On February 6th the abscess was aspirated, and several ounces of pus were withdrawn. So rapidly did it refill, that on February 10th I opened the abscess, by Hilton's method, at a point half-an-inch above Poupart's ligament, introduced a drainage tube, and applied a wood-wool dressing. The temperature, which had been running up to 101° F. and 102° F., at once fell to normal, and remained normal for ten days. A week later it was found necessary to enlarge the wound so as to admit of the reintroduction of the drainage tube. Thereafter the patient gained strength, and made an uninterrupted recovery. Since leaving hospital she has attended to all her household duties; she has recently given birth to another child, and she now enjoys perfect health.

In the light of Dr. Cullingworth's paper, the points to be noted are these:—Etiology.—Occurred after labour in which a hand (not previously rendered aseptic) had been introduced to remove the placenta. Amount of Pain.—Present, but never very excessive. Physical Signs.—Distinctly those of a cellulitis. Had the case been left to Nature, the abscess would almost certainly have pointed "above Poupart's ligament, where intraperitoneal abscesses never do." (Cullingworth). Lastly, while a pelvic peritonitis invariably leaves some evil effects behind it, and not infrequently calls for an abdominal operation, a pelvic cellulitis, even of a severe type, may be absolutely recovered from.

Edinburgh. THOMAS MACKENZIE, M.A., M.B.

ŒSOPHAGEAL VARICES IN CIRRHOTIC HÆMATEMESIS.

APROPOS of the very interesting and instructive papers on the above subject, in the BRITISH MEDICAL JOURNAL of December 27th, I may say I was called in the night, three or four months ago, to a gentleman who was believed to be suffering from alcoholic cirrhosis, and who was vomiting blood. Upon my arrival I found that several pints of blood had been vomited, and almost directly after I entered the room another attack of hæmorrhage occurred. The blood gushed from the mouth "as from a hose," or as if a tap were turned on, and to the extent of quite 1½ pint. The quantity lost was said to be increasing and to be getting fresher. There had been slight morning hæmorrhages from the nares occasionally from time to time, and some oozing in the night from the gums, which were spongy. The pharynx was congested with tortuous venous radicles, but no oozing of blood from its surface. The abdominal veins were prominent, and there was a suspicion of fluctuation. In the light of the papers referred to, the condition of the patient and the profuse and gushing character of the hæmorrhage, which was venous but unaltered by gastric action, I believe that the blood came from distended and ruptured œsophageal veins. But my purpose in writing is as to treatment. Ergot obviously is inappropriate in such conditions. Astringents are antagonistic to the physiological import of the hæmorrhage. Ice is depressing and likely to set up or aggravate gastric catarrh. The remedy is hamamelis, of which I have some twelve years' constant experience, and which is contained in the *Addendum to the British Pharmacopœia*. This remedy was followed by marked and rapid abatement of the hæmorrhage, and in three days the patient was about as usual, although he had lost six to seven pints of blood, and eating all before him, which was quite a new experience for him. There was a marked subsidence of the abdomen consequent upon the hæmorrhage, and the hamamelis was continued for some weeks once or twice a day. The superficial abdominal veins settled, the patient's general health has steadily improved, the morning hæmorrhages have disappeared, and there has been only one return of the hæmatemesis, which was promptly checked by hamamelis, taken as before, and of which the patient keeps a supply by him.

Bradford. JNO. PITNEY ASTON.

SULPHATE OF ESERINE IN KERATITIS HYPOPYON.[1]

MY object is to invite attention to a simple remedy which I have found very useful in arresting and curing keratitis hypopyon. The disease is due to the deposition of some micro-organism on an abrasion of the cornea in persons of enfeebled constitution.

The treatment adopted by the generality of medical practitioners and by a good number of specialists has been, and is still, the application of hot fomentations with decoction of camomile flowers, poppyheads, or belladonna leaves; of antiseptic lotions, particularly boracic acid, 1 in 50; or of corrosive sublimate, 1 in 5,000; atropine drops which, if they are useful in lulling the pain, are, however, hurtful in increasing the tension of the eyeball; and, lastly, insufflations of powdered calomel or of iodoform which are supposed to act beneficially in reviving the healing up process of the corneal ulcer. In case these means should fail in arresting the progress of the ulceration and of causing the absorption of the pus, cauterisation of the ulcer with the thermo- or galvano-cautery, or the emptying of the hypopyon by cutting through the cornea is often practised. Though both these procedures are very often successful, they are not devoid of danger, and require a well trained operator for their performance. Moreover, it is not always easy to get the patient to submit to an operation, and perhaps more than one, requiring the use of the cautery or of the knife.

