with difficulty that he could make his wants known, even when the mouth was moistened. At this time numerous pimples made their appearance on the forehead and face, very similar to small abscesses, being distinctly pustular from the commencement. Those on the chin and side of the face were as large as a hazel-nut, and discharged a thin ichorous secretion, which irritated the surrounding skin. Pustules began to appear over the chest, arms, legs, and body generally. The wine was increased to eight ounces; and beef-tea, arrowroot, and milk were given as usual.

Sept. 22nd. The patient was quite sensible, but could not articulate. The crop of pustules had increased considerably; those on the face and upper part of the chest still continuing to pour forth an ichorous discharge. The pulse had risen to 156. Respiration was hurried as well as laboured, 60 per minute. Chloric ether, bark and acid, with six ounces of brandy in addition to the wine, were ordered; but the patient gradually sank exhausted, and died at 8 P.M., remaining conscious almost to the last.

On the 19th, he was seen by Dr. Fincham, who was acting for Dr. Basham in his absence; and he remarked that the symptoms present were very similar to those of glanders, with the exception that there was no discharge of any kind from the nose.

No history of the patient having been exposed to the contagion of glanders could be obtained. He had attended to his own horse, and had been in the habit of drinking a good deal.

No *post mortem* examination was made.

TAUNTON AND SOMERSET HOSPITAL.

CASE OF LOOSE CARTILAGE OF LARGE SIZE SUCCESSFULLY REMOVED FROM THE KNEE-JOINT BY THE SUBCUTANEOUS METHOD.

Under the care of H. J. ALFORD, M.B.Lond., Surgeon to the Hospital.

[Reported by Mr. F. W. GIBSON, House Surgeon.]

JOSEPH Q., aged 43, admitted on June 14th, 1862, gave the following history of his disease:—Four or five years from the present time, his right knee, without any exciting cause, became weak, and "gave way under him"; it moreover swelled to such an extent that he was obliged to take to his bed, and the joint did not resume its normal state until after four or five weeks rest. Two years subsequently to this attack he noticed a "knob, like a bone" on the inner side of the articulation, which could be moved about to all parts of the joint, and which from time to time slipped under the knee-cap. When this accident occurred he could not stand or walk until he had pushed it from that position. About twelve weeks before his admission, the joint, which had previously been quite unaffected, became, owing, according to the patient's accounts, to a sudden wrench, again swollen and painful. Nevertheless, he continued to walk on it, and did not abandon his occupation, that of a tanner, until fourteen days before his admission into the hospital, when his state was as follows:—

The right knee was somewhat, although slightly, larger than the left, owing to a small amount of intra-articular effusion. Motion caused pain in the joint, which, when at rest, was painless. On the inner side was felt a hard body, oval in form, and apparently an inch and a half long by half an inch wide, freely moveable, so that it could be pushed to any part of the articulation.

OPERATION. The rest of a few days having allowed the effusion to be absorbed, the patient was put under the influence of chloroform, and Mr. Alford proceeded to operate. He first introduced the point of a long tenotomy knife on the outer side of the thigh, between three and four inches above the patella; and, the car-

tilage being fixed in the upper and outer aspect of the joint, he passed the knife, subcutaneously, downwards, and opened the articular capsule freely. Having then withdrawn the knife from the articulation, he, by a few sweeps of the blade of the knife, made a bed for the cartilage in the subcutaneous cellular tissue, into which it was easily pushed. Strapping and a figure of 8 bandage retained it in position about three inches above the patella; and the joint was kept at rest by means of a straight splint applied at the posterior aspect of the thigh and leg.

No untoward symptom whatever followed the operation; and on the sixth day after it, Mr. Alford removed the cartilage by a single incision. The cartilage itself was hard, tuberculated, and of a tawny, yellow colour. Its weight was 160 grains; its length one inch and three quarters; its width one inch and a quarter; and its thickness two-thirds of an inch. On a section being placed under the microscope, it presented the characteristic appearance of ossifying and ossified cartilage.

The limb was again placed on the back splint, the wound closed by three sutures and strapping, and it rapidly healed by first intention. The man had not throughout a single untoward symptom, and was discharged a few days after the second operation perfectly cured, wearing, however, a knee-cap, more as a matter of precaution than of necessity.

Original Communications.

