

little pus escapes from the wound, about half a teaspoonful in twenty-four hours; wound healthy; expectorates a great deal; temperature subnormal.

10th.—Swelling much less; wire drain removed. Can protrude tongue; breath sweet; has expectoration. Fomentations left off and a pad of Gamgee tissue put under the chin. Takes solids.

On the 12th the swelling had gone; wound almost healed. The patient felt quite well, and on the 15th he was discharged well.

ABERDEEN ROYAL INFIRMARY.

A CASE OF TUBERCULAR DISEASE OF MUSCLE AND ONE OF RETRO-PERITONEAL LIPOMA.

(Under the care of PROFESSOR OGSTON.)

It is somewhat unusual to meet with a tubercular affection of a muscle to the extent described in Case 1. The disease had probably spread upwards from the point of mischief in the past, and was thus a secondary and not a primary tubercular myositis. The second case shows the great difficulty—we may say impossibility—sometimes encountered in diagnosing the nature of an abdominal tumour. Fatty masses in the abdominal wall, or forming in connexion with the omentum, are described in most text-books as likely to simulate ovarian tumours, and various suggestions are made to assist in distinguishing the one from the other. Here we have a rarer condition, one simulating ovarian growth to such an extent that nothing short of exploration of the abdominal cavity after section of its walls could prove the exact character and attachments of the tumour, and the impossibility of its removal. The case is both interesting and important. For the account of these cases we are indebted to Mr. G. W. H. Tawse, M.B., C.M., house surgeon.

CASE 1. *Tubercular Myositis*.—C. D.—, aged six, was admitted into Prince Albert ward on May 18th, 1891, with symptoms of caries of the right tarsus. Two years previously the foot was run over by a cart wheel, but seemed to recover perfectly; six months ago the dorsum pedis began to swell, and continued to do so till about six weeks before admission, when an incision was made and a quantity of pus evacuated. On admission the dorsum of the foot was seen to be occupied by a general spindle-shaped enlargement extending from the ankle-joint to the roots of the toes; at the anterior part was a small sinus, lined by tubercular granulations. A probe passed inwards about half an inch. The movements of the ankle and toes were painless and fairly good. The family history was unimportant. Diagnosis of tarsal caries was made, and on June 6th Dr. Ogston opened up the sinus and scraped out a patch of skin as large as a five-shilling piece, evacuating a considerable quantity of cheesy tubercular material. On passing in a probe, it ran upwards under the skin of the front of the leg for about five inches along what at first seemed a tendon sheath. This track was opened with scissors in its whole extent, and showed a yellow cheesy mass running up the centre of the muscular belly of the extensor longus digitorum, as high as the origin of the muscle. This mass was scraped out, and the wound sutured up, except at its lower end, and drained with catgut plaits. Recovery was uninterrupted; four days after operation the upper part of the wound, which had been sutured, had healed by first intention. The lower wound, on the dorsum pedis, granulated up, and by July 10th had almost healed. The movements of the foot were almost perfect.

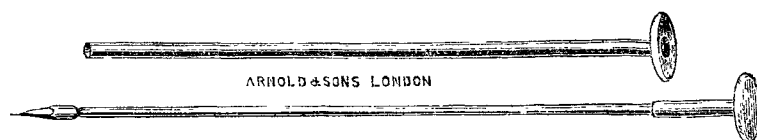
CASE 2. *Retro-peritoneal Lipoma*.—J. B.—, aged twenty-nine, married, was admitted into Esther ward on June 1st, 1891, with a very large abdominal tumour. Family history unimportant. The patient first noted unusual tumefaction of the abdomen when about two months pregnant with her fifth child in March, 1889. After confinement the abdominal fulness did not decrease sensibly, but continued to grow with moderate rapidity, especially so on the right side, where the swelling was first seen in the iliac region. Notwithstanding its enormous bulk, the tumour never caused pain—merely discomfort and slight dyspnoea from its size. On examination the abdomen was found to be completely filled by the tumour, which was more prominent in the right iliac and lumbar regions, and the abdomen itself showed the boat shape present with ovarian cysts. On tapping the tumour with the finger a very distinct undulating ripple could be

