

three inches. The os was dilated. An attack of peritonitis supervened; from which, however, she recovered well. She left the hospital relieved, feeling much better, and conscious that the tumour had diminished in size.

The supervention of peritonitis, after even so simple an operation as opening the cervix, should here be borne in mind in estimating the mortality. Mr. Brown has lost three out of the ten mentioned. I have known of two cases of death from the same cause, and several in which peritoneal symptoms supervened, but were happily successfully combated. Patients seem also liable to peritonitis for some time afterwards. In a case of flooding from a fibroid, a free incision through the os and tumour was followed by the most satisfactory results, both in stopping the hæmorrhage and reducing the size of the tumour, and the patient returned apparently cured to her own home; but in a few days subsequently peritonitis set in. The *post mortem* examination revealed cellular abscess, which had burst into the peritoneum.

We must, therefore, be prepared, even in so simple an operation as the mere incision within the tumour, for accidents. Upon the whole, however, if we bear in mind that the tumour, if once wounded, will not heal, and must undergo partial sloughing or absorption, it is clear that an incision, if performed within prudent limits, is equally as efficacious as the gouging or breaking down of the tumour. These limitations must, however, be attended to. A series of small and successive wounds will produce less constitutional disturbance than one large one. Between the operations, the patient has time to rally and gain strength. The operations may not be so grand and striking; but they are safer for our patients, and this, after all, is the great end of every surgical interference.

Another point, however, has to be touched upon. In my second lecture, I spoke of the difficulty of making a correct diagnosis of the exact position of fibroid tumours, if high up above the true pelvis. It is true, that I then pointed out to you how, by the pelvimeter, you might often make out the diagnosis more correctly. Still, if the cavity of the uterus be short, if the bladder do not extend high up, if the rectal examination be not satisfactory—then the diagnosis must be obscure; and you may, by incising the os, get into the peritoneum, as occurred in one case I then mentioned. There is another disadvantage, also, which will at once strike you from what has been before said; that, in attempting enucleation in a case where the fibrous tumour is above the true pelvis, and not easily reached from below, the traction exercised to bring it down must of necessity be more forcible, and the risk of the operation proving fatal by peritonitis following the traction be greater. Any attempt, therefore, at enucleation in such cases must be very doubtfully determined upon, and even mere incisions very carefully made, lest the peritoneum—of the posterior or anterior *cul-de-sac* especially—be wounded.

[To be continued.]

MORTALITY AMONG PHYSICIANS. Five members of the resident medical staff of Bellevue Hospital, New York, have paid the forfeit of their lives, and ten more have barely escaped death, since the 1st of May last, from fever, contracted in the discharge of their duties.

Illustrations

OF

HOSPITAL PRACTICE:

METROPOLITAN AND PROVINCIAL.

ROYAL PORTSMOUTH, PORTSEA, AND
GOSPORT HOSPITAL.

TWO CASES OF NECROSIS OF THE BONES OF THE
GREAT TOE, TREATED CONSERVATIVELY
WITH SUCCESS.

CASE I. F. F., aged 52, was admitted November 10th, 1863, under the care of Dr. Page, with necrosis of the bones of the great toe. There was a fistulous opening and considerable enlargement; the fleshy parts were otherwise in a healthy condition. The patient was unable to walk on the foot. The operation was as follows. An incision was made in the track of the diseased bones, and another across the metatarso-phalangeal articulation; the first phalanx was removed with a forceps, and the head of the metatarsal bone nipped off. The wound was brought together with sutures, and water-dressing applied. The patient was discharged cured in twenty-one days.

CASE II. H. G., aged 54, was admitted March 1st, 1864, under the care of Mr. Porson, with partial necrosis of the phalanges of the great toe and the head of the metatarsal bone. The operation and result were the same as in the previous case. The patient was discharged cured in twenty-six days.

