In mild *ectropion of the lower lid* the same technique holds, except that one applies the point inside the lid and directs it below the tarsal plate down into the connective tissue. The lid can easily be maintained with ordinary forceps. If the condition has been present for a long time and is fairly prominent, it is necessary to excise a longitudinal strip of conjunctiva, usually about one-third the width of the exposed membrane, taking the middle third. The amount taken, however, is largely to be determined by the condition present, and it may be necessary to go higher or lower. The red-hot point is then plunged deeply into the exposed tissue, going below and beyond the tarsal plate, in more places than would be used for entropion, and it is necessary to go beyond the limit of the ectropion. One is not likely to cause the contrary condition, and so it is advisable to be thorough. A drop of argyrol 5% and sterile liquid paraffin is then instilled and the eye kept bandaged for 3 days. The drops are repeated each day, of course. The two edges of the conjunctiva rapidly come together, and there is seldom any break in the continuity after 10 days.

Ectropion of the upper lid is usually more severe and requires to be done thoroughly. The middle third of the conjunctiva is resected along the whole length of lid and the red-hot point is plunged deeply into the connective tissue, to and beyond the tarsal plate, at a sufficient number of places. There is usually quite a lot of haemorrhage after the conjunctiva has been resected, but if the lid is controlled with forceps an assistant with swabs can keep the field fairly clear. The application of the cautery soon stops all bleeding. Argyrol 5% and liquid paraffin are then dropped in, and it is advisable to pass a stitch from upper lid to cheek. This stitch may remain for three days. Thereafter argyrol for a few days more will usually suffice.

Symblepharon is a difficult condition to treat by the usual methods and often recurs. I have only attempted to disengage adhesions, not to cure the condition, when the cornea is invaded. In addition to drops, some cocaine is injected subconjunctivally. The cautery is then applied to divide the adhesions at the most suitable spot, the point being carried down to the sclerotic. Each adhesion is thus treated and the usual argyrol and liquid paraffin instilled. It is seldom that the adhesions reunite.

The treatment of *distichiasis* and *trichiasis* by electrolysis is a long, laborious, and not very successful business. I have been able, with the cautery, to do both lids of an eye at one sitting of about 10 minutes, and the result proved satisfactory. The lids are anaesthetized with novutox and a drop of cocaine placed in the eye. Then a point 5 mm. long and as narrow as possible is used. I always employ the loupe to get a good view of where the point is going. This is used red-hot and pushed down each hair follicle in turn. It must be pushed down its full length and retained for two seconds. The lashes do not grow again and no damage is done to the lid margins.

I have treated a few cases of *congenital ptosis* in children, and if the results have not been brilliant they have at least been satisfactory in leaving the pupil exposed. The principle is to cause the levator to form fresh adhesions to the tarsal plate. The child will require a general anaesthetic, as it will not submit otherwise. A row of six punctures is made just above the tarsal plate, then going into each puncture again, passing the point upwards this time, and in the subcutaneous tissues as far as it will go. The point should be 1½ cm. long. No dressing is necessary, and in fact is inadvisable. I have also dealt with a variety of other conditions, of little consequence, such as warts, which are simply and permanently removed with the cautery.

I hope I do not give the impression of brandishing my cautery at every patient I see. I merely describe it as a very useful procedure in many conditions; it is not generally realized how simple and useful it can be. In my own practice the results are in almost every case superior to those of the scalpel and stitch. I have been practising it now for a number of years.

S. Zelman (*Amer. J. med. Sci.*, 1944, 207, 461) determined blood diastase values in a series of 89 cases of mumps, on admission to hospital and on discharge, with the following results: 73% were above normal on admission and 9% on discharge; 3% were sub-normal on admission and 20% on discharge; 15% of this series showed evidence of pancreatitis some time during the course of their illness.

Medical Memoranda

Large Fibroma arising from the Pulmonary Pleura of the Right Lower Lobe

The following case appears to be worthy of publication owing to its rarity and difficulty of diagnosis.

On Aug. 17, 1944, the patient, a man aged 48, consulted his practitioner for pain in the lower part of the right side of his chest on breathing. Examination revealed a dull area at the base of the right lung with weak breath sounds in the area. His temperature was 99.8° F.; he had no cough or sputum. A diagnosis of fluid was made. The basal sedimentation rate was found to be 32 mm. in one hour. His area of dullness increased rapidly, and three days after he was first seen he was screened and a large shadow was observed to move on respiration. It lay in the posterior part of the chest, above the diaphragm. Fluid was also present, and 20 c.cm. was aspirated and sent for pathological examination. It showed

numerous endothelial cells, many of which were undergoing mitosis, and the pathologist suggested that these might be malignant in origin because of this. A tentative diagnosis was made that the tumour might be an endothelioma. Removal of another large collection of fluid caused a great deal of pain, presumably because the tumour was now rubbing against the thoracic wall. It soon ceased as the fluid reaccumulated. This rather tended to support the diagnosis of a malignant tumour.

