depression or shortening of the part, by which the eyeball was unnaturally exposed. Mr. Walton pointed out the remarkable contrast between this and the affection of the upper eyelid; it was clear that the difference was due only to the dissimilar physical conditions of the lids themselves, and not to different primary causes, as the essential character in each was one and the same. He recommended the studying of the inverted lower lid especially to the student, because that lid offers a greater facility for observation, as the border is outwards and away from the eyeball, and any change in its direction can be better appreciated than in the upper, where the margin inclines somewhat inwards. Besides, there is a very marked difference in the size of the two cartilages, which throws additional light on the inquiry, the upper being broader than the under. In the most marked or aggravated stage of inferior entropion, the tarsus does not rest against the globe as though it bound it, but the lid is so completely turned on itself that the cilia are hidden, and the narrow cartilage rolled up, and its position completely reversed.

The method of operating adopted by Mr. Walton was in all respects like that described for inversion of the upper eyelid. Two incisions were made, one along the margin of the tarsus, the other above it, forming an ellipse, and the skin and the corresponding portion of the orbicularis were removed.

An attempt had been made to remedy the defect by the removal of skin, but fruitlessly. It has been said that the loss of integument alone from the lower lid will suffice. It is quite possible to restore the eyelid to its natural position, by removing skin enough to produce such tension on the remaining integument as shall overcome the preternatural action of the orbicularis palpebrarum, but it will be at the expense of depressing the part, and thus, by displacing the punctum lacrymale, causing the tears to fall over the cheek, as well as exposing the eyeball. When the operation is performed on a lid that has not been previously interfered with, there is generally no trace of what has been done.

Cases of entropion in general are aggravated, through the mistaken idea of mitigating the suffering, by pulling out the eyelashes. Many of these are not in reality pulled out, but are broken off, and the stumps so left are peculiarly fitted, especially in the upper eyelid, to irritate the eyeball. Moreover, when they are pulled out, after the frequent application of the forceps, abortive hairs are produced, and these for the most part grow irregularly, and direct their points inward, and become very injurious. Therefore, directly that entropion is detected, the proper operation should be done; it is useless to delay it, and waste time, by the application of plaster, collodion, and such like.

As a rule, when patients will not submit to this, Mr. Walton does not touch the lashes, more particularly in the severe cases of the upper eyelid, because from the habit the person gets of frequently wiping the eye, the points of them are turned out and away, while the less injurious parts, their convexities, are in contact with the eyeball.

HULL GENERAL INFIRMARY.

ON THE VIRTUES OF ACETATE OF POTASH AS A REMEDY FOR RHEUMATIC FEVER.

By HUMPHRY SANDWICH, M.D., one of the Physicians to the Infirmary.

HAVING recently treated ten cases of rheumatic fever by acetate of potash with unusual success, at this institution, I feel warranted in calling the attention of the profession to it, as a remedy, which I have found to be superior to any other. This superiority consists in the rapidity of its action as a febrifuge, which is probably owing to its power in carrying off from the blood the specific poison, which has excited the febrile commotion. I have premised a suitable cholagogue of calomel, followed by a rhubarb or senna draught, in those cases in which there was reason to suspect congestion of the portal system, as shewn by an arrest both of the biliary and urinary secretions. After this, in the majority of cases, I employed no other internal remedy than one drachm or a drachm and a half of the acetate of potash, to be dissolved in half a pint of water, and drunk during the day. The addition of a little lemon-juice and sugar is much relished by the patients. The remedy has acted freely on the kidneys, abated the fever, and moderated the anguish of this very painful disorder. It has not been necessary, except in one or two cases, to leech the inflamed joints.

The following tabular view shows the duration of the disease under this plan of treatment:—

Three cases cured in	7 days.
One " "	10 "
One " "	13 "
One " "	14 "
One " "	15 "
Two " "	17 "
One " "	20 "

In the above cases there was no endocarditis, so that we may hope that a further trial of the remedy will shew its powers in resisting this fearful complication.

In another case, that of a young woman, aged 18, who came into the hospital with an endocardial murmur accompanying rheumatic fever, acetate of potash was given, six leeches were applied over the heart, and calomel was administered, so as gently to affect the mouth. All the symptoms yielded in about a fortnight.

In another case, the patient had a quick recovery from rheumatic fever under the use of the acetate, and then resumed work too soon, and in bad weather. He returned to the hospital with a severe relapse, accompanied by a slight endocardial murmur. The rheumatic fever was again quickly relieved by the acetate; but a mercurial course, with twice leeching and blistering, was necessary to complete the cure of the heart affection.

In two other cases, after the prompt removal of the acute symptoms, we had to combat a chronic affection of one knee-joint, resembling synovial rheumatism. This, of course, protracted the cure.

I have employed the acetate of potash, in the same doses and manner, in a still greater number of cases of chronic rheumatism, and in many of them with marked advantage.

