

contracting the pupil with eserine prior to incising the cornea, withdrawing a small piece of the inner edge of the sphincter of the iris with forceps, and, the moment it emerges, excising a minute portion—not larger than a pin's head—with specially sharp scissors. In this way I have for some years past succeeded in securing a stenopuic slit quite as effectually as by Mr. Critchett's operation and with none of the drawbacks attending a strangulated prolapse. The appearance presented by the new pupil after recovery depicted in Fig. 2 is sketched from a patient on whom I have recently operated on account of central opacity of the cornea.

Nottingham.

NOTES ON TWO CASES OF AUTO-INTOXICATION AND PREGNANCY.

BY ROBERT CRAIK, M.D. GLASG.

CASE 1.—A healthy young woman, twenty-six years of age, in the seventh month of her second pregnancy, complained of an itchy rash on her body and limbs, but chiefly on her legs. It gave her much trouble at night, the itchiness interfering with sleep. On examination the rash was found to be of the nature of urticaria. A history of gastro-intestinal irritation was inquired for, but there seemed no reason to suppose that indigestion or the ingestion of irritants had anything to do with the causation of the complaint; on the contrary, the patient informed me that soon after the middle of her first pregnancy she began to be troubled in the same way for the first time. On that occasion she was treated with drugs and strict diet for a month without benefit and was much troubled with the rash right up to her confinement, but obtained relief soon after delivery. When I saw the patient her urine was free from albumin, there was no history of rheumatism, and she was not constipated. Several mixtures, including one of salicylate and bicarbonate of soda, were tried, but no relief was obtained, and she was advised to await her confinement. The rash disappeared entirely on the third or fourth day after delivery. The child was healthy and well-developed. She informed me that the rash disappeared much sooner after her first confinement—almost at once, in fact.

CASE 2.—A multipara, aged forty-four years, in the sixth month of pregnancy, was taken with labour pains, and in a few hours gave birth to a fetus which had evidently been dead for a day or two. It was necessary to remove the placenta by the introduction of the hand into the uterus. All went well and she recovered so far as to be able to sit up in a chair for a few hours a day, but she seemed weak and it was found that she had been very poorly for some weeks before the confinement, although able to be about the house till the day of delivery. She gradually became weaker, and soon had to take to bed again, complaining of pains in the limbs and cramps in the legs. Nothing particular was observed till about a month after the confinement, when it was discovered that the muscles of the calves of the leg were flabby and tender on pressure. Sitting on the bed, with her legs dangling over the edge, it was seen that there was considerable wasting of the muscles and ankle-drop, and the knee-jerks could not be elicited in the slightest degree. Her arms were similarly affected, and the grasp was feeble. She was unable to button her night-dress, she complained of numbness of the hands, and had wrist-drop, though not to the extent often seen in alcoholic paralysis. There was no tremor. These symptoms lasted for about three months, but she ultimately made a very good recovery.

Remarks.—In Case 2 delivery was easy, without much exertion or unusual loss of blood. The lying-in period was non-febrile and otherwise satisfactory. There was no suspicion of intemperance and no evidence of lead-poisoning or syphilis. She had had influenza about a year before, somewhat severely. There was no rheumatic or gouty history. No albuminuria was detected during the illness, but the urine was not tested till a fortnight after delivery. The paresis, muscular atrophy and hyperæsthesia, the cramps, and loss of knee-jerks were symptoms that no one could miss when the illness was fully developed. The sensory disturbance was much less marked than the motor.

Conisbro', Yorks.

A Mirror

OF

HOSPITAL PRACTICE, BRITISH AND FOREIGN.

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.

ST. BARTHOLOMEW'S HOSPITAL.

A CASE OF GUMMA OF THE ISTHMUS OF THE THYROID GLAND; ULCERATION; ŒDEMA OF THE LARYNX; LARYNGO-TRACHEOTOMY; RECOVERY.

(Under the care of Mr. BRUCE CLARKE.)

THOUGH gummata of the thyroid gland have no doubt from time to time been noticed, yet very few indeed have been placed on record. Wölfler¹ only mentions one instance of a gumma in the thyroid resulting from acquired syphilis; it was recorded by Navratil.² Demme³ met with three instances in which gummatus masses were found in the thyroid gland in children who were the subjects of hereditary syphilis. We are not aware that any further cases have been recorded. For the notes of this interesting case we are indebted to the house surgeon, Mr. Maurice G. Pearson.

A married woman, aged thirty-eight years, was admitted into St. Bartholomew's Hospital under the care of Mr. Bruce Clarke on Dec. 28th, 1896. About four years ago she attended as an out-patient under the care of Mr. Bruce Clarke, and suffered from a gumma of the right arm, which subsided under treatment with iodide of potassium. She ceased taking the medicine, and very soon three gummata appeared on the left side of the face, and were similarly cured. About March, 1896, a gumma appeared on the front of the neck, and again iodide of potassium was given; but in September, 1896, the swelling began to ulcerate, and she treated it by poulticing. She had been married thirteen years and had never been pregnant. No history of syphilis or any of its manifestations (apart from the gummata for which she had been treated) could be obtained either from herself or her husband. A fortnight before admission she began to have a difficulty in swallowing and could take no solids. Her voice became a husky whisper, and during the last week her breathing had been difficult. On admission her temperature was 100·3° F., her pulse was 36 and small, and the respiration was 24 per minute. Her breathing was always difficult, and occasionally severe paroxysms of dyspnoea caused the patient great distress. In the mid-line of the neck anteriorly there was a hard, cylindrical swelling, extending from the hyoid bone to the top of the sternum, so that the thyroid and cricoid cartilages could not be felt. The swelling rose and fell with deglutition. Its upper part was ulcerated, and the ulcer was "punched out" in appearance, and on the surface there was a washleather-coloured slough; in fact, it was typically a gummatous ulcer. With the laryngoscope the mucous membrane of the larynx appeared to be very red, but not markedly œdematous. The abdominal and thoracic viscera were apparently normal. Iodide of potassium was administered, but the patient grew worse rapidly; the dyspnoea increased, the left side of the larynx became very œdematous, and a sub-conjunctival hæmorrhage appeared in the right eye. On Jan. 1st she had another attack of severe dyspnoea worse than any she had had before; she sat up in bed and breathed with difficulty and distress, and was evidently greatly frightened; she said she felt she was dying; the pulse was 130 and very small; the respiration was very rapid and constantly interrupted by fits of coughing; the skin was markedly cyanosed. Laryngo-tracheotomy was performed at once without an anæsthetic, as her condition was not considered good enough to stand one; except during the skin incision she did not seem to suffer much pain. It was found necessary to cut through a thickness of

¹ Archiv für Klinische Chirurgie, 1883, p. 827.

² Chirurgische Beiträge, Stuttgart, 1882, pp. 21 and 22.

³ Handbuch der Kinderkrankheiten, vol. iii., part 2, p. 413.