

the great sacro-sciatic foramen. The index finger could be passed along the neck of the sac through the foramen. The bowel appeared to be perfectly normal. As a radical operation was considered to be impracticable no attempt was made to reduce the hernia and the wound was closed.

Remarks by Mr. GROGONO.—This case shows, in my opinion, that the sensations of the patient should not be too lightly passed over. Had I paid more attention to the statement of the patient that she felt "something moving" in her abdomen on sitting down I might have been able to arrive at a positive diagnosis of the case.

SHEFFIELD ROYAL INFIRMARY.

THREE OPHTHALMIC CASES.

(Under the care of Mr. SIMEON SNELL.)

THE case of papillitis recorded below is a good example of an important sequela of influenza. There is no tissue of the body which is not liable to be involved in this disease, so remarkable for the number and variety of its sequelæ. Dr. Weeks, in the *New York Medical Journal*, 1891, has collected several similar cases. With regard to the third case the eyelids are not very rarely the seat of ectopic primary syphilitic sores, but it is difficult to assign any reason for their occurrence in this situation. It has been stated that attacks of syphilis arising from ectopic sores are more severe than those due to sores in the usual situations, but this idea is probably due to the fact that extra-genital chancres are frequently not diagnosed early. For the notes of the cases we are indebted to Mr. J. Wilfred Stokes, late assistant house surgeon.

CASE 1. *Embolism of the arteria centralis retinæ.*—A man, aged 60 years, attended at the Sheffield Royal Infirmary on Nov. 8th, 1897, and stated that at 6.15 A.M. that morning while stooping to tie his bootlace his right eye became suddenly blind; after this for about half an hour there was some slight pain over the right eye and right side of the head. When the patient was first seen at 11 A.M. the condition was as follows. With the right eye there was the faintest perception of light, the pupil was somewhat dilated and fixed, the fundus was pale, and the arteries were empty and barely distinguishable; the veins were, generally speaking, also empty but in one or two a column of blood was noticed. The appearance this latter presented was very distinct, as on either side of the column the lumen was observed as empty. There was no distinct "red spot" at the macula and there was an absence of the effusion so generally seen in cases of embolism of the central artery. At the emergence of the artery from the disc there was a small spot suggestive of the embolism and the effect on the vessels was more marked in the descending arteries, as if the plug interfered more with the flow of blood through these vessels than it did through the ascending branches. Mr. Snell immediately commenced to massage the globe and after this had been continued for a few minutes a marked change was evident; the general pallor was lessened and the column of blood in the vein already especially alluded to was lengthened. Later the veins and arteries appeared to be charged with blood. At 4 P.M. the patient was again seen when it was found that there was blood in the arteries and that to a considerable extent circulation had been restored. The next morning he was again seen by Mr. Snell. The patient could then count fingers and the appearance in the fundus presented a marked contrast to what it had done on the previous day. Both arteries and veins contained blood though the fundus was still pale when compared with the left. Two days later a change had again taken place. He could no longer count fingers and the arteries had become markedly altered, appearing like threads. On Dec. 20th the optic papilla had passed into the white atrophic condition usually seen after embolism of the artery. The patient's past history and general present condition were good; there was no history of any illness. The heart sounds were normal, the first sound perhaps being weak; no murmur was heard. The urine was of specific gravity 1010, clear, pale, and neutral, and contained no albumin. The patient was a heavy drinker.

CASE 2. *Post-influenzal papillitis.*—A well-developed girl, aged 18 years, attended at the out-patient department of the infirmary on Nov. 5th, 1897, complaining of defective vision. She stated that her sight had been good until a

month previously when she was just out of bed from an attack of influenza which had confined her there for a fortnight. The history of this illness was that six weeks previously while at work in a razor factory she was suddenly taken ill with pains in her head, back, and neck, and a feeling of general malaise. She was unable to continue at work and took to bed where she remained for a fortnight; the chief symptoms of her attack were vomiting and the above-mentioned pains. She noticed nothing wrong with her sight until she left her bed, when she discovered that she could not read. Subsequently her sight had remained about the same. There was nothing else of interest in her past history. She had never worked in lead or suffered from plumbism; there was no history of chorea, rheumatic fever, or scarlet fever. The urine was of specific gravity 1013, acid, and contained no albumin or sugar. On examination a convergent strabismus of the right eye was seen. There was no nystagmus. The pupils reacted well to light and to accommodation. The vision in each eye was $\frac{6}{36}$. The patient could not read small print in Jaeger's types. Examination of the fundus disclosed well-marked papillitis in each eye.

CASE 3. *Chancere of the upper eyelid.*—A girl, aged seven years, was admitted into the infirmary on Nov. 12th, 1897. A pimple had been noticed on the right upper eyelid a few weeks before admission; this had later developed into an ulcer which at the time of her coming under observation involved a considerable portion of the lid. The whole eyelid was much swollen and indurated; the ulcer occupied the central two-thirds and was emitting a scanty discharge. The glands behind the angle of the inferior maxilla were much enlarged, but, unlike what is usual in cases of chancres of the eyelid or conjunctiva, the pre-auricular gland was not implicated. Two days after admission a rash appeared all over the front of the chest and abdomen and extended down on to the thighs; this after a few days began to fade and disappeared in about ten days. On Dec. 21st the eyelid was much reduced in size and the red area was limited to a small portion at the centre of the lid. The enlargement of the glands had disappeared. At the time of admission the child was put on a course of mercury internally. No history whatever as to the source of infection was obtainable.

ROYAL HOSPITAL FOR SICK CHILDREN AND WOMEN, BRISTOL.

A CASE OF VERY ACUTE DIABETES IN A BOY, AGED FIVE YEARS.

(Under the care of Dr. E. LEONARD LEES.)

IT has been frequently pointed out that diabetes mellitus is a more serious disease in childhood than later and that, as a rule, as the age increases the acuteness of the symptoms diminishes. Nocturnal incontinence of urine suddenly arising in a child should always suggest the possibility of diabetes. A case in many ways similar to the one recorded below was published in THE LANCET in 1896,¹ though the course was a little less acute. In these rapid cases any sudden insistence on an absolute anti-diabetic diet or a great limitation of the amount of water taken seems to predispose to the onset of coma. For the notes of the case we are indebted to Dr. W. A. Milligan, resident medical officer.

A boy, aged five years, was admitted into the Royal Hospital for Sick Children and Women, Bristol, at 2 P.M. on June 30th, 1899, under the care of Dr. Lees. On admission the patient was seen to be in a very weak state; he was very much wasted, had a sallow complexion, and complained much of thirst, constantly asking for water to drink. The most marked symptoms at a first glance were the rapid sighing breathing (40 per minute) and the restlessness. The pulse was 140 and the temperature was 97.4° F. The tongue was coated with a thick fur, the breath, however, having a distinctly sweet smell. The heart and lungs were normal. The knee-jerks were exaggerated.

The history of the case as obtained from the parents was that 10 days before admission the patient was very constipated, so much so that his father, who is an asylum attendant, administered enemata on three successive days with good result and much relief. Besides this, and

¹ THE LANCET, Nov. 14th, 1896, p. 1376.