

vanced, but under certain circumstances it will be almost the only means at our command of ascertaining the decrease in size. The liver might retain its area on its anterior surface, it might merely become flattened, in which case percussion would reveal nothing. Or, as in the second stage of cirrhosis, when extensive ascites exists, there is no opportunity for percussion, and mensuration is alone available.

A case of cirrhosis of the liver, complicated with cirrhosis of the right lung, showed two and one half inches in favor of left side, when subdiaphragmatic mensuration was taken. It is true, the spleen was enlarged, but on the other hand, the left lobe of the liver was pushed almost entirely out of the thorax, forming a tumor below the xiphoid process. (Case in the County Hospital; post-mortem examination made.)

Another case of cirrhosis gave only one inch in favor of the left side. General anasarca precluded a correct measurement, the finger making deep impressions in the skin, wherever the measure was applied.

I may mention yet another case, accidentally found when the patients of our County Hospital (under charge of Dr. Chew) were being examined with reference to the subject under consideration. In a man with an ulcer of the foot, who was of healthy appearance, the right subdiaphragmatic semi-circumference was smaller than the left by two inches, and percussion revealed contraction of the liver to an extraordinary extent. Still the man felt well. He was a hard drinker, and it would not be surprising to see him some day suffering from ascites, etc. This would point to the fact that the grave symptoms in cirrhosis of the liver do not establish themselves in some cases until the whole liver is degenerated; or that cirrhosis, in its so-called second stage, may exist without evident symptoms.

Decrease in size of the right lobe can be caused by contraction, succeeding to a healed abscess. As far as my knowledge goes, attention has never yet been called to such a condition. The following is the history of a case seen by me together with Dr. Carothers:—

Mr. H., twenty-three years old, suffering for two years from indigestion, general debility, pain in the region of liver, etc. Bowels had always been irregular. About half a year previously, something, as he says, gave way in his abdomen, and a large quantity of matter passed in his stools. After this he felt somewhat better, but still his appetite is poor, his bowels irregular, etc. Mensuration of right side shows one and one half inches less than left side. Percussion gives normal contour. Diagnosis: chronic ulcers after dysentery; abscess of liver, which had broken through into bowels; contraction of liver. Patient was sent to a mineral spring near by, and was doing well when last heard of.

II. (b.) *Increase of Left Lobe of Liver, Spleen, or Both.*—Here the apparently normal contour of the right lobe ought to be determined in the first place by percussion, palpation, etc. If it seem to be normal and if the difference in favor of the left side be striking, the spleen will have to be percussed, when, if found uninvolved, there must be an increase of the left lobe of the liver, or an additional cause for the increase, say an echinococcus or other tumor. There is no reason why the left lobe should not of itself become the seat of disease, the neglect of which seems to me to be due to the difficulty of observing and examining it. There are abscesses, for instance, involving the left lobe as well as the right, and why should they not form

in the left lobe alone? In this latter event the left lobe would be increased in size, and how should we ascertain this but by mensuration? And thus our proposition might help the long-neglected step-brother to its full rights.

These few lines are written in the firm belief that the suggestions are worthy of being thoroughly tested by some one who has better opportunities to study his cases ante and post mortem. It will more than reward me, if at least one point of those made should prove to be of practical diagnostic value to the profession.

SUPPLEMENTARY NOTE ON BORACIC ACID.

BY WILLIAM WARREN GREENE, M. D.,
Professor of Surgery in the Medical School of Maine.

SINCE the paper Boracic Acid in Surgery went to press certain facts have come to my knowledge which, though they may seem comparatively trivial, I yet desire to record as a sort of addendum.

While I was experimenting two days ago with boracic acid, Mr. Frank L. Bartlett, of this city, chemist and state assayer, came in, and on learning what I was handling made the remark, "It is very strange that so little is known of so remarkable a substance." He then informed me that he had experimented with it extensively in a quiet way, and I was gratified to find that his results and conclusions entirely coincided with my own views and with my knowledge, so far as I had investigated from a chemical standpoint. Mr. Bartlett's investigations have been in the same direction as Poli's, whose paper he had not seen or heard of, but his experiments were equally decisive, and his testimony to the efficacy of boracic acid as an anti-ferment, antiseptic, and preservative is quite as positive and convincing.

He—Bartlett—has found fresh meats, butter, vegetables, etc., perfectly preserved for an indefinite length of time by simply covering them with cloths wet in a solution containing only ten to fifteen grains of the acid to the ounce of water.

When we remember that boracic acid is innocuous, odorless, and practically tasteless, it seems to me that such facts should arrest marked attention.

I cannot avoid the suspicion that if great cost, offensive odor or taste, or any other striking peculiarity of a common character had obtruded it upon our notice, it would have ere this received much more consideration.

Mr. Bartlett's remarks brought to mind one fact that I intended to state in my main paper, but I forgot it, namely, that I have used to a considerable extent a combination of boracic and salicylic acids, both internally and externally, and while I am not prepared to claim any advantage from such union in any case, yet I think it desirable to test its quality in varying proportions, more especially as an internal remedy. The two solutions may be mixed, or the two crystallized acids may be fused at a high heat, forming a soluble boro-salicylic acid.