INTERNAL SQUINT; VARIETIES; TREATMENT.

BEING REMARKS IN THE COURSE OF CLINICAL INSTRUCTION AT THE CENTRAL LONDON OPHTHALMIC HOSPITAL.

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

THERE is no deformity arising out of muscular contraction that is so amenable to surgical treatment as squint, nor one that can be so completely removed. Nor is there any which so uniformly demands the application of practical surgery, that is the division of the contracted muscle. I question whether an internal squint which is attended with any degree of impaired vision, whether as a cause or as an effect, not being produced by paralysis of the external rectus, is ever removed by any other means. I have neither seen an example of such, nor met with an authentic record. The exception must, therefore, be very rare. Even without any defect in sight, after the affection has existed for a few months, recovery is an exceedingly uncommon occurrence.

But the surgical treatment should not be undertaken at random, as failure and disappointment must ensue. Some cases are irremediable, or admit but of partial benefit. Sometimes it is not very easy to say which is the defective eye; or whether the one only is affected, or the two involved; and, arising out of this, whether the one eye or both should be treated. All this, and many other matters strictly practical and necessary to be known before an operator can get the highest attainable success, I shall try to tell you easily and concisely, by classing the squints as suggested by Mr. Holthouse, and making remarks as I proceed. But I beg you to bear in mind that there must ever be much that is arbitrary in artificial tabling of disease; because, of necessity, only the more marked examples are taken, the gradations can hardly be recognised, and exceptional instances can find no place.

I shall give five varieties. The first is the fixed squint of one eye. There are degrees of this fixedness; that is, more or less power of straightening the eye under

strong volition : but there may be total absence of lateral movements. The inversion is often excessive. This is essentially produced by paralysis, entirely or partially, of the external rectus, and may, therefore, be called paralytic squint. It is, of course, the most unfavourable for surgical treatment ; but it is not always wholly irremediable ; there may be degrees of improvement after the internal rectus is divided, in proportion to the power that may yet remain in the external muscle.

In the second, there is also single squint ; the one eye is ordinarily inverted, but there is ability to bring it parallel with its fellow, and often to evert it. This is the rarest form of all. Like the first, there can be no doubt about the affected eye, and resembling it also, only the single operation is needed. The distortion may be only occasional ; hence it is often called periodic squint. It has occurred to me to be disappointed so often in the result of an operation, that I suspect the influence of some peculiarity which I have not been able to detect.

In the third, the squint is readily detected as ordinarily settled in the one eye ; but when, from strong will or any other circumstances, the eye is straightened, then the other turns in. But when the squint is slight, and there is little loss of antagonism among the orbital muscles, it may be difficult to say which is the squinting eye. As a rule, the state of vision will assist in the diagnosis ; for almost always defective sight is associated with the squint. But this test is still more sure.

I place the patient in front of me, at the distance of four or five yards, or further ; tell him to cover one eye, say the left, to look at me with the other, and to keep his head straight. The right eye will then be in the centre of the orbit. I direct him to uncover the left. Now, if the right, which has been open, be normal, it will keep its central position, while the left is turned inwards ; but if it be deformed, it will turn in, while the left will become straight. The experiment should be reversed. In the case of a child, I place an adult behind, and make him cover and uncover the eyes as required.

Where there is any doubt, the patient's attention should be directed from a fixed gaze, and volition interrupted, by causing him to wink a few times. He should also be made to close the eyes for a few seconds, then to open them, and quickly to look at an object. Cases are met with in which the greatest nicety is required to detect the faulty eye. Some are even scarcely embraced in the test.

Now, although one eye only may be implicated, there is a great tendency, as years pass on, for the other to be involved, and for one squint, as it were, to produce a second. How this seems to come about, I think I have explained in the second edition of my work on the *Surgical Diseases of the Eye*.

So it is, then, in this variety, that although at the commencement one eye only is affected, ultimately both may be implicated. I often point to this circumstance as one of the strong reasons for an early operation, when one eye only need be treated ; for when the two squint, the double operation is requisite.

Next to the ineffectual division of the contracted muscles, nothing has so tended to bring the surgical treatment of squint into contempt, as not operating on the second eye when it needed it ; and not to do so is indeed failure on the part of the surgeon. Certainly, the operator is often deterred from finishing his work, because he thinks the deformity is slight, that it may get better of itself—a great delusion ; or because he has not courage to demand that it shall be done against the objections of the patient, or his ignorant friends. Except parallelism be restored in the first instance, the second eye should always be operated on.

