

decided on removing all that was irrecoverable, but was able to preserve about 2 inches of forearm in front of the elbow-joint. Chloroform was given, and ice bags were applied. On the fourth day the wound was healed by first intention, and for several years he has used the preserved 2 inches for holding his reins while driving as a country postman seven to eight miles out and in of the county town.

CASE II.—On May 31st, 1862, thirty years ago, amputation of the right thigh at the top of lowest third was performed for a constitutional affection of the knee-joint engaging the cartilages. I was asked to perform the operation at her mother's house, two miles off, and did so, using pounded ice in two bags, which were bladders. Both were applied for a few minutes before, and continuously for seventy-two hours after, the operation, and the lower one during the operation also. On the third day I found the wound healed by first intention, and the new granulations were so strong that the only ligature (the femoral) was left till it came away with a drop of pus a week after. This drop was the only matter that ever appeared. In a very short time she was able to maintain herself, walking with a wooden leg over two miles, morning and evening, to the county town, and now she can jump off an ordinary chair on to the hard pavement, and alight on the wooden leg without the least uneasiness.

I may add that I have used cold water dressings to operations for shattered hand (all caused by gunpowder explosions during the shooting season) with very satisfactory results. In four of these cases, which I distinctly recall, all were left with the thumb and from two down to one finger. In all these the metacarpal bones corresponding had to be removed, and the remaining finger, or fingers, and thumb approximated. In the case of the one finger and thumb the patient has for years been able to write and shoot as well as ever, and in two of the other cases the young men are both sailors.

REMARKS.—1. It was chiefly as a hæmostatic that I first thought of ice, as I had been scared with the venous bleeding in a case of amputation of the leg at the tubercle of the tibia, but on turning out the clots and applying compresses the result was most satisfactory. I prepared myself against a repetition of the scare, and was confirmed in the ice idea by its successful application in a case of passive hæmorrhage from an apoplectic right lung. The patient, a young lady of 19, was emitting about a small teaspoonful from the mouth every minute or so, and had for ten days. The impacting of the ice bags over the right thorax stopped all bleeding in a few minutes, and it never returned. She is long a married lady, with a few olive branches at her side. I have made all available inquiries in Scotland, and am unable to hear of any so rapid healing of amputations, and therefore consider it proper to report the two cases referred to in one of our leading journals. Nothing could surpass both the hæmostatic and antiseptic effects of the ice (no venous blood, and only one artery to tie). 2. A good hint as to the safety of the ice dressing is afforded in the postman's case, as, by a mistake, the first dressing was on the fourth and not on the third day as intended, as it was in the thigh case. When seen the arm was livid up to the shoulder, but a little washing from cold to tepid water proved all to be well. He was in the garden walking about on the tenth day. 3. The thigh case was kept wet with an improvised siphon continually dropping on the superimposed ice bag during the three days' interval.

Edinburgh.

JOHN SHAND.

SPONTANEOUS CURE OF CATARACT: SECOND SIGHT.

THE BRITISH MEDICAL JOURNAL of May 14th contained the report of "A Case of Spontaneous Cure of Cataract," by Mr. Charles Higgins, as communicated to the Ophthalmological Society of the United Kingdom on May 5th. I believe this method of comparative cure is not so rare as is supposed. I have seen three instances of it. The following are some brief notes of such a case entered in my note book on August 29th, 1888:—"A. E., aged 92, female, bedridden with nodular rheumatism for many years. Right eye: Cataract; pupil large, quite blind, cannot distinguish light from darkness; T + 1. Left eye: Pupil small; iris, very tremulous; anterior chamber, deep; lens, formerly cataractous, has undergone softening and partial absorption. She can now only count fingers

held before the light, and cannot read. Fourteen years ago she became quite blind (cataract); seven years ago sight "somewhat suddenly" improved (pathological softening of cataract) so that she could read a Testament with large print on a bright day; for the last two or three years she has not been able to read." I believe that this advanced stage of Morgagnian cataract is what is popularly termed "second sight" in old people.

Stanhope.

WM. ROBINSON, M.S. and M.D.

REPORTS

ON
MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS
AND ASYLUMS OF GREAT BRITAIN, IRELAND,
AND THE COLONIES.

LIVERPOOL ROYAL INFIRMARY.

AURAL PYÆMIA SUCCESSFULLY TREATED BY REMOVING PUTRID
THROMBUS OF JUGULAR VEIN AND LATERAL SINUS.

