inches long, situate over the left eye, partly healed; the pupils were contracted. On opening the head, the appearance of the parts was natural. The pia mater was slightly congested; the vessels were somewhat prominent; the substance of the brain was healthy; but the vascular points were more prominent and numerous than usual. There was a small quantity of clear watery fluid in the left lateral ventricle; there was no clot, nor injury to the skull. The base of the brain was healthy. *Chest.* The heart was healthy, and of usual size; the lungs were pale anteriorly, but seriously congested at the base and posteriorly, with a good deal of mucus lining the bronchial tubes. There were no pleural adhesions. *Abdomen.* The liver was healthy; the gall bladder half full of dark thick bile. The spleen was small and firm; the stomach was distended. I removed it by ligatures, together with the intestines, for analysis. The *right kidney* was externally natural in size and appearance; it was slightly diseased internally. The *left kidney* was externally healthy; internally it was diseased, with some fat in the pelvis and surrounding parts. There was no fluid in the peritoneum; and the other organs were healthy.

In giving evidence before the coroner, on February 11th, I could not swear whether this man died of uræmia, or of poison by opium; I was not prepared to say for certain, that the amount of kidney disease found after death was sufficient to cause the former; and, as he had lived on very bad terms with his wife, and the neighbours openly said she had poisoned him, I felt, in common fairness to the woman, that an analysis was necessary. The inquest was consequently adjourned to February 25th; and in the meantime a gentleman made an analysis of the contents of stomach and bowels. His evidence proved the non-existence of opium, and a verdict was returned accordingly, but against the wishes of some of the jury, who wanted one nothing short of manslaughter.

REMARKS. This case shews the great necessity of coroners courts of inquiry; for had not a *post mortem* examination and analysis taken place, the man's wife must to the end of her days have been content to bear the stigma of having poisoned her husband. The symptoms equally answered to those of opium-poisoning or uræmic disease.

THE NEW TREATMENT OF WATERY EYE (EPIPHORA): WITH ILLUSTRATIVE CASES.

By JAMES VOSE SOLOMON, Esq., F.R.C.S., Surgeon to the
Birmingham Eye Infirmary.

WHEN the efferent lacrymal canals become either narrowed, strictured, or otherwise obstructed in any part of their course, tears collect at the inner corner of the eye, and the condition technically termed epiphora, stillicidium lacrymarum, or, in simple language, watery eye, exists.

If the lining membrane of the lacrymal sac becomes irritated, either from distension of the tears or some constitutional derangement, mucus or pus, one or both, is secreted, and, unless well diluted by the tears, its escape by the natural passages is retarded; consequently the sac is prone to become dilated, and generally remains so until relieved by the formation of an abscess, which, if followed by a permanent fistulous aperture, produces a natural cure, though at the expense of much annoyance to the patient.

Denudation of the periosteum of the bony canal I have discovered in a few instances where the secretions have been pent up in the sac, or have obtained only a tardy and imperfect vent.

A curious state of the canal is, according to my experience, a disease of rare occurrence.

The *Seat of Stricture* in the lid-canal has been found, in a few instances, to be near their middle; in by far the greater number, close to the tear-sac. Lower down, a frequent site is at about the point where the latter merges into the nasal duct, also at the terminal extremity of the duct.

The cases that demand much patience on the part of the surgeon, and faith in the new method, are those of adults affected with old standing epiphora, and in whom the lid-canal is strictured close to the sac; the remainder of the excretory apparatus being so much contracted, probably from functional inactivity, that a No. 4 probe, when inserted into the duct, gives the impression of being firmly wedged.

During the eleven years I have been officially connected with

the Birmingham Eye Infirmary, two cases only of epiphora, which were referrible to the presence of a nasal polypus, have come under my care. The symptoms in one of them simulated those of an incipient tear-abscess.

In some of the instances where the sac has suppurated before coming under surgical observation, considerable mischief has been done to the membranous walls of the nasal duct. This condition is discoverable by the freedom with which the probe may be moved backwards and forwards on the floor of the nose. The instrument is not tightly pressed against the brow, as in the healthy subject, but has a tendency to fall forwards. The abscess appears in some cases to soften down and destroy the stricture.

The mere fact, however, of the patient having been able, prior to the occurrence of suppuration, to press the contents of the distended sac into the nostril, is not decisive proof of the absence of stricture.