detected, and was felt from the side and from the xiphoid cartilage to the pubes as if in a unilocular cyst. Percussion gave a dull note over the whole tumour, except that a peculiar semilunar area of resonance was obtained below the umbilicus, ending laterally in the inguinal regions, and reaching above almost to the umbilicus. Colon resonance was very clear in the right flank, but the left flank was dull. The tumour was freely movable, was not adherent to the umbilicus, and did not move with respiration. The greatest girth of the abdomen, just above the umbilicus, was 48 in.; at the umbilical level, 47 in. No movement of air could be detected round the umbilicus, as if from adherent colon. Vaginally, nothing abnormal could be detected, except that the uterus was fixed. Menstruation had always been regular. The heart apex was beating in the third left space, and the posterior bases of both lungs were dull and the breath-sounds feeble below the ninth ribs. The above-mentioned semilunar area of resonance was found to have vanished on subsequent examination twenty-four hours later. Diagnosis of large ovarian cyst, growing for about twenty-seven months, was made, and in consultation with the staff this was adhered to, though an aspirator failed to evacuate any fluid, which was thus considered to be very gelatinous in consistence. On June 11th Dr. Ogston opened the abdomen by a four-inch incision below the umbilicus. No adhesions to the tumour were found, and the mass on presenting in the wound was seen to be covered by the greater and lesser omenta, the tightly stretched transverse colon running across it opposite the middle of the wound. The hand introduced into the abdomen found the tumour to have no connexion with the pelvis; the mass was free everywhere in front. The peritoneum was then opened behind, and the tumour found to be a huge retro-peritoneal lipoma, with very distinct fatty lobules, which were exposed freely for a considerable depth, till it was evident that no fluid or tumour lay behind. Further interference was considered unadvisable, and the wound was closed and dressed antiseptically. On the 15th the wound was examined for the first time, and found to have healed by first intention. On the 19th there was noticed considerable œdema of the left lower limb, evidently from pressure within the abdomen; this considerably lessened under treatment. On the 21st the patient was put on Paget's treatment with liquor potassæ, beginning with five minims thrice daily, and increasing to forty minims on July 6th. Measurements, however, showed the tumour to be still increasing, and the patient was discharged on the 10th.

New Inventions.

NEW FORM OF ACUPRESSURE PIN.

THIS pin is provided with a silver cannula, is bayonet-pointed, and has shoulders against which the cannula fits accurately. The head is flat, so that the thumb can rest firmly on it, and projects a convenient distance from the corresponding end of the cannula. Around the latter is a rim which serves to give a grip to the index and middle fingers when the pin is to be passed, and is also necessary for the attachment of a strong thread of carbolised silk or similar substance, to secure the easy withdrawal of the cannula from a wound in which it may have been left entirely buried. There is a slit at the other end of the cannula to admit of the passage through it of the shoulders of the pin. After the pin has been passed it can at once be



drawn out, the cannula alone being left in charge of the vessel. Being of silver, it does not irritate the tissues, however long it may be necessary to leave it in position; and, being pointless, does not fret them with little stabs on every voluntary or involuntary movement. The pin can be left in its cannula when additional firmness is required. This may be necessary, for instance, when it has been passed deeply through both sides of a wound, and the point protrudes and cannot fret the flesh. The inner surface of

the wound has still the benefit of the unirritating silver coating. A thread thrown around the pia brings the lips of the incision well together, as in a harelip operation. A similar thread could be wrapped round the cannula alone, where it is, as will generally be the case, able to bear the strain, and thus the sharp point of the pin will be accounted for without clipping it off or inserting it in a cork. Messrs. Arnold and Sons are the makers.

W. J. BRANCH, M.D. Edin.,

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NEW EYE INSTRUMENT FOR THE REMOVAL OF FOREIGN BODIES FROM THE CORNEA.

MOST ophthalmic surgeons have experienced some difficulty in removing foreign particles from the cornea, especially if these particles are flat or scale-like and lie deeply in the corneal tissue. Under such circumstances, a good deal of digging has to be done with the corneal spud or spatula to get the

instrument well round the foreign body in order to insinuate it beneath it. This effort may cause rupture of Descemet's membrane and escape of aqueous. In all cases it causes considerable destruction of corneal tissue, which may leave some degree of opacity, or cause altered refraction after healing, with consequent impairment of vision. The instrument here figured I have found to be of considerable service in the removal of foreign particles, whether lying superficially or embedded in the corneal tissue. It consists of a fine, rounded, needle-like shaft (A). The terminal end of this (B), which is very fine, is flattened at the expense of the anterior surface, which makes it slightly spoon-shaped. The very tip (C) is minutely hooked. This hook can be distinctly felt as a "catch" when the point of the instrument is drawn across the palm of the hand. After the instillation of a few drops of a 40 per cent. solution of cocaine, the instrument may be used either as a tractor or as an elevator. 1. As a tractor: Here the minute hook fixes in the edge of the foreign particle and picks it out. This is especially serviceable when the foreign body lies deeply in the corneal tissue, as there is thus less risk of causing rupture. 2 As an elevator: By this means the minute hook is insinuated beneath the foreign particle, and it is lifted out of its bed lying in the hook. In either case it is

surprising how easily the hook lays hold of and removes the foreign body with the smallest amount of destruction of corneal tissue. The instrument has been made to my entire satisfaction by Messrs. John Weiss and Son of Oxford-street, W. The cost is very moderate.