These two cases are interesting as examples of conservative surgery. Mr. Fergusson, in his second lecture at the College of Surgeons, alluded to one or two cases where the thumb or finger was saved; and a case is reported in the *Lancet* of June 4th last, at the West London Hospital, of partial necrosis of the phalanges of the forefinger, under the care of Mr. Teevan; several pieces of dead bone were gouged away, and an useful finger was the result. In both the cases treated at the Portsmouth Hospital, though the first phalanx of the great toe was removed, with the head of the metatarsal bone, no lameness followed. The patients, both labourers, are now following their usual avocations, doing heavy work. A short time ago, amputation would have been performed in both cases.

Original Communications.

FOREIGN BODIES ON THE SURFACE OF
THE EYE: THE SUBSTANCE OF A
LECTURE.

By HAYNES WALTON, F.R.C.S., Surgeon to the
Central London Ophthalmic Hospital,
and to St. Mary's Hospital.

GENTLEMEN,—You will not long be in practice before being called on to exercise your skill in the removal of substances from the eye. From the commonness of the accident, you cannot escape an application. The frequency of it, and the pressing necessity, causes the aid of non-professional persons to be sought.

The nature of the injury varies from the most trivial and temporary inconvenience to consequences

fatal to the eye; and the ill result depends on the size of the thing that is lodged on the eye or entered, the force with which it is projected, and the mode of attachment. So that the eye may be damaged or destroyed at once, or ultimately by secondary causes.

It is wholly unnecessary to describe minutely the symptoms of a patient thus injured; the thing is self-evident. The sensation, the irritability of the eye, with the flow of tears, and the almost impossibility of opening it, all point to the fact.

When a substance is lodged within the eyelids, the patient may be able to define its exact seat—a matter of some moment; but when he cannot, and a survey of all the exposed parts of the eye fails to detect it, the eyelids should be retracted, and a greater surface of the globe of the eye exposed, the entire cornea, and some of the sclerotica beyond, rendered visible. Should that not suffice to reveal it, the interior of the eyelids must be searched—the under by depressing it and pulling it from the eyeball, which should be directed upwards; the upper by reversing it, that is, turning it inside out. Nineteen times out of twenty, the object sought will be found about midway on the tarsus, and rather near the edge. Yet, with all this, a small extraneous substance may still remain concealed, as the recess of the upper eyelid has not yet been exposed; and to unfold or open it to view, a narrow spatula, or paper-knife, or something of this kind, is required. But a minute particle may still escape observation in this situation, especially by artificial light; for the peculiarity of this recess may prevent perfect and satisfactory exposure. A jet of tepid water, thrown up from a syringe with a bent pipe, projected with sufficient force, should be employed whenever, in such a case, there is reason to suppose that anything remains. There are occasions when, from the multitude of the particles, the syringe cannot be dispensed with.

From less sensitiveness of the oculo-palpebral fold of conjunctiva of the upper eyelid—the sinus, as it is more frequently called—the presence of a body may not be felt, or suspected, till suppuration or inflammation ensues, or a fungus sprouts out.

It is strange, indeed, that in these instances the occasion or time of the intrusion of the substance may have been quite disregarded, or brought to mind only when questions are put about the probability of such an occurrence; and weeks and months may elapse between the period of the accident and the first symptoms of distress, which are generally ushered in by conjunctival inflammation, with mucopurulent, and ultimately purulent, discharge, like an ordinary purulent ophthalmia. Many of such remarkable cases have been treated by me; and some of which I have recorded in my ophthalmic work.

On the cornea, next in frequency to the inside of the upper eyelid, do the intruded particles attach themselves. When very minute, they are apt to be overlooked, especially if opposite the pupil. They may merely rest in opposition, or be embedded in the anterior elastic lamina, or impacted in the true corneal tissue. In all instances, they should be removed. The chief difficulty consists in retracting the upper eyelid, and steadying the eyeball. This preparatory step demands well doing; and, as it is required in all the difficult and important operations on this portion of the eye, it should be well learned. Some men never thoroughly master it, and therefore such individuals must ever be inferior operators. Of course, if any assistance can be got from retractors and other appliances, they ought to be used. The best instrument for detaching, or hooking out the particle, is a miniature gouge. It is more generally applicable than any other, and injures the cornea

less. I have succeeded with it, when other men have failed with needles, cataract-knives, and other angularly pointed blades. A little nicety is required in the manufacture; but this is well understood by Weiss. A minute pair of forceps I have found useful in removing wood splinters. In some few cases, I have incised the cornea a little before I could extract certain bodies.