The treatment by probes passed through a slit punctum and canaliculus affords the means of ascertaining the gradual restoration of the duct to its natural dimensions. (Case VIII.)

No age is exempted from epiphora. In a young gentleman of nine years, who was recently under my care, it had existed since his birth. I found the left lower canaliculus closely strictured at its sac extremity, which required division with the cannula-lancet before a probe could be made to enter the sac.

Dr. Mackenzie considers the congenital affection to be referrible to an imperfect development of the excreting canals—an opinion which derives support from the subsidence of the epiphora, in certain cases, about the age of puberty. The *hereditary* nature of watery eye has not been, I believe, noticed by authors, and is therefore probably of rare occurrence. I am acquainted with a family in which three of five brothers were affected in childhood, and who are still annoyed by it when exposed to the wind, though now past the meridian of life. One of them has seven sons, five of whom have manifested a similar disorder of the excreting tear-functions.

Treatment. The surgical expedients that have been devised for the relief of epiphora are numerous, and evince much ingenuity. Those that have proved the most beneficial are based upon the principle of mechanical dilatation; some likewise affording relief, as Mackenzie and Vidal suggest, by exciting capillary attraction. In certain methods, the instruments employed have been introduced by the natural, in others by artificial openings.

J. L. Petit was, I believe, the surgeon who first devised the plan of opening the sac through the integument which covers it, and then inserting a wax bougie into the duct.

Beer gradually dilated the duct with catgut bougies, of various sizes, which he introduced after the manner of J. L. Petit; but, when a tear-fistula existed, he availed himself of it, enlarging the aperture when it was necessary, as a means of ingress. As soon as the passages were believed to be free, the bougie was withdrawn, and measures taken to heal the wound. The chief objections to this plan are, that it treats a part only of the excreting apparatus; in the event of failure, it obliges the infliction of a fresh wound (*i. e.*, supposing the surgeon has succeeded in closing the first one, which was prone to become fistulous), with a repetition of the whole process *ab initio*: moreover, it is by no means easy, as I know from experience, to hit upon the direction of a much contorted canal, when the probe is introduced from the outside of the lid. It embodies, however, a very important principle—gradual dilatation of the stricture, when such existed in the path along which the bougie travelled.

The methods of Petit and Beer, there can be no doubt, suggested the employment of the silver nail-headed style. The inconveniences attendant upon it have been represented by Mr. Bowman and others; and, as he graphically describes some of the ill consequences which had led me, previously to an acquaintance with his method of treating lacrymal obstructions, to almost entirely abandon the use of the style among the labouring poor, I quote his words.

"The insertion of a style or tube through an opening made in front of the sac, below the tendo oculi, has been the last and common resource in obstinate cases, where the disease has worn out the patience of the sufferer and the surgeon. It is an expedient so objectionable in itself, as never to be resorted to till the last moment. It is unsightly, especially in females; it is painful, and the patient has constantly to wipe away the discharge escaping by the orifice. The puncture made to admit the style is also frequently followed by the formation of an abscess outside the sac, spreading under the orbicularis muscle, and apt to grow into that serious complication, a sinuous ulcer,

for the cure of which, free division, and sometimes excision of the overlying skin, is necessary."

Ponteau (*Mélanges de Chirurgie*, p. 100 : Lyons, 1760), about a century since, had a young lady under his care to whom, he says, he did not dare to propose an incision in the skin of the lid. In this dilemma, the idea struck him, and he carried it into practice, that the sac might be opened from the inner side of the lower lid, near to the caruncle.

To this ingenious suggestion Lecat supplemented the introduction of a tent or mesh of charpie into the duct, which he conveyed there by means of a small, flexible, and eyed probe.

Laforest and Gensoul avoided altogether the use of the knife, and the disfigurement of an external wound, by employing curved sounds, which they introduced at the nasal orifice of the duct.

Gensoul gave particular attention to the form of his instruments, the curves of which he had worked from castings of the passages they were designed to dilate. Were it not that stricture has its seat in parts to which these sounds cannot gain access, their employment would be followed by very good results. The late Mr. Morgan bears favourable testimony to this method in his *Lectures on Diseases of the Eye*.

