

landscapes, or the forms of persons, or of other objects. These hallucinations, in the course of N.'s observation of them, often underwent the most unexpectedly grotesque movements and changes; at other times they remained stationary. They appeared sharply and clearly defined, and remained long enough to allow of their careful examination—resembling, by no means, pictures produced by the painter's pencil, but gave the same impression as though they were, in fact, natural existing objects. N., during health, had never before been the subject of similar hallucinations. He believes they were seen by the left eye alone. It is true, that by rapidly opening and closing the lids of the right eye, the cornea of which had been slightly injured, there appeared before this eye another clear picture, which quickly vanished; the pictures which occupied the whole field of vision were produced evidently by the left eye alone. The hallucinations above described did not originate in any morbid excitement of the brain, nor certainly from any preceding impression upon the sense of vision; nor were they the least under the control of the will.—*Centralblatt f. d. Medicin. Wissenschaften*, Oct. 1868.

D. F. C.

54. *Sympathetic Ophthalmia*.—MR. HAYNES WALTON records (*Lancet*, October 17, 1868) the following instructive case:—

“A farmer was accidentally shot in his right eye twenty-seven years ago. The eyeball was penetrated; some of the vitreous humour escaped directly, and with it two shots. Vision was destroyed. The inflammation which followed subsided in a few weeks. For twenty years he suffered no inconvenience in his eyes, but now the left eye occasionally became inflamed from exposure to cold winds, or from any irregularity in diet, such as drinking too much. The attacks became more frequent without any apparent exciting cause, and in 1866 this gentleman was brought to me by Dr. Edward Lawford, of Leighton-Buzzard. I found the eye damaged from the repeated attacks of inflammation; the iris was discoloured and bulging, and the pupil nearly generally adherent. The vitreous humour was a little hazy; vision was imperfect. As I could not detect any irritation in the wounded eye, which was very much shrunken, I thought I had before me a case of rheumatic ophthalmia, and prescribed accordingly. I saw my patient several times afterwards, during successive attacks of inflammation. The eye got a little worse, in spite of all treatment and all care, and sight was fast failing. On his last visit to me I examined the collapsed eye very carefully again, and pressed it firmly between the fingers. This caused much pain. A repetition of the pressure produced the same effect, and the patient said, ‘No pressure hurts the other eye, but this is most intolerant of any.’ I was now quite satisfied that there was irritation here, which was affecting the other eye, and I recommended the removal of the stump. This was at once acceded to, and I operated. A grain of shot was discovered in a mass of fibrinous effusion. Besides this there was a cup of bone deposited between the sclerotica and that which remained of the choroid. The left eye commenced to improve from the very hour of the operation. The pain disappeared, the muscæ decreased, and vision improved. At this time, two months from the operation, vision is still better, and small type can be read. The vitreous humour is almost clear. I have no doubt that the vision will improve still farther.”

55. *Operative Treatment of Conical Cornea*.—VON GRAEFE, in the course of an article which deals elaborately with the whole subject of this disease, dwells upon the ill-success which has attended all the various operative procedures which have been devised for its relief. Long-continued treatment with atropia and with bandage-pressure, repeated evacuation of the aqueous humour by paracentesis of the cornea, iridectomy, making the pupil into a long slit, like the pupil of a cat, by double iridectomy, on Bowman's plan—all these measures have proved highly unsuccessful. Graefe has, however, lately devised a method which has already succeeded, in several cases, far better than any previously known plan. A little flap (three-quarters to one line in thickness) is made, with a very narrow knife, from the apex of the corneal protrusion; and this is cut away along its base with scissors. On the next day the new surface is touched with a mixture of one part of nitrate of silver and two of nitrate of

potash (*lapis mitigatus*); and this is repeated every third or sixth day, till a slight yellowish infiltration becomes apparent. The surgeon must then drop in atropia, and wait. In from six to eight weeks there is an exfoliation of the cornea, which brings about a notable improvement in the clearness of vision.—*The Practitioner*, January, 1869, from *Berlin. Klin. Wochensch.*, 23, 24.

56. *Detachment of Retina Cured by Operation.*—Mr. J. Z. LAURENCE states (*Lancet*, March 6, 1869) that "Detachment of the retina from the subjacent choroid may be caused by a solid or a fluid. In the latter case the retina, separated from the choroid by fluid effusion, projects into the vitreous humour in the form of a spheroidal protuberance. The retina generally becomes thus separated first at its upper part; as the effusion of fluid increases, the retina becomes detached more and more downwards, till it is detached so completely that the field of view becomes totally destroyed, and the patient perfectly and incurably blind. The upheaving of the retina may aptly be compared to that of the cuticle by a blister. If the cuticle be pricked, and the contained fluid let out, it resumes its apposition to the subjacent cutis.

"Acting upon this principle, Von Gräfe, Mr. Bowman, and other eminent surgeons have punctured the retina with needles, in the hope that the subjacent fluid, by escaping and mingling with the vitreous, would permit of the retina reassuming its apposition with the choroid, and resuming its visual functions. In very few cases, however, has that hope become realized.

"The idea occurred to me that a more happy result might be obtained by puncturing the bag of fluid through the sclerotic and choroid *without inflicting any wound whatever on the retina*, and thus allowing the effused fluid to escape *outwards* into the subconjunctival tissue, instead of inwards into the vitreous humour. I have lately operated on a case, the details of which I will here but briefly allude to.

"A man, aged fifty-three, presented himself with complete detachment of the upper two-thirds of the left retina. He was completely blind in the lower and outer half of his field of vision, and had mere perception of light in the other half. On January 18th I pierced the upper and back part of the sclerotic and choroid with a broad needle. A quantity of colourless fluid immediately escaped into the subconjunctival tissue. From that time the field of vision steadily increased till on February 11th, it became absolutely entire, and at ten feet he read easily C of Snellen's types. At the same time the fundus of the eye, including the optic nerve, vessels, etc., was perfectly well seen; whilst previous to the operation it was all but obscured by the detached retina, not a trace of which could now be seen."

MIDWIFERY.

57. *Stricture of the Internal Os as a Cause of Miscarriage.*—Dr. WILLIAM MARSHALL relates (*Glasgow Medical Journal*, Feb. 1869) the following instructive case: He was called to a delicate woman, æt. 30, five months advanced in pregnancy:—

"The pains were strong and forcing, very similar in character to those which immediately precede the expulsion of the head in a primipara. I was told that when pregnant last she had miscarried at the fifth month, and that the pains then, for three hours, had been very severe—much worse than she had ever had in any confinement, and similar to what they were now. On examination, I found the os uteri dilated to the size of half a crown, and very soft. On passing my finger further up in order to feel the fetus, I found the canal of the cervix becoming decidedly narrower, when suddenly she cried out that I was cutting her, and jerked herself away. On a second attempt the same thing was repeated; but on a third, being prepared for her moving, I ascertained that a tight resisting constriction existed at the internal os, which would not admit the tip of the finger. As soon as I touched the constricted part, she