I am convinced, after a trial of about ten years, that a solution of sulphate of eserine (gr. ij per ounce) dropped, two or three times a day, into the affected eye, which has to be kept constantly well bandaged up, while the patient's state of health is improved by means of good nourishing diet and a tonic mixture, say the citrate of iron and quinine with liquor strychninæ, is all that is required to cure almost every case of keratitis hypopyon. In a very few exceptional cases only does it become necessary to perform Saemisch's operation of cutting across the cornea, including the whole ulcerated surface, and thus giving issue to the pus, reducing the intra-ocular tension, and stimulating the edges of the atonic ulcer to heal up. De Wecker, of Paris, was, I believe, the first to recommend this treatment about ten years ago. Having found it very successful in a great many cases, some of which were quite hopeless, without operation, I can recommend it very strongly.

Malta. L. MANCHÉ, Surg.-Major, M.S.

[1] Read at a meeting of the Malta and Mediterranean Branch.

REPORTS

ON

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

ADELAIDE HOSPITAL, DUBLIN.

SCROFULOUS DISEASE OF THE KIDNEY: NEPHRECTOMY: RECOVERY.

(Under the care of FRANCIS T. HEUSTON, M.D., F.R.C.S.I., Professor of Anatomy Royal College of Surgeons, Ireland.)

[History furnished by Miss MAGUIRE, Medical Student in Charge.]

J. R., aged 13 years; his father and mother are alive and healthy, as also two brothers and a sister, but five brothers and sisters died in infancy; disease not known.

When between 2 and 3 years of age he had a severe fall which injured one of his hip-joints. From this accident he was ill for a long period, a large abscess discharging itself in the groin; three years since he had scarlatina and whooping-cough, followed by a dry cough, with pains at intervals, referred to the lumbar region. In July, 1889, patient fell from a lift, his brother falling on him. He was unconscious for a short time, but was able to walk home. Subsequent to this he has suffered from a dull aching pain in the left lumbar region, lasting for about half the day, usually most severe in the morning, and was not affected by movement. In the early part of August patient noticed he had to micturate nine or ten times during the night, also frequently during the day; this was occasionally accompanied by pain in the penis, but never referred to the bladder; he did not notice any change in the characters of the urine passed. He attended as an outdoor patient at the Adelaide Hospital, when his urine was found to

contain a large quantity of pus, and on one occasion blood. His symptoms not improving, he was admitted on October 16th, 1889, when he presented the following conditions:—Patient weighs 4 stone; is very emaciated, anæmic, and delicate-looking; is restless, and sleeps badly; complains of pain, sometimes in his back, sometimes in the lumbar region; this pain, which is of a dull aching character, does not extend from the above positions; tongue is clean, transversely fissured; he takes food well, and does not complain of thirst; his bowels are constipated; temperature normal. Urine: He passes daily from 40 to 46 ounces, from 2 to 6 ounces being voided about every two hours, which froths when passed. Micturition is not now painful. Examination: Urine very pale; reaction neutral; specific gravity, 1009; deposits a thick white precipitate containing large quantities of pus with a little mucus. Albumen is not more than to be accounted for by the amount of pus present; chlorides $\frac{1}{10}$th of normal quantity; urea 1.1 per cent.; microscope shows pus corpuscles; large flattened epithelial cells, single and in masses of from twenty to thirty; a few epithelial tube casts—a specimen was examined for bacillus tuberculosis, but without success. The patient's abdomen appears normal, but becomes very rigid on palpation, when a rounded tumour is to be felt immediately below the costal arch on the left side, which moves with diaphragmatic respiration, and presents a distinct rounded margin. On deep pressure, a second tumour is to be felt below the former; pain is complained of on pressure over the anterior aspect of the abdomen in the position of these tumours, but not posteriorly.

The patient was detained under observation until October 31st without any appreciable change in his condition, when Dr. Heuston made the usual oblique incision for kidney exploration in the left lumbar region, and found the kidney much enlarged, with several opaque spots visible on its surface, which, on being punctured with a needle, gave a sense of resistance, but no solid substance was to be felt. An incision was then made into the kidney, when some pus and urine escaped from a large abscess sac, which was found to contain a quantity of caseous material, it being now seen that the organ was studded with caseous patches; the kidney was carefully separated from surrounding structures and the hilum exposed; the ureter being separated from the vessels was ligatured some distance below the pelvis and divided. The vessels were ligatured in two places with silk and divided, the ligatures being then cut short; the wound was closed with deep and superficial sutures, a drainage tube was introduced, and antiseptic dressing applied; the entire operation occupied a little over an hour.

Subsequent examination of the kidney showed it was all in a diseased condition, containing, in addition to the large cavity already described, a number of small abscesses, also numerous deposits of caseous material. Microscopic examination proved the presence of giant cells in large quantities.