Anel first probed the puncta and the tear-canals in their entire length; but his instruments, being only of the diameter of a bristle, are almost ineffective as dilating agents, while their pliability and tendency to get caught in the mucous folds render them very insufficient exponents of the pathological condition of the canals.

A moment's consideration of the preceding methods will lead to the conclusion that each possesses some one or more points of advantage; namely, gradual dilatation of the strictured nasal duct; the entrance of the duct by an invisible aperture; the employment of instruments curved to the normal direction of the duct, and of sufficient strength to force an obstruction.

It was not, however, until near the close of 1857 (November), that a mode of treatment was made known to the profession which combines all the desiderated points above enumerated, and affords some others which they do not possess. The plan to which I allude was originated by my distinguished friend Mr. Bowman: it consists in the slitting up of the punctum and its canaliculus as far as the caruncle, thus allowing of a probe one-twentieth of an inch in diameter to be passed along the remaining part of the lid-canal into the sac, and down the duct to its extremity. In this way, the whole of the excretory apparatus is commanded. The larger probes are bent near their extremities in such a manner as to allow the surgeon to adapt them to the tortuous passages they have to traverse, and to make search, by the rotation of them on their long axes, for the orifice of the nasal duct. All the defects that belonged to Anel's small probes are overcome. Mr. Bowman's instruments are of sufficient size for the efficient dilatation of a stricture, wherever situated; and of sufficient strength to overcome an obstruction when it is dense, and does not yield to a slight force. Their points, being obtuse, are little liable to be caught in the mucous folds. The drawing in the margin represents Mr. Bowman's probes in four of the sizes actually used.

In addition to the mechanical treatment, which is repeated according to circumstances, Mr. Bowman employs such constitutional and local remedies as the peculiarities of each case may seem to require. He has given a full, and, as I have learned by an experience of some fifty cases, a most careful and accurate account of his mode of treatment and its results, in the first number of the *Ophthalmic Hospital Reports* (London, 1857), to which the reader is referred.

The only departure I have made from the valuable rules laid down by the author of this method is in the mode of dividing the tear-punctum and its canal. For this purpose, I use a pair of narrow-bladed scissors, instead of a grooved director and Beer's knife: the former instrument more certainly effects a perpendicular incision; it also gives less pain and alarm to the patient. The punctum should be expanded by the introduction of a probe or pin before the scissors are used. (*Medical Times and Gazette*, February 20th, 1858.) I may also here mention that, where the brow of the patient is very prominent, the passage of the probe into the sac and nasal

duct will be facilitated by proportionately increasing the curve of the instrument. If this be omitted, there is a liability, in some subjects, of the posterior wall of the nasal duct being injured, which retards the progress of the case.

In some few patients, where the passages have become free by the treatment, and yet the eye has been more moist than natural, I have slit the upper lid canal; I confess, not very often with decided benefit.

It is advisable in all cases to carefully examine, both before and subsequently to the division of the lower canal, whether the punctum or the channel we have made is adapted with sufficient closeness to the globe to draw off the tears into the sac. If such be not the case, and there is thickening of the inner wall of the divided canaliculus—a result of inflammation, which commonly causes a slight eversion—I am in the habit of removing, as suggested by Critchett, a bit of the inner lip of the channel near to the caruncle.

CASE I. *Epiphora of five years Duration cured in a Day.* Mrs. C. W., aged 45, a remarkably healthy person, had suffered from a watery eye (left) for five years. The tears ran over on to the cheek, and the conjunctiva of the lid was inflamed. Small print was read with difficulty. On passing a fine probe, of the diameter of a bristle, a stricture was detected in the canaliculus, near to the sac.

On March 31st, 1858, I divided the tear-punctum and canaliculus as far as the caruncle with a pair of sharp pointed Maunoir's scissors, and probed the canals (left) with No. 6. Since this, the tears have ceased to come upon the cheek, and she now reads small print and threads her needle with ease.

CASE II. *Nine years Epiphora cured in a Month.* Miss C. D., 50 years of age, had suffered from a collection of tears at the inner corner of the eyes, and on the lower lids, for nine years. During the last two, the discharge from the tear-sac had been, when pressed out, of a gummy consistence. When she came under my care, there was a lake of tears in each eye. For six months, local astringents, and tonics internally, were employed.

