compression, though devoid of these risks, cannot be maintained long enough to allow of the patient reaching the nearest surgical station. These facts apply equally to wounds of the axilla and root of the thigh.

One method, however, seems to offer some practical way out of the difficulty and can be readily made use of—namely, the closure of the wound in the skin (and, if possible, in the deep fascia also) either by a continuous tightly-drawn suture or else by Spencer Wells or Kocher's forceps. By this means all external bleeding is controlled. Blood extravasates locally, forming a hæmatoma, and produces considerable tension in the tissues, and so checks further hæmorrhage. In other words, the open wound of the vessel becomes converted into a closed one with the formation of an arterial hæmatoma. This then allows of sufficient time for the patient to be rapidly transported to the nearest surgical unit without death resulting from extreme blood loss.

The advantage of the method is amply well shown by the following case :—

Private X. was admitted to a casualty clearing station about three hours after being hit in the neck by a shell fragment. His clothes were drenched with blood from head to foot. He was semi-comatose and under the influence of morphia. He was markedly blanched. He showed drooping of the left face and on stimulation never moved the left arm. Two pairs of Spencer Wells forceps completely occluded an entry wound in the right side of the neck, over the line of the common carotid artery at the level of the lower border of the thyroid cartilage. The right side of the neck was very tense and swollen. The larynx was displaced to the left and there was some respiratory stridor. The right pupil was widely dilated, the left contracted. The case was obviously a serious vascular lesion—probably of the common carotid—and required urgent surgical interference. Under a general anæsthetic, a temporary ligature was applied to the common carotid artery, just above the sterno-clavicular junction, a fair amount of blood extravasation being met along the fascial planes. The original wound was then excised and widely opened up. A tear was found in the common carotid, about ⅛ inch long and involving half its circumference. The vessel was ligated above and below and the damaged portion excised. The missile was removed from the body of the vertebra behind the pharynx, which was undamaged. The wound was "bipped" and incompletely sutured. Finally, an intravenous injection was given. The patient died 36 hours later, never having regained consciousness.

At the necropsy the wound was in excellent condition and the internal carotid patent. In the brain the convolutions of the right hemisphere were flattened, especially in the middle and the area supplied by the middle cerebral artery was obviously pale and softened. There was a small embolus lying in the commencement of the middle cerebral artery and a thrombus extended along the vessel and its branches for some distance. Death was due to cerebral embolism with œdema and compression.

Though this case terminated fatally I think that it illustrates the advantage that might be gained by closing the skin wound in cases which would otherwise end in death from uncontrollable hæmorrhage. Pierre Duval, nearly two years ago, recorded a number of cases of open wounds of the chest which would have ended in death from hæmorrhage had the wound not been closed, and so allowed of the raising of intrapleural pressure with consequent occlusion of the pulmonary vessels. Any method which offers an indication for avoiding the almost invariably fatal issue in lesions of the vessels in the above-mentioned situations merits a trial ; hence my reasons for writing this note.

A CASE OF SPONTANEOUS CURE OF CATARACT.

BY C. HIGGENS, F.R.C.S. ENG.

Patient, aged 73, consulted me on Jan. 21st, 1918. He gave the following history. Many years ago he had repeated attacks of iritis in both eyes, of which, however, no marks remained. About 40 years ago he developed cataract in both eyes, the right being the worst. The right eye was operated on by Mr. Bader with good result. He had been for years nearly blind from cataract in the left eye, and assured me he could only tell light from dark with it. His right eye had central pupil, slight capsular opacities, vision 6/18 with + 13, J. 2 with + 16. In the left eye, which he believed to have cataract, there was a deep anterior chamber, tremulous iris, small central pupil, but no sign of cataract. The lens was obviously dislocated and floated across the pupillary area on movements of the globe. To his astonishment I found he had vision 6/12, with $+ \frac{1{\cdot}50 \text{ cvl.}}{12 \text{ sph.}}$; J. 4 with $+ \frac{1{\cdot}50 \text{ cvl.}}{15 \text{ sph.}}$ I had great difficulty in making him believe that I was not letting him see with the right eye, and he would not be satisfied till I took the opaque disc out of the right side of the frame and allowed him to hold down the lid with his fingers. Eventually he left highly pleased with the result of his visit. I could get no history of any injury to the eye, but after a good deal of questioning I found that about ten years ago he had a severe fall on the back of his head, and I am inclined to believe that was the cause of the dislocation. His history of repeated attacks of iritis and the early age at which he developed cataract point to specific origin.

Remarks.—What capital the class of practitioners represented by Count Wieser would have made out of such a case—cataract cured by squirting with a syphon of soda-water or some such non-operative procedure. I have seen one other case of spontaneous cure of cataract. It was that of a man who had lived in "the Bush" in Australia and almost entirely by himself. He found that the sight of one eye was defective, and that it gradually got worse until he could only tell light from dark. Later the sight began to improve again and continued to do so. When he came to me he had very fairly good vision, but I have forgotten the man's name, and consequently cannot look up my notes. He had a central moveable pupil, and there was a good deal of opaque capsule, but no other evidence of the lens. The patient had never consulted anyone about his eye and never had an injury to it. So I came to the conclusion that it was a case of cataract, where, for some reason or other, the capsule had given way spontaneously and the lens matter been absorbed.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SECTIONS OF NEUROLOGY, SURGERY, AND SUB-SECTION OF ORTHOPÆDICS, WITH THE WAR OFFICE COMMITTEE FOR THE STUDY OF TETANUS.

Muscle Contracture Following Injury.

A conjoint meeting of these sections with the War Office Committee for the Study of Tetanus was held on Feb. 14th, Sir ANTHONY A. BOWLBY, K.C.M.G., K.C.V.O., President of the Section of Surgery, being in the chair, to consider the subject of "Muscle Contracture Following Injury."

Surgeon-General Sir DAVID BRUCE, C.B., A.M.S., said that when the War Office Committee for the Study of Tetanus had asked surgeons whether they could mention any case of persistent contracture occurring after injury under civilian conditions, and, if so, to state the percentage of cases in which such a phenomenon occurred, answers were received from 70 to 80 surgeons, and in only one instance had such a case been seen. Sir David Bruce asked why cases of contracture were almost wholly restricted to war wounds. What was the cause of localised contracture of muscles in a wounded limb?

Captain WILFRED HARRIS, R.A.M.C. (T.), demonstrated five cases of contracture. The first occurred in a case of ulnar nerve palsy ; he had seen the same thing in civil life. The second was a case of incomplete contracture, which he regarded as chronic hysteroid spasm. The third was a case of contracture following ulnar nerve injury, coupled with hysterical weakness of the forearm muscles. The fourth was that of a man who had been wounded twice in the left parotid region. Clonic contraction of facial muscles came on after the second wound, and this Captain Harris regarded as being due to mechanical irritation of the facial nerve by scar tissue. In the last case a facial tic appeared after the metal had been removed from the wound. He considered these to be cases of tonic and clonic contraction following wounds, but thought that they had nothing to do with tetanus.

Major JOCELYN SWAN, R.A.M.C., showed a case which he believed to be chronic tetanus. Five days after the first injection of antitetanic serum was given spasm had disappeared, and since then the contracture had much improved.