The man was admitted to the Royal Infirmary, Sheffield, on Sept. 8 and was referred to me for further investigation. A thoracotomy was performed, and on opening the chest a large tumour was found occupying the lower part of the right pleural cavity. It was very nearly spherical, and was lightly attached to the parietal pleura on the one hand by a few adhesions, but arose from the visceral pleura, from which it received its blood supply. Only slight effort served to separate the tumour from the parietal pleura, and it at once fell back into the thoracic cavity. Owing to its size (12 cm. in diameter) it was difficult to manipulate, and it was necessary to resect a portion of a rib in addition to dividing another. On pressing the tumour into the wound from the thorax it shot through the opening in the chest wall and tore itself free from the lung. There was a little bleeding from the area of attachment, which was circular and measured 5 cm. in diameter. The lung was sutured and no further bleeding occurred. The man made an uninterrupted recovery and was able to go home a fortnight later.

The figure is from a photograph of the specimen after removal. The pathological report is that it is a simple fibroma undergoing hyaline degeneration.

I am indebted to Dr. George Herbert of Worksop, who sent the case to me and who also primarily investigated it; and to Dr. L. C. D. Hermitte, of the pathological department, Royal Infirmary, Sheffield, for the pathological notes and photograph.

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An Unusual Case of Ruptured Aortic Aneurysm

Syphilitic aortitis with rupture of a large saccular aneurysm of the abdominal aorta into the stomach is so rarely seen that it was considered justifiable to add the following to the large number of cases of ruptured aortic aneurysm described in the literature.

CLINICAL HISTORY

A civil servant aged 60 was admitted to the Essex County Hospital, Wanstead, on Feb. 16, 1943, complaining of pains in his shoulders, back, and legs; he also had difficulty in swallowing and had lost weight. The pain in his back was of a continuous drawing nature, but he had shooting pains down both legs, accompanied by occasional swelling of his knee- and ankle-joints. He had also noticed some weakness and unsteadiness of his legs. For the past two months he had complained of difficulty in swallowing solids, vomiting almost at once, but he was able to manage fluids and soft foods such as porridge. He lost 2 st. in weight in three months.

On examination he was found to be a very thin, wasted man. His tongue was clean and moist, his throat was normal, and there was no enlargement of his lymphatic glands. No oedema was seen. His pulse was regular, slow, and slightly collapsing. His apex beat was in the midclavicular line and no thrill was palpable in the

mitral or aortic areas. Loud blowing systolic and diastolic murmurs were heard over the praecordium, loudest in the aortic area. Tracheal tugging was absent. His blood pressure was 115/70. Nothing abnormal was found in the lungs and the abdomen. A careful examination of his central nervous system did not give any abnormal physical findings. A skiagram of his chest revealed a large bulge on the right side of the heart shadow which suggested an aneurysm of the aortic arch. Cardioscopy showed a pulsatile aortic aneurysm affecting the aortic arch and thoracic aorta and displacing the oesophagus to the left. It thus caused narrowing and obstruction of the oesophagus, which could be well seen when the patient was given some barium. His left ventricle was much enlarged. The Wassermann reaction was strongly positive.

On Feb. 27 the patient developed diarrhoea, and blood was seen in the motions. On March 4 he suddenly collapsed, complaining of pain across the front of his chest. He was pale and shocked, and his pulse was imperceptible. He died shortly afterwards.

Necropsy.—Acute adhesive pericarditis was present, obliterating the pericardial sac and giving rise to the typical "bread-and-butter" appearance. No pericardial fluid was found. The left ventricle was hypertrophied but not dilated. The mitral, tricuspid, pulmonary, and aortic valves were normal and the openings of the coronary vessels were patent. Half an inch above the aortic valves the beginning of syphilitic aortitis with aneurysm formation was seen. The aneurysmal dilatation extended along the whole course of the aortic arch and descending thoracic aorta down to the first two inches of the abdominal aorta. It was mainly tubular, but one large sacculi full of laminated clot extended into the right lung from the aortic arch. In front of the first two inches of the abdominal aorta a saccular aneurysm, the size of a large orange and full of laminated clot, was seen. This aneurysm was pressing anteriorly against the posterior aspect of the left lobe of the liver, indenting it and forming part of the stomach bed. The oesophagus was markedly deviated to the left and compressed in its lower third by the aneurysmal dilatation of the thoracic aorta. On opening the stomach it was found to be full of blood clot. An area the size of a sixpence on the posterior wall of the fundus of the stomach was adherent to the large saccular aneurysm of the abdominal aorta, which had perforated into the stomach in this area. The intestines were normal. There was fluid in both pleural cavities. Many pleural adhesions which could be broken down only with difficulty were seen. The pleurae were thickened over the lower lobes. Both lungs were congested, but no evidence of pneumonic consolidation was found. The spleen was slightly enlarged and was soft. The kidneys and suprarenal glands were normal. The liver showed signs of venous congestion and fatty degeneration.

Dr. Gilmour reports: "Portion of aorta showing syphilitic aortitis. Portion of clot from aneurysm of abdominal aorta adherent to stomach wall containing many streptococci in one place. Portion of stomach with cardiac orifice showing acute and subacute pyogenic inflammation, intense on the outer surface of the stomach and oesophagus and in a small portion of the diaphragm attached. Nothing was seen to suggest a syphilitic inflammatory process." The perigastric inflammation must have preceded the final perforation of the thin stomach wall overlying and adherent to the saccular aneurysm.

