointed, my patient would have died during its performance; and I should, for the first time, have been called upon to record a death under chloroform. In this case the death occurred from "natural causes," just about the time appointed for the operation.

The coincidence is sufficiently striking to show that many a patient may die *under* chloroform though not *from* chloroform, and that such a consideration should modify our judgment in estimating the value of tables of "mortality from chloroform."

Bath-street, Glasgow, Oct. 1871.

A COMPLETE ANTERIOR LUXATION OF THE SEMILUNAR BONE FROM THE RIGHT WRIST WITHOUT TEARING THE SKIN.

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THE following case, which has recently come under my professional care, I believe to be one of unusual rarity. In looking up authority I can find no duplicate case of anterior luxation of the semilunar bone in which the skin has not been extensively torn, the bone usually hanging quite from the hand by some shreds of ligament. The case, I think, will be of interest to surgeons.

Alexander S—, aged twenty-five, a sailor by occupation, whilst taking in sail on March 24, 1871, fell from the yard-arm upon the deck of the ship, a distance of about twenty-five feet. He fell upon his right side, with his right hand doubled under him, so as, in a measure, to break the fall. He was badly bruised about the right hip and side, but as these were not serious nor extensive injuries, he rapidly recovered from them. Ten days after the accident he reached port, and came under my treatment in the Baltimore Infirmary for a stiff wrist and painful arm, supposed to be fracture of the radius near the carpus.

There was comparatively little swelling of the arm and hand. The axis of the hand was perfectly in a line with that of both radius and ulna. My finger, firmly pressed upon the outer surface of the radius and ulna from the elbow to the tip of each respective styloid process, caused no sharp pain, so constant a symptom when a broken bone is pressed upon at its point of fracture. A hard, large, rounded subcutaneous prominence existed on the front of the wrist beneath the upper wrist fold, and directly over

the site of the semilunar bone. This irregularly outlined incompressible knob stretched the skin, and was so firmly fixed as to exhibit not the slightest motion when manipulated with force. From the median position of this large firm mass, which had been detected after the fall, and which had not previously existed, luxation of the semilunar bone was diagnosed. This opinion was confirmed by thrusting a couching needle to the depth of an inch into the back of the wrist, and showing, by the free movements of the free end of the needle in every direction, that a vacant cavity existed, where normally the compact semilunar bone is found. The constant pressure kept up by the luxated bone caused forced and painful flexion of the fingers and wrist. The immobility of the bone in its new position rendered futile all attempts at reduction. Three weeks after the receipt of injury, finding that the presence of the bone would permanently destroy all the movements of the wrist, and that the slightest motion of the fingers continued to give severe pain, under the influence of chloroform I removed the semilunar bone through a single incision two inches in length, in the median line. The operation I found much more tedious than I had anticipated. The force applied at the time of the accident had not only squeezed the bone from its cavity, but had, at the same time, imparted to it a rotary movement of so extensive a character, that the concavity for the reception of the rounded head of the os magnum looked directly up the arm, whilst the convex surface belonging to the radio-carpal joint was facing the fingers. During this forcible rotation *in situ* of this semilunar bone, all of its connecting ligaments had not been torn through. Some of them had been so stretched over, and others under, the luxated bone as to tie it down firmly in its new position, and render it very difficult to enter a knife between it and its closely hugged neighbours to permit of its isolation and removal. Although these tense ligaments kept the semilunar bone immediately over its proper area, its rotated position brought together such reversed, and therefore irregular, surfaces of bone and socket as to render reduction quite impossible. Upon examining the semilunar bone when removed, a small fragment of the scaphoid was found attached to it, showing that the dislocating force had torn off a small piece of the contiguous bone.

Baltimore, May, 1871.

A Mirror OF THE PRACTICE OF MEDICINE AND SURGERY IN THE HOSPITALS OF LONDON.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

LONDON HOSPITAL.

CASES UNDER THE CARE OF MR. COUPER.

ON the occasion of a recent visit to the London Hospital, the following cases, among others, came under our notice.

A Case of Spontaneous Reduction of a Dislocation of the Femur.—A labourer, forty-eight years of age, had been admitted the night before with symptoms which, according to the description given by Mr. Curling, the house-surgeon on duty, were as follows:—The body was bent slightly forwards; the right lower extremity, slightly abducted, presented the natural amount of eversion, and was elongated to the extent of two inches and a half; there was not the slightest swelling of the groin, but great depression in the region of the trochanter major. Chloroform was administered, with a view to attempting reduction. At first the thigh was flexed to the extent of one-third, but, in the course of the struggles of semi-consciousness, it became about one-half flexed. As soon as anæsthesia appeared to have been produced, Mr. Curling placed one hand lightly on the knee of the affected limb preparatory to grasping it. Feeling that it at once descended, he slightly increased the