

into a town diphtheria may become epidemic, and be disseminated by precisely the same channels as typhoid fever; that the infection may be conveyed into any house by sewer gas, or otherwise, altogether irrespective of dampness of structure, but that its endemic breeding-grounds are to be found in certain well-defined spots in rural districts, where it is constantly liable to break out as if *de novo*, and that the constant condition of these localities is structural dampness of habitation.

ON THE SELECTION OF THE MOST APPROPRIATE TIME FOR OPERATING IN CASES OF CONVERGENT STRABISMUS IN CHILDREN.

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THERE can, I think, be little doubt that when children begin to squint, the question as to when they shall be submitted to operation, and how they should be managed previously to it, has often to be put to persons in practice who are not specialists, and, judging from my own experience, does not always receive the consideration which it merits. Much uncertainty seems to me to prevail in the profession generally on this subject, and the text books do not put the matter very clearly. All of them explain the theory and the method of the operation well enough, but they afford no information as to when it becomes essential to do the operation, and when it may be done most advantageously to the patient.

The importance of this subject does not rest on the question of appearance, but on the maintenance of a normal standard of visual acuity in both eyes; and it is most grievous to have to operate on so many cases as we do in which the acuteness of vision of the squinting eye has greatly fallen off. One cannot too strongly insist that the squinting eye is disused, and must, unless the squint is alternating or proper precautions be taken, become amblyopic. It must be understood that I am speaking only of the concomitant convergent strabismus of hypermetropic children. Now the cure of this condition does not consist in removing the deformity so as to be no longer visible; but our object is to restore binocular vision for all distances, and we can make no certainty of doing this unless the two eyes have at least nearly an equal acuteness of vision. When it happens that we have to deal with a case of alternating strabismus (in which the two eyes with equal use remain equally good), we may predict with certainty that, after correcting the hypermetropia with glasses, the squint will diminish, and that a subsequent tenotomy will produce a complete result. But when one eye is amblyopic the case is quite different; the deformity may be removed, but the result is at best imperfect and uncertain, because, as is well known, the perfecting of the operation depends on the fusion of double images by instinctive co-ordination on the part of the patient.

The answer to the question as to *when* the operation should be performed should, in my opinion, be as follows:—It should be postponed until the child is old enough to wear glasses, *provided* that the acuteness of the deviating eye can be maintained by regular daily exercise at reading &c., the sound eye being *completely excluded for half the day*. In practice it will be found that this rule is not applicable to children of all ages, but applies well to those between four and seven, provided that those in charge of them carry out the instructions to the letter. When the young hypermetropes do not commence to squint till they are seven or eight years old, it generally happens that their education has so far advanced that we can judge of their acuteness of vision, and they are usually brought to us before this has deteriorated. They can be trusted with glasses, which, either with or without tenotomy, suffice to effect a cure. These patients should therefore be thoroughly atropised, the errors of refraction corrected, and proper glasses given to them for some weeks before the operation is decided upon. But with children younger than this—say from three to seven years old—the wearing of glasses is attended with many

obvious drawbacks, and it is for children about this age that I especially advocate the education of the deviating eye as above suggested.

It is, however, surprising how difficult it is to make those in charge of the child understand the importance and the object of this plan, even in the case of people in good position, and it seems as though it were impossible to eradicate the idea that this method is intended to cure the squint. Last year I had a case of a boy at four, who had squinted for about six months, and who had V. $\frac{2}{3}$ in R., and $\frac{2}{3}$ in L., Hm. = $\frac{1}{2}$ n., and for whom I adopted the above plan. At the expiration of ten months he was brought to me again, with the statement "that he is no better," and I found upon inquiry that the exclusion of the non-squinting eye had been very imperfectly carried out, the result being that the vision of the squinting eye had come down to $\frac{2}{3}$.

Notwithstanding this example of the difficulties of the plan, I still maintain that this is the best method of dealing with these cases. Unfortunately it happens frequently that children begin to squint earlier even than this, often within the first twelve months, and here we cannot expect this treatment to be carried out. It therefore becomes necessary here to operate as soon as the squint has become confirmed, unless it happen to be an alternating squint, and even then it must be *proved* that one eye is used as much as the other. We must operate with the hypermetropia uncorrected and the vision undetermined, rather than leave the one eye to a certainty of deterioration.