Everything that relates to injury or disease of the cornea should be regarded with deep interest, as the sense of sight is more frequently impaired by the spoiling of this part of the eye than any other.

Always persevere in your attempts to extract a body, so long as it has not passed beyond the cornea. The exception must be under very peculiar circumstances. In the natural process of separation by ulceration, or by sloughing, there is more or less risk to the integrity of the eye from opacity or partial staphyloma; and more certainly there is danger of entire destruction of the organ from supuration of the cornea, and, it may be, of the eyeball. Even the remarkably rare occurrence of a body being encysted is not without its perils; for I have known the accompanying action prove fatal to the integrity of the retina, and destroy sight. I have seen ulceration of the cornea, and prolapse of the iris, occasioned by the presence of a particle of iron that had entered a week before, but which was so diminutive that a surgeon did not detect it.

I could quote many parallel cases of danger to the eye, even when the foreign body had been superficially placed. The only exception, I imagine, to interfering, except to gratify a patient, with any extraneous substance in the cornea, is when we find it deeply embedded, and many days or months have elapsed without any ill effects arising—the surrounding portion of the cornea not being hazy; and pain, vascularity, and lacrymation absent; or when there has been complete cessation of all acute symptoms.

In such cases, the process of encysting takes place; a layer, or bed of new material is deposited. But such a chance must not be trusted to, nor at all calculated on; for it is a very rare occurrence, and may never happen in the long experience of a man. Besides, the form of a body, and the peculiarity of impaction, may prevent it, as in the case of a bit of iron, with one end protruding on the inner side of the cornea. The irritation that is then set up is sure to spoil the eye. Notwithstanding the long and persevering attempts that I have made many times to remove deeply embedded things, I have never had any ill result. Never has there been supuration of the cornea; nor in the anterior chamber; nor has there been inflammation of the eyeball.

After a metallic fragment, especially of iron, has been removed, some rust, or mark, or stain, may remain. This is of no consequence, and should not be pricked at, nor be attacked with chemical reagents; for it is soon cast off. Very little practice enables a surgeon to ascertain when the particle has been removed. Carbonised and other substances act similarly; and without a knowledge of this, unnecessary injury may be inflicted. I have known vegetable matter produce stain.

The employment of magnets has repeatedly been suggested as an easy and effectual means of extracting bits of iron and steel; and various shapes have been given to them, some pointed, some crescented, and so on; but they are mere playthings, and not of any practical value.

After-treatment is seldom required; the symptoms disappear as readily as they were manifested. When inflammation has been severe, and there is pain, with heat and intolerance of light, a fold of thin rag, large enough to cover the eyelids, dipped in cold water,

applied, and renewed every few minutes, will soon give relief. The addition of some narcotic to the water may be useful. This, with rest to the eye, quiet of body, moderate abstinence, amply suffice for every case.

In all instances, the eye should not be rubbed and irritated. The sensation of something remaining often exists long after the extraction.

I suspect that the majority of metallic particles that get imbedded in the cornea are forced in by the common habit of rubbing the eye when anything enters.

No advantage would accrue from my enumerating the various substances in the mineral and vegetable kingdoms that may enter the eye.

The conjunctiva may be penetrated, and a particle of matter remain between it and the sclerotica. Encysting is likely to follow. I have seen several examples—I should say many—although I have never operated. The patients have either applied to me on account of something else, or I have met with them accidentally and spoken to them about the matter. Iron and copper have remained encysted for years.

The sclerotica itself is often penetrated, and retains bodies without much inconvenience. I have several times removed them when troublesome from snipping through the conjunctiva, raising it from its attachment, and then accomplishing the desired end. Generally it has been metal that has entered, and forceps have been required for the extraction. I do not include in these remarks, injury to the eye from lime and other chemical agents.

