The temperature begins to rise at the commencement of the process of suppuration. It rises rapidly until the process is mature, when it begins to fall.

For example, a man, aged 39, was admitted for a severe bruise of his thigh. On the evening of the third day after the accident, his temperature was 103 deg. Fahrenheit, and inflammation of the soft parts was to be felt near the seat of the injury, but no fluctuation. A poultice was applied. The next evening, his temperature was 105 deg. The abscess became matured during the night. The temperature fell gradually next day.

In cases of severe concussion of the brain, it is of extreme importance to establish with certainty the existence or non-existence of any inflammatory symptoms. Mere nervous shock will in not a few such cases cause the pulse and respirations to be very rapid. The following is a case in point. A boy, aged 14, admitted with severe cerebral concussion, had a pulse of 120 and respirations 36. The temperature, however, did not rise above 101 deg., which proved the absence of any severe inflammatory mischief.

In cases of intestinal hemorrhage in typhoid fever, the temperature falls for some hours before the blood appears in the stools, the pulse continuing as rapid, or even more rapid, than before the hemorrhage took place. The thermometer enables the physician to determine the occurrence of the hemorrhage, and to adopt preventive treatment at once; whereas if, neglecting the use of that instrument, he wait until the blood appears in the motions, much valuable time will have been lost.

To be continued.

ON THE TREATMENT OF STRABISMUS WITHOUT OPERATION.

By C. HOLTHOUSE, Esq., Surgeon to the Westminster Hospital, and to the Surrey Ophthalmic Hospital, etc.

Case II. Double Convergent Strabismus from Paralysis of the External Rectus Muscle of the Left Eye, probably due to a Capillary Abscess. Elis W., aged 54, chimney-sweep, applied to me at the Surrey Ophthalmic Hospital on February 6th, 1860, for a slight convergent strabismus affecting both eyes, diplopia, and much confusion of vision. The movements of the right eye were perfect in every direction, the pupil acted normally, and the vision was good; but the left eye could not be moved outwards beyond a central position between the two canthi; and the upward and outward and downward and outward movements were likewise very limited. In other directions, this eye moved freely, and its pupil and vision were unaffected. On shading each eye alternately, the right or good eye was always more inverted than the left. The diplopia was lateral and homonomous; and the distance between the double images increased as the object gazed at was moved further to the patient’s left side.

History. Three weeks previously, while the patient was in a warm room, her nose began to bleed. She succeeded, however, in stopping the hemorrhage, but shortly afterwards became affected with a sudden “dizziness,” and felt as if she “was going to fall off the seat.” On leaving church, she had much pain in the head, which she endeavoured to relieve by tying a handkerchief tightly round her forehead and going to bed. She awoke the following morning at her usual hour, and went to work, notwithstanding she felt very unwell, and suffered from much confusion of vision. The above symptoms continued to the time of application. She was ordered one grain of calomel and one of quinine three times a day.

Feb. 9th. The powders, having gripped and purged her freely, were discontinued, and a mixture of three grains of iodide of potassium in an ounce of camphor mixture, to be taken three times a day, was substituted for the convulsion of these two.

Feb. 13th. The paralysis remained without any appreciable diminution, but the patient’s health had improved. The medicine was continued.

Feb. 20th. The strabismus and confusion of vision had diminished, and the cornea could be reverted within two and a half times of the outer canthus. The treatment was continued.

Feb. 24th. The improvement continued; the cornea could be reverted within one line of the outer canthus; and scarcely any perceptible strabismus or confusion of vision remained. The medicine was continued.

The patient ceased to attend after the last note was taken, having considered herself well.

There may be some doubt as to the exact locality of the mischief in the above case; but less, probably, as to its cause. The preceding epistaxis pointed to congestion and rupture of the capillaries of the nose; and, had it not been for the patient’s own statement, it might possibly have ward off the paralytic attack. Being suppressed before the vessels had sufficiently relieved themselves, the preexisting congestion gave rise to rupture elsewhere; and this extravasation imputed, either at its origin or in some part of its course, the left abducens nerve. The dizziness, of which the patient complained on her first seizure, would not necessarily denote a cerebral lesion, insomuch as any sudden distortion of one eye will give rise to much confusion of vision and giddiness; but, coupling the latter symptom with the pain in the head and with the absence of paralysis of any of the other ocular muscles, it seems more probable that the extravasation was intracranial than intrathoracic.

