

reflected from the lower lid to the globe, and close to the outer canthus. Under ordinary circumstances the polypus was not visible, having made for itself a kind of pouch at the situation where it grew; and, at a cursory glance, the patient presented no other peculiarity than a slight fullness of the lower eyelid. On retracting this somewhat forcibly the polypus sprang out from its situation, and then projected between the lids. The patient himself, by a little manipulation, could, however, always replace it so as to render it again invisible. In colour it was of a dark-claret hue; in consistence somewhat firm; it was free from tenderness to the touch, and rarely gave rise to pain. Its removal was effected by dividing the pedicle close to the conjunctiva; this, however, was followed by somewhat severe hæmorrhage, a small arterial twig (as seen by the pulsating jet of blood) being implicated in its structure. Its microscopical characters were those of an ordinary mucous polypus with a slight excessive development of fibrous stroma. There has been no return of the growth.

The second case, which in many ways differed from the first, occurred in a child six years of age. The growth, which sprang also from the fold of conjunctiva between the globe and lower lid, was situated midway between the outer and inner canthus; its form was flattened and fan-shaped, its flat surface being in close apposition with the ocular conjunctiva; its pedicle was short and scarcely to be distinguished from the remainder of the growth. Vertically the tumour measured about a quarter of an inch, and horizontally somewhat more than this in diameter, and in some positions of the eye it interfered with vision by crossing the area of the pupil. Its general appearance very much resembled, on a small scale, that of condylomata as seen in the neighbourhood of the vagina and anus, and its microscopic examination revealing a structure almost identical with these, led to examination of the external parts of the child. Although there was no analogous growth in this region, there was a well-marked vaginal discharge, and it is not unreasonable to suspect that this may have some connexion with the growth, which, although freely removed, shows a very strong tendency to return; and, indeed, since its removal, several other small papillary-looking growths have appeared in the neighbourhood of the caruncle.

#### OSSIFICATION OF A LARGE PORTION OF THE CHOROID FOLLOWING CHRONIC TRAUMATIC INFLAMMATION.

A deposit of bony matter in the choroid, though by no means a very rare event, seldom occurs to the extent detailed below. A gentleman, thirty years of age, received, when about six years of age, a blow upon the eye from a piece of exploded gun-cap. His memory failed him as to whether the piece of cap had been extracted, but all vision was completely lost shortly after the accident, and since that time he has suffered from occasional attacks of severe pain and inflammation in the eye. The pain, which has always been of a throbbing character, at times became quite distracting, and on several occasions he has been obliged to keep his bed for six weeks or upwards. The remaining eye, though free from any inflammatory changes, is in a highly irritable condition, and he complains of great photophobia. The diseased globe was consequently removed. On making a section of the eye in the equatorial region the lens was found to be absorbed, its position being occupied by a dense membrane of hypertrophied capsule. The ciliary processes were of light-brown colour, and much atrophied; the whole of the posterior half of the choroid was converted into a cup of bony material of at least an eighth of an inch in thickness. This cup was occupied by the remains of the optic nerve, and there was a small aperture in its centre where the nerve entered the eye. Externally the bony deposit had no connexion with the sclerotic, from which it was separated by a thin layer of brownish pigment, the only remaining trace in this region of the choroid coat. No trace of a foreign body could be found in the interior of the globe.

THE mortality last week in London and twenty other large towns in the kingdom was at the rate of 24 deaths annually to every 1000 of the estimated population. In the metropolis there were registered 1319 deaths, including 162 from diarrhoea and 26 from the different forms of fever. The death of a match-maker at the London Hospital was referred to necrosis from phosphorus.

## THE MEDICAL VALUE OF ARTERIAL PRESSURE.

By EDWARD DE MORGAN,

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THE following deductions were made by me some years ago when experimenting with the sphygmograph. As I have found their practical application in diseases of the chest so valuable, I feel myself no longer justified in withholding them from the criticism of the profession.

