

ology and natural history, and with these, also advance in their treatment. The difficulties connected with this branch can not be overcome in a moment, but with patience and hard work every one can accomplish very much toward solving many of them. The days of hasty and careless diagnosis, and of routine treatment are, or should be, past; arsenic and zinc ointment do not represent the science of the dermatology of to-day.

In conclusion it may be stated that many of the difficulties ordinarily experienced in dermatology, are the result of the relative neglect which this branch has heretofore received at the hands of the general profession, and the relatively little attention often paid to these cases in practice. With sufficient study and thought on individual cases, many of them will appear less formidable and disappear.

4 East 37th Street.

MUCOCELE OF THE ETHMOIDAL CELLS SIMULATING AN ORBITAL TUMOR.

BY F. C. HOTZ, M. D.

PROFESSOR OF OPHTHALMOLOGY AND OTOLGY, RUSH MEDICAL COLLEGE,
CHICAGO.

If, in the course of an inflammation of the ethmoidal cells, the secretions can not be discharged into the nasal cavity because the natural outlets are blocked up, the imprisoned fluid will after a while begin to exert considerable pressure upon the bony walls and cause them to expand. The very thin orbital wall of these cells is especially apt to yield to this high pressure and to form a round, slowly-growing tumor behind the inner canthus of the eyelids, which causes more or less marked displacement of the eyeball. In some of these cases the cystoid nature of the tumefaction was readily revealed by fluctuation; but in some instances the tumor appeared so firm and hard that in the absence of fluctuation it was mistaken for a solid neoplasm and preparations were made for its extirpation. An exploratory incision into the exposed tumor of course revealed its true nature. In the treatment of these cases the chief object should be to establish a free communication of the ethmoidal space with the nasal cavity, which is best accomplished by breaking down the nasal partition at the lowest point of the ethmoidal space, and inserting a drainage-tube for a few weeks.

Judging by the very few cases on record, ethmoidal mucocele protruding into the orbit seems to be a rather rare occurrence; and therefore the report of an additional case—the only one I have observed in twenty-five years—may not be without interest to the readers of the JOURNAL.

On July 25, 1898, a girl, 13 years old, was brought to my office on account of a very strange appearance of her left eye. Four years previously she had met with an accident by which the bones at the root of the nose were fractured. Since that time she had been troubled with nasal catarrh, and the inner canthus of the left eye was drawn down so that the palpebral fissure had a decidedly oblique direction, as in the Mongolian race. During the past year her parents noticed her left eye to "bulge" and the skin of the upper lid to become at times red, swollen and painful.

I found the left eyeball slightly protruding and markedly displaced to the temporal side of the orbit, but its mobility was not impaired in any direction; the

vision was normal; there was no diplopia, and the fundus showed normal conditions. The displacement of the globe was evidently caused by a tumor which seemed to proceed from, and to be continuous with, the inner wall of the orbit. Upon palpation the tumor appeared smooth, round and firm, but upon deep pressure through the upper lid undoubted evidence of fluctuation could be obtained. The tumor reached downward to a little below the palpebral ligament, where its boundary was marked by a sharp, ragged ridge of bone; its upper contour was lost behind the supraorbital margin.

The patient was admitted to the Presbyterian Hospital on July 27, and the following operation performed under ether anesthesia: An incision was made extending from that bony ridge at the root of the nose to the middle of the brow; the orbicularis muscle and subjacent connective tissue were liberally dissected up so that the wound edges could be well retracted and the surface of the tumor exposed. An exploratory incision into the most prominent part of the tumor drew a creamy fluid of a stale odor; the incision was at once enlarged, and I found that the ethmoidal cells had been converted into one large cavity, from which at least four ounces of the creamy emulsion were withdrawn with a syringe. In exploring the cavity it was found to extend one inch directly inward and two inches downward; no carious or necrosed bones were detected. The part of the cyst wall which protruded into the orbit and consisted of a rigid membrane, like thin cardboard, was excised with scissors. Then passing a bone curette toward the most dependent part of the cavity, I there broke down the thin osseous partition to establish a free communication with the nasal cavity, and inserted a drainage-tube, and after thorough irrigations with boric acid the upper part of the wound was closed by sutures, and a dressing applied.

The after-treatment consisted in daily irrigation with boric acid; under this treatment the discharge rapidly disappeared and the wound was gradually filled up with granulation tissue. After two weeks the drainage-tube could be left out; and four weeks after the operation the wound was completely healed and the protrusion and displacement of the eyeball had entirely disappeared.

LUMBAR NEPHROPEXY WITHOUT SUTURING, WITH REPORT OF CASE.

BY EMANUEL J. SENN, M.D.

Associate in Surgery, Rush Medical College, in affiliation with the University of Chicago; Assistant Surgeon St. Joseph's Hospital.
CHICAGO.

Since N. Senn devised and described this method of treatment for movable kidney a year ago, the operation has been performed frequently by different surgeons, and it will undoubtedly soon assume its proper place in operative surgery, that is, it will supplant an irrational technic. The old method of fixing a movable kidney in its normal location by passing sutures through the glandular structure of such a delicate, as well as vital organ as the kidney, should be emphatically condemned. Sutures which are tied sufficiently firm to suspend a kidney must, through subsequent cicatricial contraction, destroy a considerable amount of kidney tissue. If such sutures remained *in situ*, it would be far better than what actually takes place in