The larvæ of insects are sometimes found beneath the eyelids; and this is not very astonishing when we remember that flies deposit their larvæ in different parts of animals. The occurrence has been noticed after a fly has accidentally entered the eye. It has occurred to drunken men asleep in fields. Several cases are on record of the successful removal of the worms. I know of one only in which the eyeball was damaged through perforations.

DEATH WITH TETANIC SYMPTOMS: THE CORONER'S COURT.

By T. C. LEAH, L.R.C.P.Ed., Hyde, near
Manchester.

ELIZABETH SHAW, aged 14, the daughter of a beer-house-keeper, a stout robust girl, previously in good health, was seized about 2 P.M. on Thursday, June 30th, with violent tetanic spasms, persistent in the trunk of the body—opisthotonos—but alternating with relaxation in the extremities. The slightest touch, as the act of examining the pulse, brought on a return of the spasms in the extremities, as if from an electric shock, and increased the trismus. The head was forcibly drawn back; the face flushed; the surface warm and moist; the pulse weak and irritable; the muscles of the abdomen were much retracted; the feet incurvated; the intellect was unimpaired. There was no vomiting from the commencement of the symptoms to the time of death, which occurred before any remedial measures could be adopted, and under an hour from the first attack.

In reply to inquiries, the mother reported that the girl had not partaken of dinner, nor of food nor liquids since breakfast, so far as she knew; that she had not complained of illness, not taken any medicine; had received no wound nor bruise; had no cause for mental anxiety; that, in fact, she had been unusually cheerful during the morning, and had taken an active part in household duties and the family washing till the seizure. The catamenia, which commenced on the previous Saturday, had

ceased on the evening before the seizure; and to this circumstance the girl had directed her mother's attention.

I declined to certify the cause of death, and advised the case to be reported to the coroner for the district. An inquisition, I understand, was held on the 2nd inst.—the day but one following the death. No medical evidence was taken; no *post mortem* examination was made; and a verdict of "Died in a fit" was returned.

The details of this case may possibly be interesting, as affording an illustration of the inefficient manner in which coroners' inquests in sudden and doubtful deaths are frequently conducted, and verdicts recorded, without the slightest medical evidence. A medical coroner would, I think, have considered a full and rigorous investigation imperative, with such characteristic symptoms present during life, conjoined with so rapidly fatal a termination.

[There can be no question that not holding an inquest in a case such as here described is quite inexcusable. The symptoms assuredly much more resembled those of poisoning than of disease. EDITOR.]

Transactions of Branches.

BATH AND BRISTOL BRANCH.

CASE OF DISEASED HUMERUS.

By CHARLES STEELE, M.R.C.S., L.R.C.P.

[Read at Clifton, April 28th, 1864.]

THE patient, from whom the specimen now before you was taken, was seen by me for the first time in August 1863. The history of the case then given to me was as follows.

About eighteen months previously she felt aching pain, similar to that of rheumatism, in her right shoulder. In addition to this pain, there were soon perceived puffy swellings, between the metacarpal bones of the thumb and index finger, and of the index and middle fingers; these swellings used occasionally to appear, continue for a short time, and in a few hours subside. Aching pain from the hand to the elbow, and from the elbow to the shoulder, was also felt. These symptoms, occasional and slight at first, gradually increased in frequency and intensity. The suffering was noticed from first to last, to be most severe at one o'clock in the night. The following occurrence, which took place in November 1862, with its consequent alarming increase of symptoms (the pains having previously not been very much noticed or complained of) was the first to draw the serious attention of the patient and her friends to her state, and make them seek assistance beyond their own household remedies.

One day she perceived her son, who was near her, slip; and, in order to prevent his falling down, suddenly extending her right arm, gave him a good push (bending back her fingers in doing so). She immediately felt as if she had struck first the elbow and then the shoulder, and as if the arm were broken. The same night she complained of great pain in the shoulder. After this she was never able to cut her own meat, or to raise a teapot or any such weight; but could for some time feed herself, and perform slight actions. The hand swelled much, and was obliged to be kept in a sling. The upper extremity also required to be kept warm, as increased pain was complained of on its becoming at all cool. At first, and for some long time, considerable relief was experienced from the application of hot water; this failing, ease