March 30th, 1858. The largest sized probe (No. 6) was passed through a stricture in the neck of the sac on the right side, and pressed down to the floor of the nose. The instrument was tightly embraced by the walls of the canal. The left canal was also probed (No. 6): the seat of stricture in it was close to the nasal cavity.

In two days the epiphora was much relieved, and in less than a month a cure was effected. I saw this lady in November 1858, and she had not suffered a relapse.

CASE III. *Epiphora of twenty years standing: Cure.* Mr. B., aged 36, a solicitor, in good health, consulted me on August 22nd, 1858, respecting a tear-abscess on the right side, which was at the time in the stage of delitescence. The eye, he said, had watered for twenty years, but had been specially troublesome during the last five.

August 27th. I divided the right lower punctum and its canal as far as the caruncle, and passed a probe (No. 6). The duct, which contained a quantity of inflammatory effects, tightly embraced the probe: it was most narrowed at its lower fourth.

The patient's profession frequently took him from town; hence his attendance was not very regular. Nevertheless, on November 26th, the coldest wind failed to excite epiphora. At this date, the canals had been probed twenty times. The secretion from the sac consisted for some time of a transparent gummy mucus. In addition to the surgical treatment, tonics and a regulated diet were prescribed.

CASE IV. *Epiphora may continue for a time, notwithstanding the Excretory Apparatus is to a full sized probe normally patent.* Mrs. M., a pale healthy woman, of lax fibre, aged 29, suffered, when nine years old, an attack of small-pox, since which her left eye had been affected with an accumulation of tears, which collected at its inner angle, and streamed down the cheek.

A probe was passed through the slit canaliculus, for the first time, on August 31st, 1858; and, on its being carried into the nose, the nasal duct was found to be narrower than normal, and much constricted at its lower orifice. By September 21st, a No. 6 probe traversed the whole length of the canals with freedom. No improvement, however, took place in the epiphora till October 15th, when, for the first time, there was a diminution; and, on the 22nd, the eye was normally irrigated by the lacrymal secretion. The patient continued under observation for several weeks. No relapse occurred.

CASE V. *Epiphora since Birth: Cure: Relapse from continued Crying.* Master C., a delicate fair complexioned boy, 9 years of age, diathetically strumous, had had a collection of

tears on the lower and inner corner of the left eye ever since his birth. Pressure upon the sac caused tears and mucus, mingled with a little pus, to escape by the upper punctum.

April 1st. I slit the lower canaliculus with a knife and grooved director; but, in consequence of a dense stricture close to the tear-sac, a probe could not be passed until it was divided by the cannula-lancet. This proceeding was obliged to be delayed some little time; hence the upper punctum and canaliculus were divided, and a No. 4 probe passed down to the floor of the nose.

At the end of six weeks treatment with the probes, aided by constitutional remedies, the tears were properly excreted; and, on May 29th, the patient returned to the country cured.

It is worthy of remark, that it was not until both canaliculi were free from stricture, that the slightest apparent progress was made toward recovery.

After the Midsummer holidays, the little patient was sent to a boarding school, and, being unhappy, gave way every day to floods of tears, which, by exciting irritation in the excreting passages, reproduced the epiphora. A case has recently come under my care, in whom weeping proved to be a primary cause of an epiphora followed by tear-abscess.

CASE VI. *Epiphora five years: Tear-Abscesses: An occasional and slight Epiphora continues.* H. L., a widow, 35 years of age, has been subject to a watery eye (right) and flowing of the tears on to the cheek for the last five years. In February 1858, an abscess formed in the tear-sac, which discharged itself through an opening in the skin of the lid, near to the inner canthus. She says "it gathered up and broke every four or five days."

April 13th. I slit the lid-canal with scissors; at the time there was a copious muco-purulent secretion discharged through a fistula in the integuments covering the sac, which were inflamed and tumid. After a good deal of trouble, a probe was passed into the nasal duct, which was found to be contracted and blocked up with lymph, etc. The probing was repeated twice a week, and the fistula occasionally cauterised. At the expiration of a month, my notes state that the fistula is healed; the cutaneous inflammation has subsided; epiphora much diminished.

May 25th. The epiphora was slight, and only of occasional occurrence.

