

2. Incision of the intermarginal space according to Jaksche-Arlt.

3. Curved incision of the skin, 3 to 4 mm. above the ciliary border. Removal of a small strip of muscle along this incision.

4. Grooving of the tarsus according to Streatfeild.

5. Passing sutures through the lower lip of the wound, the upper edge of the tarsus, and the skin of the upper lip.

6. Detaching from the upper lip of the wound, with a straight pair of scissors, a strip of skin, 1.5 mm. broad and as long as the incision in the intermarginal space, and implanting it into the gaping and cleansed incision. Sutures may be used, but are not essential.

7. Tying the skin-tarsus sutures, four or five in number. The threads may be cut short, or stretched and fastened to the skin above the brow by collodion (Panas) or strips of plaster (Born) if the free edge of the lid is not sufficiently everted.

8. Dressing with bichlorid gauze, greased with a salve, or leaving the eye uncovered.

9. Cutting the sutures in from three to five days. Cleansing the eye every day, very gently so as not to disturb the implanted flap, or leaving the dressing undisturbed for a week. The flap in almost every case unites in its whole extent.

This plan of operation is to be simplified or modified, according to the conditions of the case.

CASE OF EPITHELIOMA OF EYELIDS PLASTIC OPERATION, WITH EXHIBITION OF PATIENT.

Read in the Section on Ophthalmology at the Forty-sixth Annual Meeting of the American Medical Association, at Baltimore, Md., May 7-10, 1895.

BY HERBERT HARLAN, M.D.

BALTIMORE, MD.

After a large number of experiments in the removal of malignant growths affecting the eyelids, or their immediate vicinity, by caustics and various surgical procedures, I have come to the conclusion that the best method is extirpation by the knife and restoration of lid by plastic operation, and as a good example I present the following case:

Basil Shipley, farmer, age 60, from Carroll County, Md., was first seen by me March 1, 1892. At that time he had what was evidently (I speak from a clinical standpoint) an epithelioma of inner side of left eye. It involved the inner margin of both lids; the upper to about one-fifth its extent, and the lower to nearly or quite one-third, and extended over or to the side of the nose. Roughly speaking, it covered a surface the size of a quarter of a dollar.

Two previous operations had been done; one by a prominent surgeon, and one by a skilled oculist. Each operation had been followed by a prompt recurrence, with increase of symptoms.

The lacrymal sac and both canaliculi were involved. The patient was put under chloroform at the Presbyterian Eye, Ear and Throat Hospital, and the whole mass freely dissected away. A very large gaping wound, certainly as large as half a dollar, was left. After the bleeding had been pretty well checked, a balloon shaped flap was dissected from the forehead, twisted down and carefully stitched in position with silk. I regarded it as quite impossible to preserve any tear duct, and made no attempt to do so. The forehead wound was closed by a single row of sutures.

Iodoform and gauze was used as dressing and the healing was uneventful. He returned in March of this year and a small growth down on the nose was burned freely by the galvano-cautery. The ectropion which you see, while unsightly, I regarded as harmless, and did not advise further operation.

DISCUSSION ON PAPERS OF DRS. ZIMMERMAN, JOHNSON, HOTZ, KNAPP AND HARLAN.

DR. R. A. REEVE, Toronto—My experience with transplantation of flaps without a pedicle was given at the Canadian Medical Association in 1879, I think. The first one was largely a failure. The technique was not at fault but the patient had psoriasis and there was hardly enough healthy looking skin on the body to suffice for a flap. As, however, there was ulceration of the cornea from exposure I operated. Another case of double cicatricial ectropion proved very successful. I think it is important to maintain the union of the lids for a long period so as to diminish the ultimate shrinkage of the flap. In another case the lids were kept united for several years though sufficiently open to permit useful vision. The patient had nothing but cicatricial tissue from the chin to the nape of the neck. There was complete ectropion of all the lids, with keloid cicatrices. In using a flap without a pedicle in order to permit wearing of an artificial eye it is desirable to implant it as centrally as possible so as to get the minimum contraction. Blepharoplasty by horizontal sliding flaps has given me gratifying results in a number of instances.

DR. H. V. WURDEMANN, Milwaukee—Referring solely to the first paper under consideration, I would say that there will soon come a time when *water* not *ether* will be deemed the only suitable anesthetic for nearly all operations connected with the skin. The injection of cocaine in percentages over .2 per cent. (not 2 per cent.) is harmful not only to life itself but to the life of the skin flap. Injection in higher solutions is radically dangerous and should be abandoned in favor of infiltration anesthesia by injection of harmless fluids into the tissues. I will not occupy your time at this moment by any further reference to the matter which I will sufficiently elaborate in the session of Thursday morning.