(By RUSHTON PARKER, B.S., F.R.C.S., Professor of Surgery in
University College, Liverpool.)

A PAINTER, who had been kicked in the left ear at the age of 14, and had occasional subsequent discharge of offensive matter, was admitted into hospital under the care of Dr. Caton, about August 18th, 1891, having suffered pain in the affected ear for a week previously, and for three days rigors, vomiting, and restlessness. The temperature was 105° on the evening of admission, falling to 102° next morning. He felt giddy when attempting to walk, but in bed, where he was kept, he was drowsy most of the time, with occasional delirium. The left ear was almost entirely deaf, discharging fetid pus. There was swelling and tenderness of the neck over the upper part of the jugular vein, but none of the mastoid region. Everything suggested that plugging of the jugular vein had occurred, probably extending from a similar state of the lateral sinus, and that, in fact, phlebitis pyæmia existed. Double optic neuritis was found, more on the right than left, and it was agreed on consultation that the man's only prospect of escape lay through the radical operation practised by Mr. Arbuthnot Lane in 1888 and 1889, and by Mr. Ballance in 1889.

Mr. Parker feels indebted to Mr. A. Macleod Ross for having drawn his attention to the reports—overlooked at the time of publication—of this most important operation, in time for the first opportunity he has had of putting it into practice.

At least four rigors occurred during two days in hospital, and another of severe kind, with chattering of the teeth, came on while the patient was being conveyed to the operating theatre.

Under chloroform on August 21st, 1891, an incision 7 or 8 inches long was made down to the left jugular vein and mastoid process. The vein was found firmly plugged from the base of the skull to below the junction with the facial trunk, also plugged for an inch or so. Both veins were cut between two ligatures in their healthy parts, and their plugged portion raised along with a crop of swollen lymph glands that, no doubt, accounted for the swelling of the neck. The mastoid region was opened with gouge and mallet, and emitted a very foul odour from the lateral sinus thus exposed, and now found disorganised and occupied by green purulent lymph, with the tail end of a purple blood clot that thickened downwards. The detached firmly distended jugular was opened, being lined with adherent grey membranous lymph surrounding a solid plug of purple blood clot, partly softened and puriform within. The thrombosed vein was cut away, except about an inch attached to the base of the skull, of which remaining portion the lymphous lining was scraped off. The lateral sinus was scraped, and sublimate solution syringed freely through the sinus, and the stump of the jugular vein and other exposed parts. On probing the sinus upwards blood flowed freely, but was easily stopped with a plug of antiseptic wax (of composition unknown to me, but kindly provided by Mr. Victor Horsley and Messrs. Squire). The lower half of the wound was stitched, and healed at once by first intention; the upper half, and the parts about the ear, were kept open and dressed with cyanide gauze.

The patient was found next day reading the newspaper as if nothing had happened, and remained free from symptoms for two days, after which the mastoid region became more tender, and the temperature rose to 103°, so he was put at once under chloroform, the plug of wax removed, and further excavation of the mastoid done in order to expose the antrum, which had not been opened on the first occasion. Fœtid pus was found behind the wax, and a little cheesy material in the antrum, so all was well washed with sublimate solution. The dressings were changed several times a day, and the temperature fell to normal, and so continued for five days. A rise to 103°, and once to nearly 105° (without other symptoms) then occurred, owing apparently to some intermissions of dressing, but a prompt fall to normal followed the more frequent dressing and washing. No pus or other trouble having from the first appeared in the stump of the jugular vein, or in the upper half of the associated wound, this latter was pressed together and held with a strip of plaster, and adhered right off.

In sixteen days after the principal operation, and fourteen after the second, the patient left his bed and never looked back. The mastoid aperture was kept open two or three months with a plug of cyanide gauze, on removing which it quickly closed. Optic neuritis continued in the right eye, followed by some atrophy, which, early in December, 1891, was, somewhat unexpectedly, found to have improved by Mr. T. H. Bickerton, oculist to the infirmary, who repeatedly examined the patient's eyes. The progress of the ear and hearing were frequently noted by Mr. George Stone, who, with Mr. R. A. Bickersteth and Mr. W. Thelwall Thomas, gave material assistance at the operation.

The case recently recorded in the BRITISH MEDICAL JOURNAL by Mr. Clutton, as well as the above instance, afford the amplest confirmation of the salutary importance of this excellent procedure, which is not as difficult of execution as might at first be supposed.

