clude the probability of its expulsion, the first measure tried should be the shaking of the patient's body with the head in a depending position."  

In the statistics compiled by Dr. Gross, inversion of the body alone is said to have been successful in five cases, and in both it was a shilling that entered. After tracheotomy, prone inversion would, perhaps, be best, as to favour expulsion through the wound, if the substance should fail to pass the glottis. If, however, the easier operation of laryngotomy be performed, as recommended by Mr. Lee, in order not so much to allow of the exit of the substance through the wound, as to prevent spasm of the glottis, and thereby enable it to pass through the natural opening when the body is inverted—then, if the view here taken be correct, the supine position should be the one most likely to attain that end.  

In some cases of doubtful diagnosis, this proceeding would probably assist to clear up the doubt. Such an instance, I think, was that already quoted from the British Medical Journal, in connection with Case I, in which, from the comparative quiescence of the patient, a doubt existed in the mind of the surgeon as to whether a foreign body was in the air-passage or not.  

In explaining the much more frequent entrance of foreign bodies into the right than into the left bronchus, Dr. Stokes, while properly attributing the chief influence on both it to the greatest ease of the trachea, has given two additional explanations—"a more horizontal position of the bronchi," and the statement is repeated in the Lectures of Dr. Watson. This does not seem correct anatomy. The right bronchus, passing off directly into the lung, takes a nearly transverse course. The left bronchus would tend to descend, and by the shortness of the thorax has to take a more vertical direction in order to reach its destination. The point is, perhaps, of little moment, yet worth correcting, especially when endorsed by such eminent names. Mr. Bryant, in the last number of Guy's Hospital Reports, says that when a foreign body has passed into the bronchi, the left is its most common seat. This is not, I believe, in accordance with general experience.

TEN YEARS OF OPERATIVE SURGERY  
IN THE PROVINCES.  

By Augustin Pritchard, Esq., Surgeon, Clifton, Bristol.  

[Continued from p. 908 of volume for 1860.]  

V.—Operations on the Eye.  

I have arranged the operations on the eyes under the fifth general division of my operative cases; but, upon looking over them for the purpose of further classification, I find that they are so numerous that any particular account of each case is quite out of the question. They are probably more in number than all my other operations put together; and since, according to my own experience, the tabular form does not give a reader any inducement to persevere in his studies, I have avoided it, and have written most of them out verbally, as briefly as possible, merely indicating the sex by the letters M and F. Many of the cases may appear trivial to my experienced readers; but they shall be very short, and are comparatively few; for the greater number of the minor ones have escaped any accessible record. I have in these papers been anxious to give a true idea of our surgical proceedings in connexion with a provincial hospital, and have been therefore included slight as well as severe, and unsuccessful as well as successful cases.  

It is necessary to subdivide my ophthalmic cases into ten groups; and, even with this classification, it has been requisite to omit all the little tumours of the lids, serous cysts, operations for pterygia, and fistula lacrimalis. The groups are, the Extraction of Catarrh (in one eye and in two—first the successful, and then the un-
successful cases); Needle Operations; the Removal of Hard Capsule and Dislocated Lens; the Formation of Artificial Pupil; the Magnetic Pupil; and for those requiring several operations, which will not allow them to be included under the former heads: Operations for Staphyloma; Strabismus; Expiration of the eye; and lastly, Operations for Ectropion, Entropion, Trichiasis, and Ptosis.

The period of time in which those eye operations were performed extends further back than the ten years.

Extraction of Cataract. CASE CXXXIV. M., aged about 50. (This was my first cataract case.) Left eye amaurotic from a blow; right lens dull; pupil large and inactive. Made an upper section, which was enlarged with the scissors; and the cataract escaped readily. He was blind in one eye for pain in the head, and was able to work for years.

CASE CXXXV. M., aged about 60. Double cataract. I operated on the left eye by lower section. He recovered without a bad symptom, and went home in two weeks with excellent sight and an active pupil.

CASE CXXXVI. M., aged about 60. Double cataract, of recent formation; the whole of the right lens being opaque. I made a lower section of the left eye; the eye returned to its usual position, and the pupil of the right eye showed an active pupil. He was able to see quite distinctly.

CASE CXXXVII. F., aged 75. Double cataract. She said that she lost the sight of the right eye suddenly. I made a lower section in the left eye, and successfully operated; and the cataract escaped readily. She recovered quite well, and was able to work for years.