DR. D. S. REYNOLDS, Louisville—I would like to have the last sentence of the first paper re-read.

DR. M. W. ZIMMERMAN, Philadelphia—Cocain is the only suitable local anesthetic. For the conjunctiva it may be applied to the surface in 2 to 4 per cent. solutions. When the skin is involved, subcutaneous injection becomes necessary. The punctures should be few and the dose not exceed 2.5 grains.

DR. REYNOLDS—I noted that point and wanted it repeated that it might be thoroughly understood. I have seen a single drop of the 4 per cent. solution applied to the conjunctival membrane produce almost instant pallor with cessation of the heart beat. I have noted a dangerous reaction repeatedly and it has been referred to by others.

DR. E. J. BERNSTEIN, Baltimore, exhibited a patient. When first seen she had lost both upper and lower lids and the entire nose by syphilis, and had a beginning ulceration of the cornea due to lagophthalmus.

DR. LUCIEN HOWE, Buffalo—In regard to putting the flap in hot water, it would seem to me to be entirely unnecessary when the transplantation is made without difficulty. Promptitude seems of considerable importance.

DR. J. P. WORRELL, Terre Haute—I have made a number of grafts introducing skin from back of the ear or more frequently mucous membrane from the lip. It is rare that one fails to get union. When there is entropion I did not find it necessary to make the graft. It has seemed to me that if you can make an operation somewhat like Dr. Hotz, with the incision posterior to the ciliary margin, we shall get such a contraction that we will not have a return of the entropion. I have some cases operated upon some years ago and the results are still satisfactory. I dissect down the skin absolutely to the ciliary margin and remove all of the palpebral part of the muscle; strip the cartilage entirely. From the cicatrization that follows, I have never yet had reversion to the entropic condition. I always do these operations under cocaine and have never yet seen a single case of injury from its use. I am inclined to think Dr. Reynolds' case due rather to shock than to cocaine.

DR. P. D. KEYSER, Philadelphia, here exhibited a photograph

of a case of transplantation for epithelioma of inner canthus operated upon by him over one year ago successfully and in which there had been no return of the entropion. I find too that grafts take equally as well on cicatricial tissue as any other.

DR. S. D. RISLEY, Philadelphia—I have now quite a group of interesting lid cases in which I have done the grafting operation and I expect good results, even though the cartilage has been usually involved. I take the graft from the forearm as described by Dr. Hotz. I do not think there is any call for any more serious operation.

DR. G. C. SAVAGE, Nashville—It is not often necessary to do extensive or bloody operations for entropion and trichiasis, nor can it often be necessary to transplant skin in an inter-marginal incision. By means of the entropion forceps devised by myself, the blades of the forceps terminating in a stirrup as wide as a diseased lid is usually long, with a shoulder extending up each arm of the stirrup for one-eighth of an inch, to compress the lid margin, a bloodless and effective operation can be done. When the lid has been grasped by passing one blade of the forceps beneath, the other on the outer surface of, the lid is easily inverted and held in position. At least one-eighth inch of the lid margin is included in the fenestrum. The forceps are closed tightly by means of a sliding clamp and the pressure thus exerted makes the operation bloodless. The knife is used first for making the Burow incision the entire length of the tarsal cartilage and through all structures down to the skin and one-eighth of an inch from the free margin. This done, a vertical cut is made from either end of the Burow cut, in the lid margin through all the structures down to the skin, and two similar cuts are made at equal intervals between these. The operation thus completed the forceps are removed, when there follows a good deal of bleeding. The Burow incision widens the lid; my vertical cuts lengthen it, and the two together effect a complete out-turning of the lid margin. One or more times daily the lid should be slightly everted so as to make the wounds gap widely that the deposit of new tissue may be as abundant as possible. The operation is easy and its results effective.

DR. FRANK ALLPORT, Minneapolis—In view of the fact that we have in the operation of Dr. Hotz a procedure almost universally successful for the relief of entropion, it seems hardly necessary to multiply operations. I have used this process for fifteen years and have been almost universally and permanently satisfied with the results. In extreme cases it is usually necessary to combine with it a suitable canthoplasty and when thus applied there are but few cases in which satisfaction will not be achieved. It is an operation requiring exactness and deliberation and where failures are noted it may be because these elements are wanting.