November 1st. Patient did not sleep much, and vomited frequently during the night. Morning temperature, 102.6° F.; urine, 17 ounces; acid in reaction; specific gravity 1028, contains lithates, a few pus cells, and a number of granular casts.

November 2nd. Slept well; wound dressed and found healthy; urine, 60 ounces, pale, acid; specific gravity, 1016; temperature, 101.8° F.

November 4th. Slept well; bowels moved three times; urine, 46 ounces; specific gravity, 1024, acid; temperature, 100°F.; wound nearly healed.

November 5th. Passed urine three times during the night, 36 ounces acid; specific gravity, 1022, high coloured, contained pus, mucus, and tube casts, with some albumen; chlorides $\frac{1}{10}$th normal; urea, 2.5 per cent.; temperature, 100° F.

From this date patient progressed favourably, and on November 18th the urine was as follows: 27 ounces, acid, normal colour, specific gravity 1018, urea 2.3 per cent., chlorides $\frac{1}{4}$ normal, pus small quantity.

November 23rd. Allowed out of bed, and on January 18th, 1890, he was discharged from hospital, being then 4 stone 7 pounds in weight; sleeping and eating well, and did not complain of pain, or frequency of micturition.

Remarks.—In publishing the above careful notes so fully, I am induced to do so as the case may prove of interest to the members of the profession, owing to the uncertainty which exists as to the diagnosis of such cases, and the advisability of operative procedure. The success of this operation being so dependent on the limitation of the disease to one kidney, it is of the utmost importance to form a correct diagnosis. The devices recommended by such authorities as Silbermann, Sands, Glück, Pawlik, etc., must be placed on one side as impracticable, the only reliable method, in my opinion, being that of Mr. Greig Smith, who depends upon the characters of the urine, as to quantity, percentage of solids (especially urea), and the presence of no more albumen than is to be accounted for by the pus in the urine. The above, taken in conjunction with the signs and symptoms of the case, should generally enable a tolerably accurate opinion to be formed as to the condition of the kidneys. As to the advisability and advantage of such an operation, it will suffice for me to state that this patient called to show himself to me about a month after his discharge from the hospital, when the improvement in his general appearance was most marked. He looked strong and healthy, and had gained considerably in weight. He stated that he did not suffer in any way, and felt quite well.

REPORTS OF SOCIETIES.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

Tuesday, January 13th, 1891.

Timothy Holmes, M.A.Cantab., President, in the Chair.

A Case of Nephrolithotomy (following Nephrectomy) for Total Suppression of Urine Lasting Five Days; Complete Recovery and Good Health Five Years after the Operation.—Mr. R. Clement Lucas read notes of this case, which was mentioned by the medical journals at the date of the operation, in 1885, as a case of exceptional interest, but the author had delayed publishing it until sufficient time had elapsed for a judgment to be formed as to the permanence of the cure. The patient was still enjoying the best of health and freedom from pain, discomfort, and hæmaturia, which, for seventeen years before her right kidney was removed, were almost constantly present. The operation for total suppression of urine was one that the author had long considered justifiable, and he had on more than one occasion previously publicly advocated its performance. The patient had been under the care of Mr. F. D. Atkins, of Sutton, Surrey, to whom much credit was due both for the original diagnosis and for the prompitude with which he acted when total suppression occurred. F. F., aged 37, was first admitted into Guy's Hospital on June 22nd, 1885. There was a strong family history of consumption. For seventeen years she had suffered from hæmaturia at intervals, and for nine or ten years this had been accompanied by pain on the right side of the abdomen, and for seven years a tumour, diagnosed as a floating kidney, had been felt on this side. On July 14th the right kidney was removed by lumbar incision. It was a mere shell containing masses of stone and weighing 21 ounces. The wound healed completely, and she left the hospital convalescent on August 10th, just within a month of the operation. All went well for three months. She had returned to her household duties, was free from pain and hæmaturia, and much satisfied with the result of the operation. On Sunday, October 24th, 1885, she was suddenly seized, between 7 and 8 A.M., with agonising pain in the back and left loin. The pain passed through the loin to the front of the abdomen and groin. About 8 o'clock she passed a little urine, but from that time all secretion stopped. Vomiting commenced about half-past 8 on the same morning, and was continued at intervals and whenever anything was taken. Mr. Atkins was called to see her, and found the bladder empty. Vomiting and anuria continued throughout Sunday, Monday, and Tuesday. On Tuesday Mr. Lucas met Mr. Atkins in consultation, and advised operation. The symptoms continued without cessation on Wednesday, when she was brought to London, but Mr. Lucas's medical colleagues still advised him to postpone operation till a further trial had been given to diuretics, and in deference to their opinion he waited another day. On the afternoon of Thursday, the fifth day of anuria, the patient became drowsy and weaker, so that it was difficult to rouse her to obtain answers to questions. Her pulse was weak, her tem-