Original Communications.

DISLOCATION OF THE THIGH BONE INTO THE FORAMEN OVALE, REDUCED WITHOUT THE AID OF MECHANICAL APPLIANCES.

By RICHARD STEEL, Esq., M.R.C.S., Surgeon to the Blaenavon Iron Works.

On April 19th, 1856, John Corfield, a hale, muscular man, aged sixty-eight, was crushed by the fall of a bank of earth which he was excavating. He received the following injuries: fracture of the neck of the right femur, fracture of the right tibia and fibula, and dislocation of the head of the left femur into the foramen ovale.

I reduced the dislocation in the following way. Standing on the same side as the dislocated limb, and grasping the knee with my left hand, I used the thigh as a lever, the fulcrum being my right hand placed close up to the fork, so as to make a powerful outward traction of the upper part of the limb; the knee was pressed forcibly inwards towards the middle line, and at the same time backwards, *i. e.*, towards the bed on which the patient was lying on his back. Reduction took place on the first attempt and at once; as soon as the previously immovable limb yielded to the pressure a loud snap was heard, the knee became straight, the form of the hip was restored, and the man at once began to move the joint freely in his delight at being relieved from the previous pain. No traction was made, nor any force whatever used except as above described as applied by my own two hands. The dislocated hip gave no farther trouble.

For the fracture of the neck of the femur and of the leg on the opposite side, I employed Liston's double-inclined plane. The man's recovery was complete; he walks with a moderate amount of limp, with the assistance of a stick only. I diagnosed the fracture of the neck of the femur to be partly within and partly without the capsular ligament.

REMARKS. I have been induced to send this case, by reading Dr. T. Walker's communication in the JOURNAL of January 24th. He therein alludes to a previous case of dislocation into the foramen ovale converted into one into the sciatic notch by manipulation. In the year 1847, I saw in consultation a case of dislocation into the foramen ovale, which had resisted the efforts of two surgeons to whose skill I can bear the fullest testimony. The usual method, most carefully carried out, had failed. Under the idea that the head of the

bone might be hitched against a muscle from which change of position might liberate it, I flexed the thigh on the pelvis and adducted the limb gently; total change of position suddenly took place, so much as to make me hope that reduction had taken place. One of the gentlemen to whom I have alluded, in examining the limb in its new position, repeated the manipulation, when luxation into the sciatic notch followed, from whence it was reduced with comparative facility with the assistance of pulleys.

The accident would occur if the thigh were too much flexed on the pelvis, and at the same time brought too much across the opposite limb. I believe the proper way to avoid it is to follow the course employed in the reduction of the case detailed above, viz., to keep the thigh well backwards, and to avoid bringing it across the middle line. Repeating both forms of manipulation by means of a pelvis and femur, will, explain the reason better than a written description.

I am happy to be able to confirm Dr. Walker's views by these cases, which I hope may contain some practical points, while they will at all events illustrate the kind of cases which occur not unfrequently in the practice of iron-works surgeons.

ON CHOLERA: ITS DIAGNOSIS AND TREATMENT.

By C. W. BELL, M.D., K.L.S., late Physician to H.M. Embassy in Persia, etc., Buxton, Derbyshire.

[Concluded from page 87.]

HAVING now sufficiently considered the nature and symptoms of those complaints which most predispose the system to an attack of cholera, and which have most frequently been mistaken for that disease, we may proceed to examine more minutely what symptoms, etc., specially belong to it, in its true congestive form. These are, first, blueness of the nails and contracted veins of the extremities, which appear like dark narrow lines, in consequence of their retaining in them a small quantity of blood adhering to their interior by capillary attraction; for though this force is not exercised between the coats of the vessel and its contained blood during health (but appears, on the contrary, to be exchanged for electrical repulsion), it certainly is operative during the blue stage of cholera; the features are sunk, the eyes look hollow, the lips are bloodless, the tongue is as clean and bloodless as if it had been macerated in water for days, and as cold; the breath is cold, the voice is without tone—all these symptoms occur in a more or less marked degree before any rice water stools are voided. In slight cases, a sudden fluid dejection, unexpectedly copious, but without pain, now takes place, and is perhaps followed by cramp in the legs. At this stage a sharp stimulant, such as brandy or sal volatile, will often cure at once; for it is remarkable how completely the tendency of this formidable disease to return seems to be broken, if the incipient congestion be arrested by any means. This is the only stage of true cholera in which stimulants do not do more harm than good. The blood has been forced into the interior veins by the contraction of the capillaries of the extremities; the passage of the blood through the lungs is just beginning to become arrested by the same cause; but the congestion thus produced has been greatly relieved by the rapid fluid exudation into the bowels. A stimulus to the stomach, acting through the sympathetic, gives a flip to the heart's action, the failing vital activity of the capillaries is restored, and all goes on well again; the circle of morbid action thus broken has little tendency to recommence, and the attack is cured. The case is very different, however, if there be no natural relief at this stage of the disease by purging. The most anxious oppression of the heart then comes on, and it may be heard in violent and convulsive action, as if churning the blood within it. There is no want of stimulus to its action here; on the contrary, at each repetition of a stimulant the tumultuous noise increases, and along with it the agony of the patient, who, bathed in ice cold perspiration, is tossing restlessly from side to side, and throwing up his arms. To open a vein now, while yet the congestive stage is on the increase, and succeed in getting the blood to flow until it changes from its first dark tarry condition that requires to be squeezed out, and regains the red fluid state that belongs to health, spouting freely from the orifice, is to achieve a triumph for medicine that has no parallel; for the cure is as perfect as it is immediate.