As regards the influence of the treatment on the favourable result, I am unwilling to speculate. Suffice it that the patient recovered within three weeks of its commencement.

Case III. Double Convergent Strabismus of the Left Eye to one Line, and of the Right to one Line and a half, from Paralysis of the Left External Rectus Muscle, probably of cerebral Origin. Robert B., aged 35, bricklayer, and healthy looking, applied to me on January 9th, 1866, for a double convergent strabismus affecting the left eye to one line, and the right to one line and a half, when the head was straight; but, left to himself, he kept his head rotated on its axis to the left shoulder, thus making his eyes parallel, and so avoiding diplopia.

The attack came on without obvious cause, and unaccompanied with pain in the head or vertigo. He confessed, however, to having suffered from occasional giddiness and confusion, on stooping down, for the last two or three years.

On testing the movements of each eye separately, those of the right were found to be normal; but the cornea of the left could not be moved beyond the centre of the palpebral aperture. In all other directions, not influenced by the external rectus, the movements of the eye were perfect. The vision of each eye was good, but the accommodation of the left rather less perfect than the right, being in the right eye ½, and in the left ⅓. After some trials and shifting of the head, he was able to see stereoscopically through the ordinary refracting telescope; but, how improving, as will be shown hereafter, that he had the power of keeping the eyes parallel. When first seized with the paralysis, and for some time afterwards, he was much annoyed with the diplopia; but
he had now learnt to correct it by the position of his head. It is worthy of remark, in connexion with this symptom, that the double images were invariably parallel and of the same height, in whatever direction the object (a paper-knife) was held. Now, theoretically, the left hand image ought to have been slanting; because the left eye not being exerted, owing to the paralysis of its adductor, its vertical meridian would remain nearly vertical, while that of its fellow would be inclined to the left; and thus the parallelism of the two meridians would be destroyed. I shall have occasion to revert to this anomaly in another case. As regards the range of the diplopia, it occupied not only the centre and left of the visual field, but extended more than two feet into the right half.

Feb. 19th. He had had counterirritation kept up by means of sinapism in the cervical and upper dorsal regions of the spine, and had been taking a tonic mixture. To-day it was found that he could evert the cornea to three lines beyond the point at which it rested five weeks ago. Notwithstanding this, and it is likely that two or into the right field of vision. This phenomenon was due to the action of the adductor of the paralysed eye not being sufficiently controlled by its weakened antagonist. Thus the visual axis of that eye, instead of being in a line with the object, passed beyond it, as was proved by shading the sound eye, when the paralysed one immediately made a slight movement outwards.

This patient is now being treated by galvanism twice a week, according to the method recommended by Benedikt of Vienna; and, although not yet perfectly well, he is steadily advancing towards complete recovery.

[To be continued.]

ON THE DISCOVERY OF TRICHINE IN THE HUMAN SUBJECT.

By THOMAS NUNNLEY. F.R.C.S.E., Leeds.

From the repeated references which from time to time have appeared in the British Medical Journal and other publications, as to who first discovered trichine in the human body, and the date of the discovery, it would appear that much interest attaches to the question.

Some time ago, I observed that it was stated, in this Journal and also in others, that Owen first noticed the parasite in 1835. Then it was asserted that it had been discovered by a German anatomist; and now I find in the Journal of February 24th, a statement, made on the authority of the present curator of Guy's Museum, to the effect that Mr. Hilton was entitled to the honour of having first called attention to the subject in 1832. As the last date so nearly corresponds with the time when I dissected a subject in which I found trichine in enormous numbers, and it is hardly likely that two subjects affected with so uncommon a disease should have been seen so nearly together in the same dissecting-room, I cannot but suspect this latter statement refers to the subject in which I first noticed the existence of these enzoonas, and that it may help to settle the question of priority of discovery if I relate what then took place; and put in such claim as may fairly attach to the person who first noticed the presence of the trichine. It is by no means improbable, that some who were then students at Guy's may, on reading this communication, have their memory recalled to an occurrence which, at the time, excited considerable interest. I made a full memorandum of the facts in my note-book; and have a firm conviction of the correctness of what I now state.