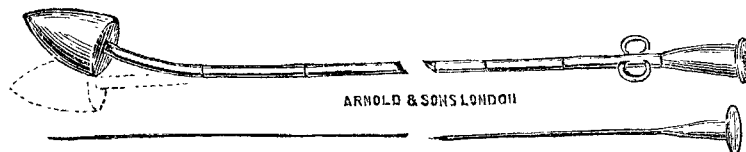
Inverness.

J. WILSON BLACK, M.B. Edin.

A NEW INJECTOR BOUGIE.

GLEET, when not dependent on stricture, is generally due to the presence of granular patches. How are they best discovered and treated? First by means of the endoscope, and again by a modified "bougie à boule," such as that I beg to bring under notice. The endoscopic method, however, is not always available, and entails much special experience, and can, I think, be well superseded in the instance of gleet by simpler processes. Having discovered these patches, the best and acknowledged treatment is to inject a few drops of solution of nitrate of silver on to them, but this must be done the moment they are discovered. Why is this treatment so often unsuccessful? Surely because the patches are not accurately localised; because when localised the mucous membrane is not distended at the moment of injection, so that the solution may be efficiently applied; and, lastly, because the patches are covered by a layer of muco-pus which neutralises the strength of the solution. How are these deficiencies of ordinary treatment to be met? Simply by having an instrument which will do for diagnosis and treatment *at the same moment*; to have it made so that its bulb will distend the canal at the site of

injection; and to have it with abrupt shoulders which will sweep the patch clear of its muco-pus, or, if need be, mildly curette with additional force the granular areas. How to use it: Pass it in to the bulb of the urethra, and gently withdraw it, injecting at one place or more a few drops of the solution where extra sensitiveness or roughness indicates the probable existence of patches. If the membranous and prostatic portions are to be injected, the instrument may be bent (as indicated) and a smaller bulb used, lest the



contraction of the deep muscles should offer resistance to the withdrawal of the instrument. In a like reason of resistance, the injector ought not to be used in the presence of stricture. I have used it many times, and, taking these precautions, I have found it an efficient means of treating chronic granular urethritis. The instrument is made for me in varying sizes by Messrs. Arnold, and the cut represents it faithfully enough, except that the point appears too acute.

Crouch-end.

JAMES MACMUNN.

ON BLOODLETTING IN PNEUMONIA.

To the Editors of THE LANCET.

SIRS,—Having just read the interesting papers of Dr. Ogle and Dr. Wilks in recent issues of THE LANCET, may I be permitted to pen a few lines on cupping in cases of pneumonia? I first awoke to the value of cupping and some other remedies on reading many years since Dr. Hare's paper on "The Revival of some Disused Remedies." During the last ten years I have had a large number of cases of pneumonia in a fairly large country district, and two of them I can particularly recall, one of them being almost *in extremis*.

One case I was sent for to see in June, 1885, about fifteen miles from the village of Rouxville, where I was living, was that of a Dutchwoman about thirty years of age, said to be dying from inflammation of the lungs. On arriving at the house I was told that the patient was dying, and, in fact, the friends were praying round her. Having cleared the room, I examined my patient, who was blue and speechless, and her lungs posteriorly were like a deal board. I lost no time, but cupped her at once freely between the shoulders; in about half an hour she began to rally, and at the end of two hours, when I left, had recovered her voice, and sat up again and began to swallow. The next day I found her rapidly proceeding towards recovery. Internally I gave her antimonial wine, digitalis, and acetate of ammonia, with brandy, broth, &c.

I saw another case in April, 1883, of a Dutchwoman about forty, whom I was called into the country late one night to see. She had typical symptoms of pneumonia, and had been ably and carefully treated by a brother practitioner on the approved modern treatment, but she was getting worse. She was in a very low state, and with a harassing cough, which had kept her from sleeping for five nights. I cupped to about 2 oz. between the shoulders, after which she fell into a sleep which lasted five hours, and from this time she steadily improved.

Just recently, in December last, I saw in consultation a young Dutchman, nineteen years old, who had an obscure paroxysmal pain over the epigastrium, the nature of which was by no means evident, and auscultation threw no light on the subject. However, two days after, I was fetched into the country to see him, and found him almost breathless from the intensity of the pain. I applied a cupping-glass to the præcordium, and drew about two ounces of blood, completely relieving him of the pain, which has never returned.

In my younger days I was a disciple of Todd and Bennett, and scorned cupping-glasses and antimony; now I never travel without my cupping case. I think, on such high authority as that of the two eminent men who have written in your columns on general bloodletting, I shall look up the numbers of THE LANCET my father had, and put them in order.—I am, Sirs, yours obediently,

CHAS. WM. BROWNE, M.R.C.S., L.S.A.,

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Smithfield, Orange Free State, South Africa, June 17th 1891.