The patient was kept under observation for four or five months, the excreting canals doing their duty all but perfectly. A tear every now and then appeared at the corner. The duct was quite free, except at its nasal extremity, where it continued more contracted than natural.

For the relief of a chronic inflammation of the Schneiderian membrane, iodide of potassium and Plummer's pills were given with good effect. It did not, however, entirely subside, being associated, as I thought, with a specific taint.

CASE VII. *Epiphora: Distension of Tear-Sac: Cure.* Mrs. B., aged 50, constitutionally healthy, had had a watery eye (the right) for four years. The discharge ceased spontaneously, and did not return for twelve months. In February 1858, it was reproduced by an attack of erysipelas (tear-abscess), which commenced at the inner corner of the weak eye.

November 12th. She came under my care at the Eye Infirmary. At this time, the sac was prominent on pressure, and a muco-purulent secretion regurgitated through the lower punctum. I performed the usual operation, and passed the largest sized probe. The examination revealed a slight stricture of the lid-canal near to the sac, and a general narrowing of the nasal duct.

The probe was passed two or three times a week; and, on December 31st, the disease was perfectly cured, the eye being dry, and the excreting canals of their normal diameters.

February 8th, 1859. There was no relapse.

CASE VIII. *A Case in which the New Treatment arrested the Formation of a Tear-Abscess.* E. S., aged 21, of scrofulous habit, a resident of Tanworth, came to the Eye Infirmary on November 16th of last year, with an acute abscess of the right lacrymal sac, which was pointing; and with a tumid and highly painful condition of the left, the integuments of which presented a red blush. For two years he had suffered from epiphora.

The right abscess I opened with a bistoury, in the usual manner. On the left side, I slit the punctum and its canal as far as the caruncle, and then passed a No. 6 probe through the whole length of the ducts. Pus oozed out from the side of the instrument. The patient was ordered to take quinine, to have a good diet, to poultice the abscess, and use a saturnine wash to the left side.

November 20th. The probe was again introduced, with the effect of rendering the passages free, and of curing the epiphora that had existed for two years.

November 30th. The lower punctum and canal were divided in the usual manner. At the expiration of three days, the parts were more healthy, and the epiphora diminished. A No. 6 probe was passed to the floor of the nose. The parietes of the duct were found much damaged. They were broken down, so that the instrument lay loosely in it, and fell away from the forehead.

December 14th. The eye (right) watered only when exposed to cold and wind; yet puro-mucus was regurgitated when the sac was pressed.

December 28th. The left eye continued well and dry. The discharge in the right sometimes finds its way into the nose.

January 4th, 1859. By the probe, I ascertained that the nasal duct was undergoing repair.

January 11th. To-day, for the first time, the probe was pretty firmly fixed against the brow, indicating that the sac and duct were rapidly recovering their normal dimensions. The discharge was now thin glairy mucus. The eye watered only when exposed to out-door cold.

Since December 22nd, the greater part of the sac-secretions, etc., have passed into the nose. The left eye remains quite well.

January 18th. The right duct has recovered its calibre. For the last fortnight, the epiphora has been cured.

February 8th. There is no relapse.

CASE IX. *Occlusion of the Right Lower Punctum: Chronic Tinea Tarsi: Epiphora on both sides: Cure.* W. B., aged 18, of scrofulous habit, was admitted under me at the Eye Infirmary on November 5th. He had suffered from chronic inflammation of the lids (tinea tarsi) for the last nine years, which had much thinned the eye-lashes; and from epiphora on both sides for the last five or six, the disorder being most troublesome on the right side. The sight was complained of as being dim. The right lower punctum was covered over by thin integument, and the upper appeared to have closed. The course of the canaliculus of the former was indicated by a pale streak in the conjunctiva, contrasting with the vascular condition of the rest of that membrane. I divided with a scalpel the inferior lid-canal, in a transverse direction, at about two or three lines from the occluded punctum; but was unable to discover either of the cut orifices till four days afterward, when I slit the canal as far as the caruncle, and in about a week acted in the same way on the punctal end. The left canal was also slit. On each side, the excretory apparatus was throughout much narrowed, especially on the right side, which had been the more inactive. With difficulty a No. 4 probe was passed. The left nasal duct was much constricted at its nasal meatus.