Supposing, however, that the patient has not been bled and saved at this critical period, the struggle continues, and very

often in the course of eight hours the powers of life fail; the feet, hitherto intensely cold, become warm, and the patient dies. But this is an extreme case; for, in the majority, about the eighth hour after the commencement of the attack, the symptoms begin to become somewhat mitigated, and from the eighteenth to the twenty-fourth hour the patient, though not asleep, lies so tranquil as to appear to slumber. Suddenly, precisely at the expiration of the twenty-fourth hour, he sighs, tosses up his arms again, and in a few minutes is a second time in all the agony of suffocation. Now again an opportunity is offered to save the patient's life with the lancet; but it much more quickly passes away than in the first accession, and then bleeding will only hasten the end.

The great error in practising bleeding for the cure of cholera lies in waiting till the pulse becomes distinct. It has been observed that about eight hours after the commencement of the attack, symptoms begin to become mitigated, the pulse then becomes perceptible, and continues pretty steady. Let us mark the consequences of bleeding after this stage, which is that of attempted reaction, has recommenced. Twining unwittingly gives several examples of this, and also some cases in which he tried arteriotomy. These too well illustrate the effects of acting on a rule in ignorance of those principles of physiology on which the practice of bleeding in cholera and ague is founded. If, instead of bleeding while yet congestion is increasing, we draw blood about the twelfth hour when the pulse is somewhat steady, and the skin comparatively dry and warm, the consequences are most appalling; the blood flows, indeed, without any of the difficulty that would have been experienced in the first stage; but it does not do so long; it suddenly becomes black and tarry and stops, the ice-cold exudations again bathe the extremities and forehead, jactitation recommences, and nothing will then save the patient. In these cases of pure congestive cholera there can be no greater cruelty than to persist in employing stimulants and heat. It is remarkable that the congestive form which we have assumed to be the true type of algide cholera, when uncombined with any other malady, is now much less rarely met with in this country than was the case in 1832 and the four following years. In recapitulating its essential symptoms, it will be no departure from our expressed intention of confining ourselves in this paper to the endeavour to deduce the principles of treatment required in the various diseases classed under the head of cholera, if we venture somewhat dogmatically to lay down rules of practice in this case; for the *modus medendi* will no less illustrate the nature of the constitutional disturbance it is intended to remove or obviate than will the symptoms.

We recognise the case, then, by the peculiar colour and wet coldness of the extremities and brow, the cold breath, and the perfectly clean cold tongue; by the absence of odour in the dejections, if any, but more than all by that unmistakable symptom, the churning sound of the struggling heart, which once heard will never be forgotten. Our first duty in such a case is, with the utmost accuracy, to ascertain if possible the first moment of attack; and if it be clearly ascertained that not more than four hours have elapsed since the commencement, we should bleed at all hazards if the attack be severe; but if it be at all doubtful whether the attack have not lasted longer, we should not run the risk we have described as attendant on mistimed bleeding, but await a second opportunity some hours later, which we must endeavour to secure by the unremitting exhibition of quinine and sulphate of iron; say a grain of each dissolved in an ounce of water by the aid of sulphuric acid every quarter of an hour at first, and afterwards given at longer intervals. In the large majority of cases that set in with little or no purging, this treatment will cure always, provided that the feet have not become warm while the thighs and knees remain cold; for that is the invariable harbinger of death. If, however, a complete cure have not been effected, or at least such improvement as shows the danger to be past before the twentieth hour from the commencement of the attack, life or death will depend on the accuracy with which the hour of its first setting in has been estimated; for between the twentieth and the twenty-fourth hours is the period during which the lancet may be used with the greatest certainty of success. The blood will then flow more freely than it would have done in the first eight hours, or than it will do after the twenty-fourth hour, and there will be no danger of producing the collapse that attends phlebotomy between the eighth and eighteenth hour. It will sometimes bring on a regular shivering fit; but, if so, the patient is safe, for a full rigor is always evidence of commencing reaction. It ought to be a rule of practice to bleed only before the fourth hour or after the eighteenth in