

The patient had some slight elevation of temperature during the first three or four days after the operation, but otherwise progressed without a bad symptom. The sutures were all removed at the first dressing on the tenth day, when the wound was found perfectly healed, and she left the hospital on the twentieth day.

The details of the operation leave no doubt as to the truly extra-peritoneal nature of the cyst, inasmuch as all attempts made to open into the general peritoneal cavity, either by passing the hand upwards over the upper margin of the tumour, or by endeavouring to effect an opening through the base of the cyst into Douglas' pouch, failed entirely in effecting their object. When attempting the former procedure, Mr. Thornton came upon the cæcum and vermiform appendix completely enclosed in loose vascular connective tissue, and closely applied to the cyst wall. This condition of things was evidently due to the adhesive inflammatory action set up in its immediate neighbourhood by the rapidly growing cyst.

With regard to the question of the mode of development of this tumour, I believe the following to be the true explanation of its origin:—The cystic disease commencing in the outer end of the ovary (whether from a distended Graafian follicle or as the result of an epithelial ingrowth, it is not at present my intention to discuss), probably gave rise to the formation of a true ovarian cyst, lying at first encapsuled in the cellular tissue between the layers of the broad ligament. In the subsequent course of its growth this cyst, distending the layers of the broad ligament, continued to develop in the direction of the least resistance—viz., more or less directly outward—until having reached the seat of reflection of the parietal peritoneum, it gradually opened up the layer of subperitoneal cellular tissue which lies beneath the transversalis fascia lining the abdominal wall, and thus came to constitute a truly extra-peritoneal tumour.

ON SCLEROTOMY.

By C. BADER,

OPHTHALMIC SURGEON TO GUY'S HOSPITAL.

CONTINENTAL oculists, especially De Wecker of Paris, restrict sclerotomy to certain forms of glaucoma. In course of time the operation will, I believe, be adopted in every case of glaucoma. Already von Graefe has been struck by the favourable course of iridectomised glaucomatous eyes with a cystoid cicatrix.

When iridesis was the fashion, leakage of the aqueous chamber beneath the conjunctiva and decrease of tension was one of its undesired consequences. Many sclerotomised patients state that excitement, sleepless nights, grief, &c., which before the operation produced hardness of the eyeball and obscuration of sight, since the existence of staphyloma of the conjunctiva (leakage after sclerotomy) gives rise to a sensible increase of staphyloma, but no more to obscuration of sight.

If, a considerable time after the operation, a vascular zone surrounds the base of the staphyloma the prognosis is not so favourable. De Wecker and others do not make a sub-conjunctival sclerotic flap. It seems to me that the more we secure a staphyloma of the conjunctiva, and through it a leakage of the aqueous chamber, the better. No repetition of the operation will be required if leakage exists.

The incision through the sclerotic should be made close in front of the insertion of the iris, whether the iris be in contact with or adherent to the cornea, or in its normal position, or displaced backwards. Our knife should be guided by our knowledge of the place of insertion of the iris in health; whether the iris be cut through or be displaced beneath the conjunctiva, no heed need be taken, provided the sclerotic be divided in front of the insertion of the iris.

Cases in which the iris had been perforated during sclerotomy seem to recover more rapidly than others; cutting too far backwards through the ciliary region may lead to shrinking of the eyeball.

An important point in the after-treatment is to explain to the patient the necessity for binding up the eyes without exercising pressure upon the eyeball. A soft, black silk

bandage suffices, it gives the patient a sense of security, and excludes light.

Case of Dr. Henry Pain of Cardiff (published with his permission).—Dr. Pain, aged sixty-three, consulted me on Oct. 6th, 1879, for glaucoma in both eyes. He had previously been seen by other oculists. Right eye: tension + 1; bare perception of light with nasal portion of retina; optic disc whitish, apparently swollen; the retinal veins full in the disc and retina; cornea clear; good aqueous chamber; pupil somewhat dilated; fixed media slightly turbid.

Left eye: tension + 2; retina sensitive to light throughout; optic disc deeply cupped, pink; retinal vessels very thin in the disc and displaced; spontaneous pulsation; remainder like right eye.

The patient, highly myopic, had suffered five years ago from albuminuria. I advised sclerotomy at once. On Oct. 10th the doctor consented, and both eyes were operated on under the anæsthetic. The eyes were kept shaded without pressure upon eyelids. He left London Nov. 13th, with good leakage and tension below par.

April 19th, 1880: Tension below par; corneæ clear; pupils drawn upwards; left iris well pushed into the bulging conjunctiva; media clear; optic discs pale-pink, flat; no trace of cupping—i.e., no trace of displacement of retinal blood-vessels in their course across the disc. Perception has returned to the entire right retina, and even large objects can be recognised.

Left eye reads well without glasses No. 2½ of Snellen's type at four inches.

Finsbury-circus, E.C.

A CASE OF

FATAL ULCERATION OF THE DUODENUM, PRODUCED THROUGH SCALDING BY HOT WATER USED AS A HÆMOSTATIC.

By J. R. GREENWOOD, M.R.C.S.

IN February, 1880, I was consulted by J. H—, aged forty, a commercial traveller, relative to an epitheliomatous growth on the penis, which he stated had first made its appearance some two years before, since then he had suffered considerable pain. The glans and prepuce were now completely lost in a large mass of ulcerated warty granulations, which constantly discharged a thin sanious fluid, having a most offensive odour. There was very slight glandular enlargement, and the patient experienced little, if any, difficulty in passing his water; he stoutly denied ever having had syphilis, but owing to the presence of some very suspicious scars on his legs and thighs, I felt much inclined to doubt his statement. I strongly advised him to let me amputate the penis before the growth should have invaded any more of its substance, but it was some weeks before I could obtain his consent.

On the 29th of March, the patient being brought fully under the influence of bichloride of methylene, administered by my father, I amputated the penis about an inch beyond the pubes in the usual manner, leaving the urethra projecting slightly beyond the dorsum. The patient passed a good night after the operation, and when I saw him the next morning was in a very satisfactory condition. During the morning, however, I was suddenly summoned to him, and when I arrived found him bleeding profusely from the wound; as he was rapidly becoming collapsed, I despatched a messenger to my surgery for some perchloride of iron, and in the meantime endeavoured to check the hæmorrhage *secundum artem* by cold water and vigorous pressure. When the perchloride of iron arrived I found—as has usually been my experience with this much-vaunted styptic—that it was of absolutely no avail in checking the hæmorrhage. Matters had now reached a crisis when it suddenly occurred to me to employ the method advocated by Mr. Keetley, of St. Bartholomew's Hospital, of sponging the bleeding surface with hot water; I did so, and in a very short space of time had the satisfaction of seeing the bleeding entirely cease.

My pleasure at this fortunate result was destined to soon change into a feeling of anxiety, for when I visited