This youth submitted twice a week to the process of dilatation, and in nine days the eyes watered only when exposed to cold wind; and, on December 31st, he was cured. At this date, the right canaliculus gave no evidence of the transverse incision, and the superior punctum was for the first time observed to be patent: it is exceedingly small. The "tinea" is nearly well. In addition to the means above related, cod-liver oil was given, and the usual treatment for tinea put in force.

The patient was directed to attend occasionally at the institution, that the canals might be kept free by the passage of an instrument.

February 8th. No relapse had occurred.

CASE X. *Dilated Sac: Epiphora: Tear-Abscesses: Speedy Relief by the New Method.* The following case I recently attended, in consultation with my friend Mr. Yarwood, of Aston Manor.

Mrs. P., aged 61, for many years a valetudinarian, and of feeble constitutional power, suffered since six years ago from an accumulation of tears and mucus in the right lacrymal sac, which she, at my suggestion, emptied two or three times a day by pressing its contents into the nostril. For the last two or three years, tears had passed over the lid on to the cheek.

On September 30th, 1858, after walking in her garden, she felt chilly and aching pain in the sac. On the following day, the eye felt as if it would burst. On the third day, a tear-abscess discharged itself through the skin of the face. The suppuration recurred twice in December: on the last time, the abscess broke before I saw the case, which was on the first day of the present year, 1859. At this time, the lid presented three fistulous openings. The skin over the sac was elevated, pinkish and puffy. It was agreed, in consultation, that I should slit

the lower punctum and its lid-canal; and that some local application, of an astringent and alterative kind, should be used to the eyelids. A stimulating ferruginous mixture was also prescribed.

January 5th. The fistulæ were healed. A No. 4 probe was passed to the floor of the nose through a stricture near to the middle of the nasal canal. We determined to apply a small blister behind the ear, and to commence on the following morning the daily application of a weak solution of nitrate of silver.

January 8th. We were told that, since the use of the probe on the 5th, the eye had not watered. A No. 6 probe was passed, without encountering a stricture; and the same operation was repeated on the 15th, although no epiphora had occurred. On this day, the passage was free.

February 24th. No relapse.

CASE XI. *Chronic Inflammation of the Tear-Sac of four months duration, in a child two years of age: Operation under Chloroform: Rapid relief.* A healthy looking fat child, aged 2 years, was brought to me at the Eye Infirmary, from Barford, near Warwick, on January 28th last. The right tear-sac discharged a purulent matter; and on the lower lid was observed a horizontal and linear cicatrix—the result of an abscess that had formed four months ago; since which, the eye had watered and moistened the cheek. Local astringents were prescribed.

February 4th. While the child was drowsy from the inhalation of chloroform, I slit the punctum and canaliculus of the affected eye, and directed the mother to press out the sac contents several times in a day. Half a drachm of cod-liver oil was ordered to be given twice a day.

February 18th. Tears alone were discharged, and those only occasionally. A No. 4 probe passed with ease through the canals, which were quite free.

The case is still under treatment, and is here related as evidence, that patients of tender years may be advantageously treated by the plan it is the object of the present paper to illustrate.

CASE XII. *Right Tear-Sac distended by inspissated Mucus to the Size and Shape of a small Almond: no Regurgitation through the Lid and Nasal Canals: immediate Relief to all the Symptoms.* A young woman, whose tear-sac, from being in the state noted above, seriously marred a pretty face, was placed under my care on the 24th of February, by my friend Professor Berry. No amount of pressure sufficed to evacuate any of the contents of the tumour. In early childhood, the measles left the right eye watery, and it had so continued. Two years ago, the eye inflamed, and, at the end of a year, the deformity at the inner corner of the eye first appeared; it had gradually grown to its present dimensions. An exploration of the passages through a slit canaliculus discovered an impervious stricture of the inferior lid-canal, close to the sac; and, after this had been penetrated by a sharp pointed steel probe, the silver sound, No. 4, passed with a snap through two strictures in the nasal duct. The contents of the *mucocele* (the name given to this class of lacrymal tumours by ophthalmic writers) were readily pressed down into the nose; a small quantity regurgitated through the inferior punctal canal.

On the following day, a No. 6 probe passed easily through the excretory apparatus; it was not removed for half an hour.

On the morning of February 27th, no mucus was found to have collected in the sac during the night. The patient had carefully carried out the directions to press the sac from time to time during the day. There has not been any return of the deformity since the operation was performed.