Let us assume that pressure be applied to both axillary and femoral arteries; then, roughly speaking, about half the blood in the systemic or greater circulation is withheld. The remainder returns to fill the left ventricle of the heart, which either contracts upon half its normal amount of blood or delays its contraction until sufficient blood has returned from the unobstructed vessels to distend it to its normal contracting volume. If the latter of these two alternatives were the case the pulse would be diminished in frequency and its fulness greatly increased. It may at once be ascertained, by pressure on a femoral artery, that there is no alteration in frequency, and the sphygmograph shows that there is no increased tension in the radial pulse when the femorals are compressed. Hence it follows that the left ventricle contracts upon half its normal quantity of blood, and that the right ventricle contracts upon half its normal amount of blood, and that, the area of the pulmonary or lesser circulation being undiminished, the pulmonary artery contains but half its normal amount of blood; and thus it follows that the blood speeds through it less rapidly, and pressure within its walls is greatly diminished.

I determined to apply this theory in three different sets of cases.

1. (a) Hæmoptysis in consumptive cases; (b) hæmorrhage from wound of lung.

2. On the supposition that damming back venous blood from the lungs would diminish the necessity of oxygenation; (a) spasmodic asthma; (b) emphysematous and cardiac dyspnoea.

3. As a direct *dry cupping* of the lung in inflammatory diseases.

Of Class 1 I have had but little experience. We have but little hæmoptysis in South Africa. In the case of a Kaffir with a bullet-wound of the left lung, pneumothorax and hæmothorax present in great degree, axillary pressure gave immediate relief to the dyspnoea.

Of Class 2 I have applied pressure in five cases, and afforded immediate relief to dyspnoea in all.

Miss S— has spasmodic asthma every month. She came to my consulting-room in great distress. I applied my thumbs to both axillary arteries, and she expressed herself immediately relieved. Pressure was continued for about five minutes. Upon removing it the dyspnoea did not return for about ten minutes, when pressure was again applied, and she left with her breathing nearly natural, the dyspnoea this time not returning for some hours. Her friends by my directions compressed her arteries, each time affording her relief. She states that this was the severest, but shortest attack she has had, and that less bronchitis was left than usual.

W. S—, an old missionary, aged seventy-six, has been failing since I first saw him one year ago. Has chronic bronchitis, emphysema, and dilatation of the right ventricle, besides other complications. One evening in May last I was summoned to him in haste, as his friends feared he was dying. I found him sitting up in bed; orthopnoea extreme; face livid; hands plucking at the bedclothes; cough incessant. He had had every door and window thrown open, and permitted no one to stand at his bedside. He just managed to gasp out that "I was too late this time." I applied my fingers to his axillaries alone, and in less than half a minute he expressed himself relieved. In less than two minutes he was thanking me in his old manner, and inquiring into the *modus operandi* of the means I had used. The pressure was removed after ten minutes, but the dyspnoea did not return. He began to cough up mucus more freely, and in a quarter of an hour fell asleep. On subsequent occasions, if pressure was removed too soon,

he would start up, and cry out that "It was coming back," but was again tranquil upon its reapplication.

The sequel of this case is interesting, as bearing upon this treatment. The following morning, whilst Mr. S— was turning in bed, he fractured a rib on the left side. I was sent for, and found him in great agony, the crepitation being audible to those around on each laboured inspiration. Strapping and subcutaneous injection of morphia relieved him.

The following evening I was again sent for, this time to find him in a state of extreme cardiac apnoea; face deadly pale; pulse rapid and exceedingly compressible; respiration rapid; air entering freely into all parts of the lungs. Complained of a death-like feeling over præcordial region. Axillary pressure gave scarcely any relief. In fear and trembling, and feeling my way with small doses, I gave morphia, and this relieved the dyspnoea and procured sleep.

Subsequent experience in this patient's case, which ended fatally a few days after, convinced me that cardiac dyspnoea was not to be relieved in nearly the same degree as that of pulmonary origin, but in the latter relief was immediate and unailing.

I will not occupy space by enumerating other cases; suffice it to say that mine, although few, have all been most unequivocal. And although I cannot imagine but that the principle and practice have been recognised before, yet, as I have never hitherto met a medical man to whom the effect of arterial stoppage upon the circulation has not been a novelty, I earnestly beg the profession to adapt it to treatment, and trust all may give the same relief to suffering that I have been enabled to do.

With respect to Class 3, where there is active inflammation of lung tissue, I cannot, from want of experience, speak with conviction. I think that gentle pressure of the femorals (it need not be complete) might be serviceable in the intractable catarrhs at the apex of the lung in phthisical people. I can speak from personal experience of the relief that pressure on one or both femorals gives to those irritating coughs that destroy the rest of those with consumptive disease. It might be well to remind experimenters that pneumonia predisposes to the formation of a pulmonary clot, and that it might be dangerous to slacken the pulmonary current in that disease.