In my suggestions as to the ages at which the plan above proposed is to be adopted of course I do not wish to be understood literally, but discretion is to be used according to the character of the particular child in question.

Finsbury-circus.

ERGOT IN THE TREATMENT OF ANGIO-PARALYTIC MEGRIM.

BY DR. SCHUMACHER.

OF the numerous theories proposed to explain the peculiar symptoms of megrim, that which attributes this to an affection of the cervical sympathetic appears to be the most plausible. Du Bois-Reymond and Brunner, themselves subject to the disease, assume as its immediate cause a tetanic contraction of the cerebral vessels due to an irritation of the vaso-motor nerves, whereas Möllendorf holds that it proceeds from dilatation of the vessels in consequence of a paralysis of those nerves. Both views seem correct, and there is every reason to believe in the existence of two forms of megrim, an angio-tetanic and an angio-paralytic.

It follows, therefore, that the treatment of megrim must vary according to the nature of each case. For while the angio-tetanic form of the disease would be relieved by nitrite of amyl, the angio-paralytic can be benefited only by such remedies as serve to contract the cerebral blood-vessels. Upon this ground Eulenburg recommended ergot of rye in the treatment of the latter form, and the favourable results obtained from the exhibition of that drug have been confirmed in America, England, and Germany. As there are, however, but few cases on record showing the benefit to be derived from ergot in angio-paralytic megrim, I think the following may not be uninteresting, distinguished as it is by its long duration and its great resistance to all other methods of treatment:—

Mrs. S——, of Aix-la-Chapelle, aged forty-nine, of a rather feeble constitution, and affected with kypho-scoliosis for the last fifteen years, enjoyed tolerably good health until the end of 1873. At that time the menses ceased, and she began to suffer from intermittent but violent palpitation, usually occurring at night, and accompanied by painful oppression of the chest—symptoms resembling those of angina pectoris. There was no history of either gout or rheumatism. The kidneys were healthy, but the heart was enlarged in its transverse diameter, inasmuch as the cardiac dulness exceeded the right sternal border and also the nipple line for about one centimetre in each direction. The heart-sounds were normal; the pulse was 80, and rather weak. I concluded at the time that the case was one of dilatation of the heart in consequence of the kypho-scoliosis and the compression of the lungs.

In January, 1874 Mrs. S—— began to complain of severe

headache on the right side. Without any known cause it generally came on after midnight, when she was roused by it from her sleep, and then kept awake for several hours. Bicarbonate of soda, rhubarb, and small doses of morphia, gave her immediate, but only temporary, relief. About the end of January the palpitations ceased altogether, but the nocturnal headache increased in violence. The headache now regularly returned every night between two and half-past two o'clock. It was mainly situated in the right occiput and thence spreading to the forehead. There was a feeling as of a heavy pressure upon the eyes, a forcible pulsation of the right temporal arteries, and a distinct rise of temperature on the affected side of from 0.3° to 0.4° C. Gradually the pains subsided towards the morning. At my morning visits I found the patient greatly fatigued, and, as the sole objective symptom, an injection of the vessels of the right sclerotic, which, however, disappeared in the course of the day. As the attacks seemed to be of a typical recurrence, I therefore ordered large doses of quinine, but without any benefit. Caffein not only gave no relief, but produced also nausea and sickness. The induced current also failed, but the treatment by means of the constant current (stable current of from six to eight elements applied for from eight to ten minutes) seemed to be, for a time at least, most successful. During three weeks the electricity was applied about twelve times, and the intensity of the pain greatly diminished; no attack appeared in the nights following the days on which electricity had been used, and the intervals between the attacks also increased from three to four days. The treatment, however, was unfortunately interrupted, whereupon the headache returned with its former violence. Again the patient was roused between two and half-past two o'clock; again the pain started from the right occiput, radiated to several branches of the trigeminus, accompanied by a humming noise in the right ear, beating of the arteries, and rise of temperature on the right side. Again the constant current was applied, without, however, producing the same favourable results as before. Iodide of potassium and the nervine tonics were then tried, but they failed to relieve the distressing symptoms.