WEST RIDING LUNATIC ASYLUM, WAKEFIELD.

CASE OF SOFTENING OF SENSORY TRACT OF INTERNAL CAPSULE, WITH LESION, APPARENTLY TROPHIC, ON THE OPPOSITE SIDE OF THE BODY; DEATH FROM GANGRENE OF THE LUNGS AND PULMONARY HÆMORRHAGE.

(By EDWIN L. DUNN, M.B., Assistant Medical Officer.)

J. F., aged 60, female, was admitted on June 8th, 1891, suffering from epileptic dementia. Her mental state was characterised chiefly by almost complete loss of memory and by lengthy periods of furor occurring after fits. Her dementia progressed gradually. On February 8th, 1892, it was noted that she had severe conjunctivitis of the right eye. She could not be questioned, being in a state of epileptic furor. On February 10th, the mental condition being as before, there was also interstitial keratitis of the right eye. The conjunctivitis was more severe. No history of injury or any obvious cause for the condition of the eye could be obtained. On February 19th the eye was much worse. Hypopion was present. There was cellulitis of the right leg and foot, extending up to the middle third of the leg. This commenced from a focus in the right second toe. No obvious cause for this condition was detected. On February 25th the cellulitis of the leg was improving, except at the toe. The hypopion had burst externally. The breath was extremely fœtid. On March 1st the fœtor of breath was extreme. The proximal phalangeal joint of toe was disorganised, and the two distal phalanges were becoming gangrenous.

From this date until March 6th the patient was in a constant state of maniacal excitement, and quite unable to give any information respecting herself. Her breath was so fœtid that it was almost impossible to approach her. The two distal phalanges of the right second toe sloughed, and remained attached to the foot only by a small shred of skin. The eye was quite disorganised. On March 8th in the morning the patient vomited about eight ounces of bright red blood. She became collapsed, and died shortly after.

A *post-mortem* examination was made thirty hours and a-half after death. Weather frosty. The right eye was completely destroyed. The lens had fallen out, and was found on the ex-

ternal surface of the organ. Anterior cusp of mitral valve atheromatous, but the heart was otherwise healthy. The left lung weighed 555 grammes, the right 920 grammes. On removing the sternum the left lung was found to be ruptured anteriorly in two places—at the middle of the superior and the middle of the inferior lobe. On the surface of the ruptures were two firm clots, together filling a half-pint measure. There were no adhesions to the parietes. The whole of the lung, except the extreme base and apex, which were in a condition of red-grey hepatisation, presented a dark green mass, extremely fœtid and structureless. The lower half of the right lung was adherent to the anterior chest wall and diaphragm. The superior half of this lobe was extremely gangrenous. The remainder of the organ was in a similar condition to that of the non-gangrenous portion of the left lobe. No evidence of food or foreign body in the bronchi was found on either side; there was no bronchiectasis. Nothing noteworthy was found in the liver, kidneys, or spleen.

The skull cap was normal; the dura was strongly adherent to its front and sides. A delicate membrane was adherent to the inner surface of the dura, at places, over the left hemisphere. The sinuses were normal. The lepto-meninges show slight opacity and swelling; they stripped with undue ease. There was some general diminution of consistence of the cerebrum, and a general diminution in the size of the gyri. The white substance of hemispheres fairly normal. The basal ganglia were of average size. On the right side there was a local softening (cyst) the size of a pea at the posterior end of the outer segment of the lenticular nucleus. No naked-eye appearance of disease was observed around this or in the capsule. On the left side there was a minute cyst, the size of a split pea, at the posterior end of the lenticular nucleus, in a position somewhat similar to that on the right side. The posterior half of the portion of the left capsule behind the genu was very obviously softened, breaking up with extreme ease under a stream of water. The anterior half of this portion also showed some diminution in consistence; this, however, was slight in comparison with the softening of the posterior half. In the white matter behind the left capsule and in front of the descending cornu there was patchy softening with blood extravasation. The cerebellum, pons and medulla appeared healthy.

REMARKS.—Primary gangrene of the lung in the chronic insane is not sufficiently uncommon to call for special notice. The occurrence of spontaneous hæmorrhage and extreme laceration of the lung in two places is, however, noteworthy. In this case the point of interest lies in the extreme degree of disintegration existing in that part of the internal capsule which is commonly considered to be the seat of the sensory nerve paths, associated with the lesion of the eye, leg, and foot on the opposite side of the body, for which during life no cause was apparent. The patient's mental state precluded satisfactory examination, and therefore nothing can be said as to the sensibility of the right side of the body; only the objective disturbances noted above can be given in evidence of disordered sensibility.