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Small-bowel Obstruction due to Dried Fruit

The following case of small-bowel obstruction may be found of interest.

The patient, a woman aged 60, was admitted on May 14, 1945, with the history of a sudden onset of abdominal pain and vomiting the previous day. The pain was colicky in nature and vomiting had persisted up to the time of admission. The bowel action had been quite regular until the previous evening. There was a history of acute appendicitis many years before, and following appendectomy five abscesses in the scar had occurred.

On examination her temperature was 99.8°, pulse 120, and respirations 28. She was well nourished and not particularly dehydrated. The cardiovascular system was normal, but there was evidence of well-marked bronchitis. The tongue was coated. The abdomen was somewhat distended and showed an old adherent appendix scar. There was marked tenderness in both hypochondria and over a point at the left of the umbilicus, with guarding and audible peristalsis. Rectal examination revealed nothing abnormal. A diagnosis of small-bowel obstruction was made, thought possibly due to bands in the region of the old scar.

Laparotomy was performed through a right paramedian incision. On opening the peritoneum the omentum was found to be adherent to the old scar, but the small bowel, which was distended, was not involved. The distended small intestine was traced down to within two feet of the ileo-caecal valve, where a fusiform mass about 3 in. long filled the lumen. The gut below this was collapsed. The bowel was opened and the mass removed, the incision repaired, and the abdomen closed. She was discharged after an uneventful convalescence on June 5, 1945.

Examination of the object revealed it to be half a dried apricot, which was folded over on itself. Later questioning of the patient disclosed that eight days before admission she had been bottling some apricots and "may have eaten one or two." She wears artificial dentures.

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Workshop.

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J. NAGLE, M.B., B.Ch.

Acute Intestinal Obstruction due to Dried Fruit

This form of intestinal obstruction seems to be a post-war risk, judging by the cases recently recorded. In this case the obstruction was caused by a dried peach.

CASE REPORT

An edentulous old lady aged 64 was admitted to Hammersmith Hospital on May 18, 1945. Six days previously she had eaten dried peaches. As she had no teeth she had sucked the peaches before swallowing. She denied having gulped down any large piece. Four days later she was seized with colicky umbilical pain and began to vomit. This continued until her admission after a further two days. She then presented a picture of acute low small-intestine obstruction. Visible and palpable peristalsis was present in the centre of the abdomen. After a pint of intravenous saline and gastric aspiration by Ryle's tube, the abdomen was opened under regional block analgesia supplemented by nitrous oxide and oxygen. The small intestine was grossly distended. In the lower ileum about 18 in. from the ileo-caecal valve a firm object the size of a peach was felt. It was at the usual site of a gall-stone obstruction, but was not hard enough for a calculus. I could not push it on into the caecum through the contracted ileum below, but it was easily pushed back into the distended coils above. When it had reached a healthier portion of the ileum this was shut off with light intestinal clamps and incised vertically over the object, which was removed and the bowel sewn up transversely in two layers. The abdomen was closed in the usual way. The patient has made an uninterrupted recovery.

The object was yellow and of the characteristic size and shape of a dried half-peach (see photograph).

Peach removed from ileum

COMMENTARY

Elliot (1932) reviewed the cases reported during the previous 22 years and gave the following table:

Obstructing Material	Cases	Obstructing Material	Cases
Mushrooms	5	Poppy seeds	2
Cherry stones	4	"Ammunition bread"	1
Beans	4	Sauerkraut	1
Figs	3	Gooseberries	1
Oats	3	Raisins	1
Potatoes	2	Half an orange	1
Apples, pears, peas	2	Popcorn	1
Corn	2	Bran	1
Grapes	2		

Latchmore (1940) in an article on the cause of "ordinary stomach-ache," which he considers is usually due to bolus colic of the small intestine, reported four cases which required emergency operations for the removal of monkey-nuts, almonds, portions of coconut, and three segments of an orange. No fewer than five cases were recently reported in three papers in the *British Medical Journal* (Jones and Davies, 1945; Lyall, 1945; Radclyffe, 1945)—three due to oranges, one to dried apples, and one to unspecified dried fruit.

It seems that with the release of a considerable amount of dried fruit we should temper our delight with mastication, for the power of dried fruit to swell by the absorption of water is considerable. The risk would appear to be greatest when a portion of unprepared dried fruit is swallowed whole. But there is another risk in the case of edentulous people, who, unable to bite, chew and suck the fruit dry before swallowing. In either case it absorbs fluid in the alimentary canal. It usually has no difficulty in passing through the pylorus and jejunum, but gets held up in the ileum at its narrowest part at the junction of the mid- and hind-gut, one or two feet above the ileo-caecal valve. Often peristalsis is sufficient to pass the bolus on with no more symptoms than stomach-ache (bolus colic of Latchmore). Sometimes at operation it is possible to push the mass on into the caecum. Rarely, as in the case here reported, it has to be removed by enterotomy.

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