DR. HIRAM WOODS, Baltimore—In an operation for upper lid entropion, performed yesterday by Dr. Savage as he had described his operation, the primary results were excellent. As Dr. Knapp says, many cases show this good primary result but later relapse. This seems specially true of the Arlt operation. Green's operation has been used a great deal within the past few years at the Presbyterian Eye and Ear Hospital with excellent permanent results as observed in cases two or three years old.

DR. HERMAN KNAPP, New York—I want it understood the mode of operation which I have sketched refers in its whole extent only to extreme cases. Canthoplasty is necessary in many cases because by a general shrinkage of the conjunctiva and tarsi, a more or less marked blepharo-phimosis is present. When the tarsus shows extensive cicatricial contraction on the conjunctival side and irregular thickening and curving in of its body with no intermarginal space preserved, the excision of a wedged-shaped slice on the outer part of the tarsus and the restoration of the intermarginal space is indispensable. The strip of skin can be most conveniently taken from the upper border of the elliptical wound when the sutures are inserted but not tied. The strip is then immediately placed into its bed at the edge of the lid. I have seen the inter-marginal space thus gained nicely preserved years afterward.

Exercise for the Weary.—The following is from *Puck*: Dr. Schmerz: "The trouble, Mr. Tyers, is that you don't take enough exercise." Mr. E. Z. Tyers: "Aw, I confess I don't go in vewy heavy on athletics, doctaw. What could you wecommend as a mild exercise to begin on?" Dr. Schmerz: "H'm! You might stretch your arms over your head when you yawn!"

POST-ALCOHOLISM.

BY S. V. CLEVENGER, M.D.

Alienist and Neurologist of the Reese and Alexian Hospitals, Chicago:
Late Medical Superintendent of the Illinois Eastern Hospital
for the Insane, and Pathologist of the Cook County Insane
Asylum; Author of "Comparative Physiology and Psychology," "Spinal Concussion," etc.
CHICAGO.

Ethyl alcohol, spirit of wine, is commercially assumed to be the base of intoxicating drinks, and the purest of these is capable of working great havoc when abused, but the demand for cheap liquor in vast quantities substitutes for portions of the less harmful ethyl or vinic alcohol what is known to chemists as the poisonous amyl alcohol (potato spirit or fusel oil). The aroma or bouquet of liquors is largely due to certain ethers of the more poisonous amyl and butyl alcohols, notably the acetic and valeric; then super-added, all too often, by distiller, rectifier, wholesaler, and especially by the retailer, are sophistications, flavors and perfumes for the purpose of cheapening the resulting compound, which, by the time it reaches the average consumer, contains in addition to the alcohol diluents to increase bulk, articles to give it false strength, fictitious appearance, odor and taste.

In the English Licensing Act of 1872 (35 and 36 Vict. c. 94) there is a schedule of substances called "deleterious ingredients" found to have been used in adulterating intoxicating liquors; they are cocculus Indicus, common salt, copperas, opium, Indian hemp, strychnin, tobacco, darnel seed, logwood, salts of zinc or lead, and alum. Since then, ingenuity and cupidity have extended the list indefinitely among dye materials, both organic and inorganic; and there are also added correctives of acidity, such as litharge, lime, soda, potash; astringents like catechu, oak bark and aloe leaves; earths for decolorizing; sweetening agents, and ethers for flavoring. Most of these articles are unwholesome, to say the least, and tend to debilitate and otherwise set up depraved bodily states.

Chronic alcoholism in its most obvious features is a condition of functional poisoning such as is seen in its production of lethargy, stupidity and acute narcosis. Less noticeably, but gradually, it operates as a tissue poison, affecting parenchymatous elements, particularly epithelial and nerve structure, if not to a greater or lesser degree all the cellular components of the body. A slow degeneration is produced until the blood vessels are involved in thickening and fibroid changes. Oxidation of tissues is checked, since alcohol is consumed in place of the fat, leading to fatty changes which may advance to general steatosis.

Dr. Magnus Huss, of Stockholm, in 1849 first prominently directed the attention of physicians to the subject of alcoholism, a term he was the first to use. He described the paralytic and anesthetic forms of chronic alcoholism, also later referred to by Hammond ("Diseases of the Nervous System," 1881), Ross ("Diseases of the Nervous System, 1885), and other neurologists.

Gowers ("Diseases of the Nervous System," vol. I, 110, et. seq., 1892) under the heading "Multiple Neuritis," gives still more recent details of these distressing consequences of drinking alcoholics.

Magnan (*De L'Alcoolisme des diverses formes du Delire Alcoolique, et de leur traitement*, 1874), Virenque, Hammond and others observed an occasional loss of sensation involving only one lateral half of the body, as in hysteria. The other special senses are generally implicated. Thus the patient loses the sight of