CASE XIII. *Supernumerary Punctum on the Lower Lid: Epiphora.* Mrs. R., aged 46, applied to me at the Eye Infirmary on January 25th, 1859, on account of an epiphora of the right side, of two or three years duration. While examining the inferior punctum and canaliculus with a fine probe, previous to dividing them with scissors, I discovered an orifice on the margin of the lid directly opposite the centre of the caruncle, which would just admit a probe of the diameter of a bristle, and that communicated with the canaliculus and tear-sac. The patient declared that neither inflammation nor abscess had attacked the part: of the watery state of the eye, she could afford no explanation. I conclude the supplementary punctum to have existed at birth. In dividing the punctum and canaliculus, I took care not to disturb the interesting point in the case.

February 4th. The epiphora had ceased.

February 26th. There was no epiphora.

Reviews and Notices.

THE ENLARGED PROSTATE, ITS PATHOLOGY AND TREATMENT; with Observations on the Relation of this Complaint to Stone in the Bladder. By HENRY THOMPSON, F.R.C.S., M.B.Lond. Pp. 320. London: Churchill. 1858.

THE industry with which Mr. THOMPSON pursues his investigations, and the intelligence with which he works, fully entitle his writings to more than a cursory review.

In dealing with Enlarged Prostate, Mr. Thompson has gone far to exhaust the subject. He has been able to explode much of the traditional pathology of the organ, as well as the reputation of some of the standard *materia medica* long held in esteem in the treatment of bladder-affections. Mr. Thompson takes nothing on hearsay, and asserts nothing without giving his reader full means of judging of the reasonableness or the truth of his statement. He treats the dogmas of the fathers of the just past school of surgery, with exactly the amount of respect they are entitled to, when erroneous. Sir Everard Home's views come in for a considerable share of criticism. For example:—the English student has long been taught to believe in a third or a middle lobe to the prostate, chiefly on the authority of Sir Everard Home, who, after the dissection of five prostates, announced its discovery. Mr. Thompson dissects fifty, and disproves Sir E. Home's statements. With the five prostates, and middle lobe, borne trophy-fashion on the shaft of his pen, like the turban of an overthrown Saracen entangled in the lance of the victorious knight, Mr. Thompson proceeds to deliver another thrust through the shield of poor Sir Everard; who, in error in respect of his views of median development, is shewn to be equally infelicitous as regards lateral enlargement. Thus:—

“Sir E. Home, up to the date of publication of his first volume on the prostate gland, had never seen predominating enlargement of the right lateral lobe, and he inferred, as a rule of some importance in relation to the introduction of catheters in enlarged prostate, that such enlargement, and by consequence, that a deviation of the canal to the left either did not occur, or was extremely rare. He met with an enlarged right lobe, however, before the publication of a second volume on the same subject, but still regarded it as uncommon, and in this light it has been viewed, I observe, in the latest works on this subject. There is, however, no ground for supposing that there is any difference in the liability of either lobe to the affection, since among existing specimens the predominating lobe is to be found in nearly equal numbers to the right and left respectively.” (P. 25.)

As another instance of exposure of fallacy, we quote as follows:—

“It occasionally happens, but very rarely, more so than has been supposed by some continental authors of note, that one result of prostatic enlargement is undue patency, and not obstruction of the urethro-vesical orifice; and this circumstance, regarded as it has been as not infrequent, is supposed to explain the occasional occurrence of genuine incontinence, the bladder being empty in the place of retention of the urine. Submitted to the test of extended anatomical research, the supposed fact disappears, and consequently the theory based upon it. First, it is rare to find expansion of the internal meatus; secondly, when it does occur, it is almost invariably associated with distended and hypertrophied bladder, proving incontestably that obstruction was present during life, and that retention, not incontinence, was the result.” (P. 27.)

Of remedies, especially those lauded for their virtues against chronic cystitis, Mr. Thompson says, (p. 123):—

“In regard to the efficiency of each one of the principal medicinal agents which have been enumerated, it is impossible to overlook the fact that the most opposite opinions are held by experienced practical surgeons. Nor is it possible to resist the conclusion that either the virtues of these agents have been overrated, on the ground of estimates formed from the observation of some successful but exceptional cases; that is, of