Upon the supposition that the case was an affection of the sympathetic nerve, and that the headache was due to a paralysis of the arteries, I had in February, 1874, begun to give the ergotine de Bonjean, but the doses were small and the results not at all satisfactory. Meanwhile Eulenburg had recorded (*Berl. Klin. Wochens.*, 15, 1873) a case of intermittent headache with disturbance of circulation—cephalgia vasomotoria—which was completely cured by large doses of ergotine. As the symptoms of that case resembled those of the one just described, six grains of ergotine were at one time given per diem, and this quantity was gradually increased to twelve grains. The exhibition of one drachm and a half in the course of two weeks was followed by an abatement of the symptoms; for though the headache returned every night, it was less violent than before. From the 15th of April, 1874, the daily quantity of ergotine was increased to fifteen grains, and after the patient had thus consumed two drachms more of the drug the attacks had a much shorter duration and were much less severe. The above dose of fifteen grains was continued for one month. During that time the ergotine produced no disturbance of the general health, while the headache gradually subsided, so that towards the middle of May the patient was discharged as cured. She had taken not less than seven drachms of ergotine in a very short time, and has ever since been free from any of the angio-paralytic symptoms.

Aix-la-Chapelle.

CONTRIBUTIONS TO PLASTIC SURGERY.

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(Concluded from p. 179.)

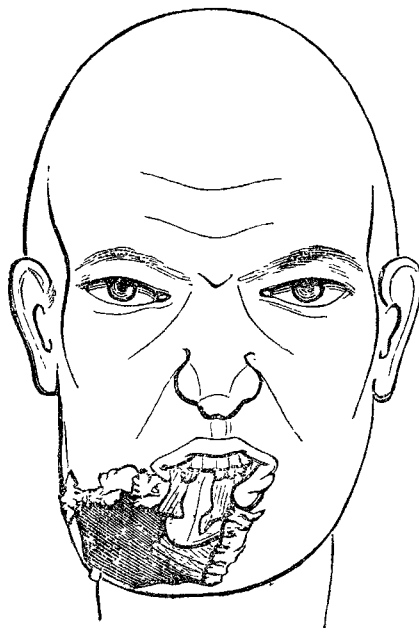
CASE 7. *Restoration of the Chin and Lower Lip.*—Harju, aged thirty, a hill-man, employed as a jhampan-bearer, was brought to the Simla Dispensary on the evening of Oct. 2nd, 1877, on account of a very severe gunshot injury of the face. The lower jaw was smashed, and the soft parts covering it, including the right half of the lower lip, were completely torn off. The tongue had escaped uninjured,

but, from want of support, hung down on the neck, amidst shreds of muscles and integument and fragments of the shattered bone.

The comminuted fragments of bone having been removed, the remains of the lip were brought together with a twisted suture, and an endeavour made to close the wound as far as possible. Sloughing, however, ensued, and a hideous gap resulted.

Fig. 8 shows the appearance on Oct. 18th, sixteen days after the accident. On that date a plastic operation was

FIG. 8.

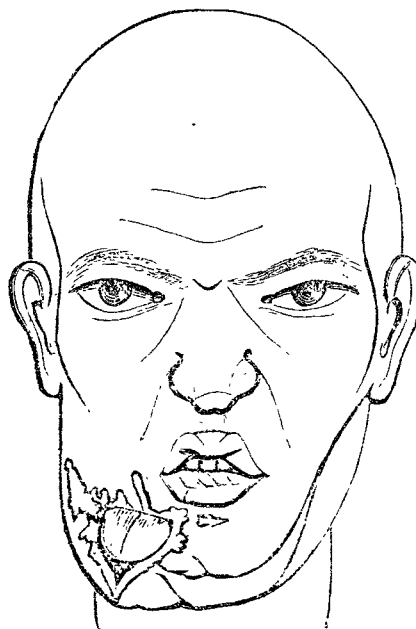


resolved on, which was divided into two stages: (a) restoration of lip; (b) complete closure of wound. The following are the details.

On Oct. 18th, 1877, healthy granulation having been established, the patient was placed under chloroform, and, the remains of the lower jaw being found necrosed as far as the angle on the right side and the socket of the first molar tooth on the left, the bone was removed to that extent with saw and forceps. The cut extremities of the lower lip, having been pared, were then brought together with a harelip pin and two silver sutures, and the wound strapped with court plaster.

Oct. 23rd.—Outer bandages changed; strapping on lip not interfered with.

FIG. 9.



26th (eight days after operation).—Strapping removed for the first time. Complete adhesion of the lip has taken place. Harelip pin, being loose, was removed. Sutures allowed to remain.

31st.—Sutures removed. The lower lip has completely