RAILWAY DISPENSARY, NAGPUR.

A CASE OF "WRIST-DROP," OR MUSCULO-SPIRAL PARALYSIS. (By Surgeon-Major G. F. A. HARRIS, I.M.S., Officiating Civil Surgeon, Nagpur, C.P.)

In the following case the most minute and searching inquiry failed to elicit any possible source from which the system could have become affected with the poison of lead; there was no history of "colic," and there is complete absence of the characteristic blue line on the gums, or any other symptom of saturnine toxæmia.

X., a native clerk, aged 28, employed in the office of the Bengal Nagpur Railway, at Nagpur, presented himself at the Railway Dispensary on July 14th, 1891, exhibiting well-marked paralysis of the extensor muscles of the right hand, with the characteristic "wrist-drop."

The condition of the hand was first observed on the morning of July 12th. He had slept on the platform of a small station on the line, and when he awoke in the morning he could not use the extensor muscles of the right hand. He had slept on the ground in the ordinary sitting posture, resting on his heels and soles, his buttocks not touching the ground, which

is commonly adopted by all natives (and which I may remark in parenthesis is so difficult for Europeans to assume and keep up for any length of time), resting his head on his arms crossed above his knees; there had been heavy rain during the night. As the position is an easy natural one for all natives, and one frequently assumed, it is difficult to understand how excessive or long-continued pressure could have played any very important part in the causation of the paralysis. He himself attributed the condition to a chill. The patient was somewhat thin and anæmic, but he gave a history of previous good health, and stated that he had never before suffered from any form of paralysis, rheumatism, or from any form of venereal disease. The only premonitory symptom which he had observed had been a sensation of formication in the affected hand during the night, without any loss of sensation. Inquiry as to any possible sources of infection with the poison of lead gave negative results. The water he was accustomed to drink was well water, and his food was cooked in brass vessels. The gums appeared quite normal, and there was no history of intestinal colic.

On examination there was almost complete loss of power in the extensors of the wrist, and supination was very imperfectly performed. He was able to grasp with the affected hand, but there was some weakness of the flexor muscles also. The electric contractility of the muscles was little if at all impaired. No abnormal thickening could be detected in the region of the musculo-spiral nerve. The left hand and wrist were unaffected.

Assistant Surgeon Lakdawalla, of the B.N. Railway Dispensary, under whose immediate treatment the case was, told me that some benefit had resulted from friction and roughly-conducted massage of the affected parts with the application of the interrupted current, and that the extensors appeared to be recovering their power. He contemplated making an empiric trial of iodide of potassium if the above failed. By July 24th the paralysis of the extensors had almost quite disappeared, and the power of supination was completely restored. The benefit appeared to be mainly attributable to the massage, etc. On August 1st recovery was almost perfect.

The etiology of this case is not quite clear. If an effusion causing pressure on the facial nerve and consequent Bell's paralysis can result from exposure to cold,¹ presumably a similar cause may produce paralysis of the musculo-spiral nerve, as is, in fact, asserted by M. Duchenne.² The patient's arm was exposed to a current of cold, damp air. The onset of the paralysis was sudden, and accompanied with the sensation of formication or tingling; the supinator longus was very distinctly affected; the paralysis was unilateral; and, lastly, recovery has been very rapid. These facts seem to exclude lead palsy, and to point rather to the cause being a chill. Professor Erb, however, states³ that "in cases of sleeping on damp earth," or "near a moist wall," or "of exposure to a draught of air," the true cause of the paralysis may almost always be shown to be compression of the nerve. On the same page, however, he states that "of traumatic paralyses, and of those arising from chill in the upper extremity, it is by far the most common." These two statements appear to be somewhat contradictory. It is possible that the musculo-spiral nerve, as it winds between the two heads of the triceps muscle at the back of the arm, may have been compressed between the head and the knee owing to the position in which the man slept. But, as I have above remarked, the position is one frequently, and even, I may say, habitually assumed by all natives; and my personal experience is that musculo-spiral paralysis, exemplified by "wrist drop," is of very unusual occurrence—at least, I have seen very few cases.

¹ Gowers and other writers.