CASE CXXXVIII. F., aged 60. Her left eye was amaurotic, and he had a cataract operation performed some years before by Mr. Estlin, but without advantage. I operated on his right eye by upper section, and a very hard cataract was suddenly jerked out upon his cheek. On the fifth day, he struck his eye accidentally; but, with this exception, he went on well. His pupil was always dull; with a strip of court plaster and light compress, treating both eyes alike, although one has been operated on. He made an excellent recovery, and could see to read small print with a two-and-a-half inch lens.

CASE CXXXIX. M., aged 58. His left eye was amaurotic, and he had a cataract operation performed some years before by Mr. Estlin, but without advantage. I operated on his right eye by upper section, and a very hard cataract was suddenly jerked out upon his cheek. On the fifth day, he struck his eye accidentally; but, with this exception, he went on well. His pupil was always dull; with a strip of court plaster and light compress, treating both eyes alike, although one has been operated on. He made an excellent recovery, and could see to read small print with a two-and-a-half inch lens.

CASE CXC. F., aged 67, a little fat old woman, with sunken eyes and double cataract. Right eye affected two years, and the left nine months. I made the upper section in the right eye, the knife shaving the iris. Soft part of lens removed by a corneal curet. Went home on the eighteenth day with good sight, but the eye still weak.

CASE CXCVII. F., aged 57. Operated on the right eye, and Mr. Estlin on the left; some vitreous humour escaping with the cataract in the latter eye. She was bled at night for headache, and made a slow recovery.

CASE CXXIX. M., aged 60, a corpulent publican, who had had paralysis. I operated on both eyes at the same time. With the right cataract (upper section from behind), a considerable quantity of fluid vitreous humour escaped. Made also the upper section in the left eye, standing in front of the patient. The cataract escaped with no vitreous humour. The next day, he had a severe attack of gout in the knees; but he recovered his sight in both eyes, and died of apoplexy about eight months afterwards.

CASE CXXX. M., aged 71, an extraordinary old man, who had chores affecting one side of the body, and paralysis of the other from birth. He was constantly moving (involuntarily) the most strange grimaces and contortions of the body, and this he said had continued all his life. He had been married and had a healthy family. It was with great difficulty his head and face could be kept steady. I made an upper section in the right eye, and extracted a dark amber cataract. On the fifth day he opened his eyes, which appeared quite steady, and the upper lid, which was hanging down, quickly recovered. During the cure, the lower lid irritated the corneal flap, and rendered necessary two applications of the nitrate of silver to it. Recovered with good sight in both.

CASE CXXXI. F., aged 60. Operated on both eyes. In the right the corneal section was small, and the lens was extracted with a pair of scissors. She had no very unfavourable symptoms, but her eyes remained weak. She went away, and returned in six months, when I found that she had entropium of both eyes, and prolapsus iridis of the left eye. I took a piece of skin from her lid, and applied nitrate of silver to the prolapsed iris, and she soon repercurred. She went away with quite a good sight in both.

CASE CXXXII. M., aged 60, lost the left eye by a blow, and the right eye had been getting gradually blind, when he became suddenly blind. I operated on the right, and made a good upper section. He went on well for nearly a week, when pain, especially at night, occurred, and he had severe inflammation of the eye, with thickening of the corneal skin. After three weeks,anding the eye, the cornea bulging, and the wound not healed, I passed the corneal through the white scar, thinking to remove some debris of the cataract, but nothing came away, and the eye healed more quickly. He went away with but little sight in this eye; and when I saw him, six months afterwards, he had closed pupil. I cut his iris with the scissors, and he had immediately a new pupil, which became circular, and he went away with a four-inch glass and good sight.

CASE CXXXIII. F., aged 65. Operated on the left eye, making a lower section. He went home with good sight in eighteen days. The pupil was a little dense.

CASE CXXXIV. M., aged 57, whose father was operated on for cataract eleven years before. Double cataract. I operated on the right eye, making the upper section, and the left eye, making the lower section.
which required to be enlarged with the scissors. Recovered with good sight, without a bad symptom.

Case clxxxii. M., aged 72. Double cataract. Mr. Estlin extracted the right and I the left lens. He had a good deal of inflammation in both eyes, which eventually subsided; and, when he returned home to Wales, his sight was improving, but it was still imperfect.

Case clxxxiii. F., aged 50, had been gradually becoming blind for four years. I made first the upper section in the left eye (standing in front), and enlarged it rigidly with a scissors, and the lens with a considerable quantity of vitreous humour gushed forth, and it required some management to replace the corneal flap. I then made the upper section in the right eye, and the lens and a small quantity of vitreous humour escaped with a little pressure. He went home well, with good sight in both eyes.