Now, it is not always possible to say till the one eye is done, whether the second squints. I assure you

that, after many years of practical acquaintance with the subject, and many hundred operations, I cannot be certain. When it has seemed that two operations would be necessary, one has sufficed ; but still more commonly, when it appeared that one only was needed, two have been imperative. It is, therefore, well not to commit oneself in any unnecessary communication or discussion on the subject. I undertake to set the eyes straight, but this only, if full sanction be given me to act as may seem necessary.

I do not think, therefore, that the two eyes should ever be done as a matter of course. Putting aside the argument against an unnecessary operation, I am sure that eversion is often caused by operating on the second eye, when there is no permanent contraction of its internal rectus ; and more certainly when, with this immunity, there is any very marked defect in the vision of the squinting eye. Such caution necessarily requires, when chloroform is given, that the patient should sufficiently recover to be able to use the eyes, so that they may be examined. All the necessary information may be got even before consciousness is completely restored. A single glance of the eyes, as they roll from side to side, is enough for one accustomed to the examination. No certain information can be obtained, so long as the patient is in the anæsthetic sleep. I have been often deceived. My conclusion then is, that one operation may suffice where both eyes have appeared to be implicated, and that the double operation is not always requisite ; that, therefore, there should be a selection, and the more implicated eye first attended to, and the effect ascertained before the other is touched.

The fourth kind is that in which the squint seems to pass from the one eye to the other, alternating so readily, so that either might for the time be regarded as the only affected. This is undoubtedly the most common of all, and is nearly always double squint, and therefore requires the double operation. With much care, it may generally be perceived that the eyes are not quite equally deformed. For the most part, there is very little, or no deformity in vision, the exception being very rare. Although I am convinced that this is not very uncommonly but an advanced stage of the third, or the last named variety, I am equally sure that it is more frequently an intermediate condition. When there is no disparity in vision, nor in the muscular movements of the eyes, the two may be operated on at once. When there is any marked difference in the latter, I do the worst first, and look to the effect.

In the fifth and last, both eyes are always more or less inverted, although the one is generally the more turned in, but not always the same eye : so that there is even here a tendency, although a very limited one, to alternation. It is seldom either can be fully everted ; and any degree of eversion is attended by remarkable inversion of the other. This is, for the most part, the squint of the adult and the aged. It is merely a more advanced stage of the ordinary double squint of early life, treated of in the last division ; and sometimes too of the third variety. Next to the paralytic squint, it is the least amenable to treatment.

The deviations from the horizontal position, in an upward or downward direction, occasionally existing in internal squint, require no more notice, besides mentioning the fact, and adding that they cannot be considered a complication, since they do not, according to my frequent and special observation, at all sensibly affect the result of an operation.

I am almost always asked, when a squinting child is brought to me, if the operation had not better be delayed till about the fourteenth year. The profession put the inquiry as well as the public. This is my answer. When I am satisfied that a squint has settled into a permanent deformity, there not being apparent any symptoms of the disease to which it seemed due, or which

least accompanied it; when general treatment has proved unavailing; when, on first seeing my patient, I learn that the squint has existed for years, or even many months, unless it is congenital, I advise an immediate operation.

There are many disadvantages in delay. Vision gets worse when its impairment is due to the squint; the contracted muscle undergoes pathological changes; and we have evidence, too, of its antagonist becoming abnormal; the other recti, in all probability, acquiring a different sphere of action. During the years of growth, the distorted position favours the irregular development of all the displaced parts, so that success must be imperfect in proportion to the postponement. These are the reasons why the treatment in manhood is so very seldom beneficial.

[To be continued.]

Transactions of Branches.

EAST YORK AND NORTH LINCOLN BRANCH.

DISLOCATION OF THE FEMUR INTO THE SCIATIC NOTCH:
FURTHER DISLOCATION INTO THE OBTURATOR FORAMEN
DURING ATTEMPTS AT REDUCTION: EVENTUAL
REDUCTION BY MANIPULATION.

By R. M. CRAVEN, Esq., Hull.

[Read September 24th, 1862.]