Again, in speaking with my friend E. Dana, Jr., of this city, a most excellent and widely known pharmacist, he suggested the substitution of cocoa butter for waxa spermaceti in making the boracic acid ointment, for the reason that wax is not only insoluble, but does not melt at the heat of the body, while cocoa butter

does. For some cases where adherence to the surface is unobjectionable this is a good plan, but the value of the wax is not only to give firmness, but to prevent sticking to the sore surface, which, mixed with vaseline, it does entirely. After considerable trial I have come to the following conclusions:—

(1.) In cases where an aqueous solution of the acid is not needed, or after its sufficient primary use, an ointment is the best form for continuous application.

(2.) In cases where it is especially desirable to avoid any adhesion of the dressing to the diseased surface the following is the best formula:—

R̄ Glycerit. acidi boracici sat. ¹	f3ij.
Ceræ albæ	
Cetacei	āā 3i.
Vaseline	3vi.

Melt the last three together, and add the glycerite with trituration.

(3.) *Unguentum acidi boracici.* Where it is essential to make the application as thorough as possible an excellent method that I often employ is to apply either the glycerite of the acid freely to the surface each time immediately before renewing the ointment, which may be done with a camel's-hair brush or by sopping, or if the glycerine is objectionable apply a mixture of pure vaseline with the glycerite (prepared by melting the vaseline, of course) of such strength as is desired, which mixture is soft enough to manage easily with a brush. Then the ointment, spread on some proper material,—there is nothing better than nice sheet lint, spreading on the soft side, as it holds so much and so firmly,—is applied over all.

If, however, adhesion is unobjectionable, as in non-suppurating or slightly secreting sores, requiring infrequent dressing, the following is excellent:—

R̄ Glycerit. acidi boracici sat.	f3ij.
Butyr. cocœ	3ij.
Vaseline	3vi.

Melt the vaseline and butter together, then add the glycerite with trituration.

It is well to know that this last preparation requires a long time comparatively—twenty-four hours at least—to cool, or rather harden to its *maximum*.

On the whole, I think the first formula—which is the one published in the first paper—will stand as the representative *boracic acid ointment*, as that which will best fulfill all the indications in the majority of cases, especially when supplemented in the manner I have described with the glycerite or the mixture of pure vaseline and the acid. But in many instances I have no doubt that the second formula will prove an advantageous modification of the regular ointment.

I am aware that after all I have in this note called attention to and emphasized certain points in my original paper rather than brought out anything really new, and if I seem inclined to press my subject with some persistence upon the notice of the profession it is because I believe it worthy of any degree of interest which I may be so fortunate as to awaken.

PORTLAND, August 30, 1880.

—The health department of Chicago are again after the milk dealers. The commissioner claims that he has good proof against the dealers, while the latter declare themselves innocent, and purpose fighting.

¹ It will be remembered that hot glycerine dissolves over three drachms of the acid to the ounce, and holds it perfectly on cooling.

RECENT PROGRESS IN OPHTHALMOLOGY.

BY O. F. WADSWORTH, M. D.

CONJUNCTIVAL SYPHILIDE.

A CASE reported by Sichel² is interesting from its extreme rarity. A man of twenty-eight years presented himself with the complaint of itching at the inner canthus of the right eye, and a sensation as of a foreign body. The inner part of the bulbar conjunctiva was moderately congested, and in the centre of the congested part was a small, oval, firm tumor, which resembled somewhat a developing phlyctenula, somewhat a pinguecula. Sichel only saw the patient nine days later. The tumor had then increased in size, was 13 mm. in transverse, 6.5 mm. in vertical diameter, of horse-shoe shape, its concavity toward the cornea, which it reached but did not encroach on, and situated on the inner and lower quadrant of the globe. It was but little elevated, its surface flattened, excoriated, with slight depressions, and covered with a grayish, muco-purulent secretion. It was elastic, and diminished in size under pressure. To close observation it appeared as if composed of a series of little elevations crowded together. There was much congestion of the tumor and its immediate neighborhood. No conjunctival secretion; no pain.

Inquiry and examination developed a history of recent infection, and a papular and papulo-squamous eruption on arms, body, neck, and chin. Six weeks of mercurial treatment brought about total disappearance of the conjunctival affection; other symptoms were still present.

PRÆCORNEAL TUMOR FOLLOWING EPISCLERITIS.

Manz³ describes a case of considerable interest from the change of character shown in the growth at its various recurrences. The patient, a man of fifty-seven years, was first seen in 1873. For several years he had suffered from inflammation in the neighborhood of both corneas, and of late a small tumor had developed at the lower edge of the right cornea, firmly attached only at the corneal edge. It was removed, and proved to be a simple granuloma. The inflammatory condition of the two eyes, a form of episcleritis with rather firm infiltration at the limbus and marginal opacity extending into the cornea, was treated for a time and improved temporarily. The following year, however, another, larger, and firmer tumor had appeared, a little more to the inner side than the first. This also was closely adherent only to the limbus, was removed without difficulty, and was of the same character. The episcleritis continued, and in 1875 the man had a granular conjunctivitis, mainly confined to the lids and fold. Then a dense, circum-corneal chemosis formed and was excised by peritomy. Some months later this swelling had returned, and by the end of December, 1875, a tumor covered the cornea to its centre, where perforation had taken place. The eye was enucleated, and the microscope showed now, besides formation of granulations, an active growth of the epithelium, which had begun to send prolongations backward.

In 1878, a tumor of some size, growing from the bottom of the conjunctival sac, apparently not involving the lids or surrounding skin, was dissected out to-

² Centralblatt für practische Augenheilkunde, May, 1880.

³ Bericht der Ophthalmologischen Gesellschaft, Heidelberg, 1879.