² Bristowe's *Medicine*, p. 1, 116.

³ Ziemssen's *Cyclopaedia*, vol. xi, English Translation.

THE LATE DR. MARION SIMS.—A full length figure of the late Dr. Marion Sims has been executed in bronze by the eminent sculptor, Ferdinand von Müller, of Munich, and will shortly be formally presented to the City of New York, and set up in the Central Park. The figure, which is nine feet high, stands on a pedestal of granite eight feet in height. The counterfeit presentment of the distinguished gynecologist is said to be at once life-like in its fidelity to Nature and touched with rare artistic grace.

REPORTS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF LONDON.

TUESDAY, MAY 17TH, 1892.

SIR GEORGE MURRAY HUMPHRY, F.R.S., President, in the Chair.

Tumour of Breast.—MR. LOCKWOOD showed a specimen to illustrate "duct cancer" of the breast, taken from a woman, aged 39. Pain commenced 18 months before, and there was a discharge of blood from the nipple. The breast was large, hard, and nodular, and there was an enlarged axillary gland. Operation was followed by a safe and rapid recovery. Histological examination showed that the lumens of the ducts were enlarged and that epithelial papillæ projected into them. The epithelial lining of the ducts had in numerous places proliferated and invaded the connective tissue of the breast. The axillary lymphatic gland showed no trace of cancer.—MR. RAYMOND JOHNSON did not think that the condition could be asserted to be carcinomatous. He was inclined to consider that it was a case of proliferated epithelium with simple cystic degeneration of the mamma. Three pathological processes might produce the conditions found in the sections: 1, simple papilloma; 2, cystic carcinoma; 3, duct papilloma. He then referred to a card specimen, which was being shown to the Society by Mr. Bland Sutton, of a duct papilloma. The conditions in Mr. Lockwood's specimen might, he thought, possibly be antecedents of carcinomatous growth in the mamma.—PROFESSOR HAMILTON, of Aberdeen, asked if there might not be a combination of papilloma and carcinoma in the specimen shown. He had recently met with such an unusual case.—MR. BLAND SUTTON admitted that the specimen he showed was not carcinomatous, but showed papillomatous growths projecting into cysts. There was no interstitial epithelial growth.—MR. LOCKWOOD, in reply, pointed out that in his specimen there was interstitial epithelial growth which seemed to separate it from the cases Mr. Johnson was referring to.

Deposit of Indigo in the Urine, with Experiments.—DR. ORD exhibited a drawing showing indigo deposited naturally in the urine of a patient who had suffered for ten years with symptoms indicating enlargement of the prostate. The urine was alkaline and offensive, and contained a number of flaky masses, which under the microscope were found to be altered mucus, containing embedded in them a large number of dark blue bodies, apparently composed of some crystalline material partly stained by indigo, partly having indigo deposited on them. These Dr. Ord considered to be either urate or phosphate. He knew of no artificial method whereby indican present in alkaline urine might be decomposed so as to form indigo blue without inducing an acid reaction. It appeared to him that the form of the indigo was determined by the form of the substance upon which it had been deposited. He described the ordinary method of obtaining indigo from urine either in the form of a solution in chloroform or in a film deposited on the surface of the fluid, of which he showed the microscopical appearances. If a solution of uric acid were added to the urine before performing the test, crystals of uric acid partly stained and partly encrusted by indigo were found at the bottom of the fluid. Epithelial cells, yeast cells, and rod-shaped bodies resembling bacteria were also found similarly stained, and coloured drawings illustrating these were shown. Occasionally hedgehog crystals of presumably uric acid were found deeply coloured. It appeared to Dr. Ord that the use of nascent indigo might possibly be of use in the staining of bacteria.—DR. WHEATON asked if there might not be another interpretation, namely, that the indigo was due to the growth of the bacteria. He mentioned the case of a hysterical woman who had passed indigo in the urine for a few hours only.—DR. CROOKSHANK asked if any cultivation of the organisms had been attempted.—DR. ORD, in reply to Dr. Wheaton, said he had found bacteria in one or two only out of numerous specimens. In reply to Dr. Crookshank, he said the organisms had not been isolated, but he hoped that it would be done.

Lesions of the Pyramidal Cells in the Cerebral Cortex in Chorea.—DR. F. CHARLEWOOD TURNER showed microscopic sections of the brain from 5 cases of fatal chorea in females from 12 to 19 years of age, in 1 case complicated with puerperal septic-