J. S., aged 38, was admitted into the hospital, under my care, July 17th, 1859. A large mass of wooden palings had fallen upon him, burying him beneath them. On examination, the nature of the injury was found to be dislocation of the femur into the sciatic notch.

He was put under chloroform; and while attempts at reduction were made with jack towels, etc., the head of the bone slipped into the obturator foramen; the limb, from being shortened, now being considerably elongated and a little everted. By means of manipulation, flexing the thigh on the pelvis, and drawing it across the opposite one, the head readily passed into its proper cavity; and the appearance of both sides was now similar. He left the hospital on the 23rd.

PERFORATION OF ILEUM, WITH EFFUSION OF INTESTINAL CONTENTS INTO ABDOMINAL CAVITY:
PERITONITIS: DEATH.

By R. M. CRAVEN, Esq., Hull.

[Read September 24th, 1862.]

On December 29th, 1859, I was requested to go immediately to a village a few miles from Hull, to see J. C., aged 57, who was stated to be very ill and in great pain. On my arrival, he told me that at 6 A.M., while in the act of having intercourse with his wife, he was seized with violent pain in the abdomen. I found him in great distress, and rolling about with agony, great tenderness of the abdomen, and a very anxious countenance. He was not in a state of collapse. I prescribed the remedies most likely to relieve, such as opiates, etc.

The next morning, a messenger came in a great hurry, stating he was much worse. When I arrived, I found him dead—twenty-eight hours after the sudden pain. I had not seen anything of him since the previous June, when he suffered from symptoms of colic and general derangement of the system; from which, however, he apparently recovered.

I made a *post mortem* examination twenty-four hours after his death. The abdominal cavity contained a quantity of fecal fluid. There had been intense periton-

itis; the surface of the intestines, which were adherent by recent lymph, and the lining of the abdominal walls, being of a brilliant scarlet hue. This appearance was most marked towards the right side. About the middle of the ileum was a perforation a quarter of an inch in diameter, nearly circular, and looking as if a portion had been punched out. It had evidently been an ulcer, the result of previous disease, which had perhaps healed; or the intestine had become adherent to another part at that situation, and the exertion of coition had severed the adhesion.

Introductory Lectures.

KING'S COLLEGE.

At this institution, the business of the session was opened by Professor FERGUSON. After a few introductory words, he noticed certain changes which had taken place in the system of medical education.

Before University College and King's College sprang up, the medical schools of London were constituted very differently from those of the present day. A pupil might enter on his "walk" at any hospital he fancied, and take his lectures from any accredited source he chose. He might learn his anatomy in the west, and his surgery in the east, and might roam from Mile End or the Borough to the far west at Hyde Park Corner; he had the choice of the three great institutions with sainted names—St. Bartholomew's, St. Thomas's, and St. George's—and of others, with the well known and respected appellations of Guy's, the London, the Westminster, and the Middlesex. He roamed like the bee, and sucked the sweets where he chose; but—whether for better or worse may be a question—the custom now is, that a youth shall select a certain institution, whence he may expect to derive all that essential part of his education which shall enable him to secure his title and qualification to practise his profession. Now, instead of learning his anatomy at one point, his surgery some three or four miles off, his physic at some equally distant school, and "walking" his hospital in still another direction, he settles calmly down in a comparatively limited sphere, and lays his mind open to the teachings of a single institution. There may be advantages and disadvantages in both systems; but custom, which, rightly or wrongly, always rules for the time being, has so settled it, that each school of medicine in London has become a kind of college in itself. A pupil can, in such a school, get all the required elements of his profession. He can reverse the order of nature in this respect—that whilst he must be content with his maternal parentage, as Nature has so ordained, he can select at will his future *Alma Mater*. In former days, a man boasted of having been a pupil of a single teacher; but now he refers to the school in which he has been reared. Whatever influence a teacher's name may have, the reputation of a school generally has the greatest weight. And very justly so; for, as one man can teach only a section of the great scheme of medical education, so it is fitting that the strength of a teaching establishment should depend more on the general perfection of the whole than upon accidental single influence. Some of the warmest early friends of King's College saw no occasion for a hospital as part of the medical school; but it was soon observed that a change in the habits of schools and pupils had come over former customs. A fashion arose for pupils to take their whole professional education from one establishment. A youth remained at St. Bartholomew's, St. Thomas's, or Guy's, throughout the