Stoppage of epistaxis by elevating the arms may be due to the same cause by compressing the axillary arteries. This would act, I imagine, by facilitating the return of blood through the superior vena cava. If so, digital compression would be better. This is rendered probable by the arrest of hæmoptysis by tying up the arms of consumptives. My friend, Dr. Grabham, of Madeira, whose experience is large, told me that he often treated hæmoptysis in this way with success.

Lest I should override my hobby, I will only suggest the probability of lowered temperature in lungs whose bloodstream is much diminished, and the possibility of inflammation resulting, as after great amputations.

Queenstown, South Africa.

## FURTHER REMARKS ON THE TREATMENT OF NOCTURNAL INCONTINENCE OF URINE.

By WILLIAM THOMSON, M.D.,

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It may seem to some minds that there is no such thing left nowadays as medical doctrine; that each man is his own teacher, and does what is best in his own eyes. Men have not gone to their old books with so much frequency or so much faith as they were wont to do. In some respects this is a change in the drift of medical work which is every day bearing testimony to the advance in medicine. There are many ailments that until recently have been passed over by our standard authors in a way which would lead young practitioners to conclude that they were either incurable or insignificant. Incontinence of urine is one of these, and I have now much pleasure in verifying the opinion I expressed nearly three years ago, in *THE LANCET*

of Nov. 19th, 1870, and subsequently in November, 1872—viz.: that chloral hydrate would prove the most valuable remedy in this disease which has hitherto been employed. My excuse for again bringing the subject before the profession is that I have had several communications from medical men inquiring particulars as to the mode of administering the drug.

1. We must bear in mind that chloral is not always certain in its action. (The peculiar effects of chloral are well described by Dr. Murphy in *THE LANCET* of Aug. 9th.)

2. Only give it at night, the patient having fasted for two hours previous to going to bed.

3. Give it in full doses, and when in bed.

4. Let the patient have as little fluids as possible; beer and spirits to be entirely prohibited.

5. Not to be continued longer than a week or ten days; if benefit is not derived within that period, the case is either not one of incontinence depending on habit solely, or the peculiar idiosyncrasy of the patient prevents the beneficial action of the chloral.

I might say much on the employment of chloral in combination with other remedies when the incontinence depends on some specific cause, such as disease of the bladder, urethra, or kidneys, or from reflex irritation from ascariides, from constitutional debility, or anæmia. In all these cases it may prove useful in combination. But in fifteen simple cases treated by me during the past three years, it has proved alone a perfect cure in all in less than a week.

In conclusion, I would add that it is my belief that when chloral is employed in this disease, with the rules advised, it will prove highly satisfactory both to the physician and patient, as it enables us to cure speedily a disease the mere discussion of whose symptoms is a source of humiliation to the sufferer.

Peterborough.

## 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. Proæmium.

### LONDON HOSPITAL.

#### CASES OF CURVATURE OF THE SPINE; PARAPLEGIA; RECOVERY.

(Under the care of Dr. RAMSKILL.)

THE subjoined cases furnish good illustrations of paraplegia following curvature of the spine. The changes in the cord which produce loss of motion, with or without loss of sensation, in cases of angular curvature, are not exactly known; still less the manner in which the cord recovers its functions. As a knowledge of the anatomy and physiology of the various tracts in the spinal medulla would lead us to anticipate, loss of motion commonly exists without any interference with sensation; whereas it is doubtful whether cases are ever met with in which there is paralysis of sensation alone in cases of angular curvature. It is, moreover, interesting to note that, notwithstanding the loss of motor power, the reflex movements remain active, and that the patient may suffer from severe and distressing spasms of the paralysed limbs. Happily the prognosis is favourable in many cases, although the disease is liable to recur at uncertain intervals.

For the notes of the following cases we are indebted to Mr. R. Kershaw.

The first case is that of R. H—, aged twelve years, who was admitted as an in-patient on July 11th, 1872. His mother stated that about eighteen months ago he fell and injured his back, and from that time he held his head a little to the right. After this a lump appeared in his neck, and it subsequently burst and became very sore. It