Case clxxxiv. F., aged 50, with fully formed cataract in each eye. I made an upper section in the right eye, and extracted a soft white lens. Went home with good sight.

Case clxxxv. M., aged 60, with long standing cataract in each eye. I operated on the left, and when he recovered, he had good sight; but after a time the capsule became opaque, and the pupil was drawn down. I therefore operated on the right eye with a needle, reclining and breaking up the lens. Some inflammation came on, and he was leached once or twice; but ultimately the eye recovered completely, and he went home with very good sight.

[To be continued.]

\[\text{Reviews and Notices.}\]


Diphtheria is another of the innumerable evidences of the truth of the wise man’s dictum, “that there is nothing new under the sun.” We are apt to regard this affection (with its modern title) as a disease of the generation we live in. A certain indistinct history of the disease, it is true, some years ago came to us from France; but in Great Britain diphtheria was, until lately, little more than a clinical curiosity. The last few years have, we need hardly say, totally changed this disposition of things. We have had to make frequent and painful acquaintance with the disease, to investigate its nature, to look up its history, and to endeavour its arrestment (if this might be). Naturally enough, under such circumstances, our professional brethren have, some of them, made a special study of the epidemic, and have given the profession the benefit of the result of their investigation.

Dr. E. H. Greenhow has thus favoured us; and we are glad that he has done so. The natural tendency of his studies has been in the direction of epidemics, their causes, nature, and special visitations; and we therefore are sure to have in him a satisfactory guide to a knowledge of this epidemic also. For diphtheria is truly an epidemic, even though it be also endemic and sporadic. Like cholera (and here we follow Dr. Greenhow) the disease is no novelty here; it has had its being here ages ago, has vanished, and now has reappeared in this country once again and in the present century. It was described by physicians of former long-past ages; but our fathers and grandfathers knew it not. Aristeus has described it,—so says Dr. Greenhow at least. In the sixteenth and seventeenth centuries it prevailed in Spain, Italy, Sicily, and other European countries. In the middle of last century, it visited England, France, Italy, Sweden, Germany, and even North America. Then it seems to have lain perdu for a season, until it again manifested itself about the end of the first quarter of this century. During the last three or four years it has prevailed, in epidemic form, on the Continent, in England, North America, and distant Australia.

Dr. Fothergill gives the first notice of the disease in this country in 1748, in an “Account of the Sore Throat attended with Ulcer.” Other physicians of that date also described the affection, Drs. Huxham, Starr, etc.; and the extracts given by Dr. Greenhow from the writings of these worthies, leave little doubt that they had indeed diphtheria to deal with. The history of diphtheria in the nineteenth century dates from Tours, in a communication from M. Bretonneau to the French Academy of Medicine. In fact, to the epidemic in question, Bretonneau first applied the term diphtherite. His memoirs on the subject have become, thanks to the Sydenham Society, classical works with us. From Tours the disease seems to have spread over, or to have arisen, in various parts of France. Louis described it in a paper “On Croup in the Adult.” The acquaintance of living English physicians with the disease in its epidemic phase, at least, was commenced at Boulogne during its outbreak there in 1854. This epidemic lasted until 1857, and carried off 366 persons, 341 of whom were children under ten years of age. It was said to have especially attached itself to the English residents there; but probably the saying was a mere vague rumour.

In 1856, Dr. Greenhow marks its first appearance in England in Whaplode Drove, in Lincolnshire. It also appeared at Leek and Birmingham about the same time; and it is important to note, that the disease seems to have commenced spontaneously in several centres remote from each other. In London, the first case noticed was in 1857. A curious coincidence here has been suggested; viz., that during this visitation of diphtheria other diseases (especially those of the acme sort) assumed a diphtheritic type, and not only amongst men, but also amongst animals. We must not, however, suppose that because the disease has been raging as a true epidemic among our people, that its onset is simply and solely of an epidemic kind. Dr. Greenhow affirms that the records of our medical literature clearly show that diphtheria, like cholera, has always been present with us in a sporadic way, i.e., when not raging as an epidemic. Sometimes it has adhered so pertinaciously to certain limited spots, even to single houses, as to give it an endemic character. He gives numerous illustrations of this peculiar character of the affection; its extension through one part of a poor-law union, for example, and its entire absence in the other part,—a fact which reminds us of the vagaries of the cholera on the opposite banks of a river.

In the days of Huxham and of Fothergill, as in our own, scarlet fever appears to have run hand-in-hand with diphtheria. We must not, however, as some have done, therefrom conclude that there is any actual identity between the two affections, notwithstanding that scar-