appears to have been the immediate cause of the ossification of the choroid.

The organ in which these remarkable changes occur is rendered useless, and, as regards the eye, the importance is perhaps greater from the fact that sympathetic inflammation of the opposite eye will sooner or later be set up, and lead to complete destruction of sight in it. Various theories have been advanced to account for the production of sympathetic inflammation. Into these it is not necessary to enter now. However, in the case before us I believe the inflammation of the second eye was caused by the direct irritation of the ciliary nerves by the ossific (foreign) material lying in close contact with them, and in which, perhaps, they had also become incorporated.

With these preliminary remarks I shall now read the notes which I have made of the case.

Poongavanam, aged 38 years, was admitted into the Ophthalmic Hospital on April 5th, 1888, complaining of complete loss of vision of the left eye and steady and rapid impairment of vision of the right eye. His previous history is to the effect that he was admitted into the Ophthalmic Hospital in 1887 for synechia of syphilitic iritis, for which he was treated by increasing doses of iodide of potassium. The improvement in the left eye was limited; and as the organ continued to be sensitive on palpation, and as all sense of sight had entirely gone, he was advised to submit to enucleation. To this he objected, and left the hospital. He returned on April 5th, 1888, and urgently sought admission into hospital, at the same time requesting that the left eyeball might be removed. His reason for making the request was that he felt that the diseased stump of the left eye was injuriously affecting the right eye by causing serious deterioration of vision in it. He had now well-marked signs of insidious irido-cyclitis of the right eye; the eyeball was congested; a well-defined ciliary zone of vessels of a dusky purplish hue surrounded the corneal margin; the aqueous was muddy; the striated appearance of the iris structure was very distinct, especially at its lower half; the pupil was irregularly dilated, and the posterior synechia at the upper and inner margin held this structure down to the anterior capsule of the lens. On the anterior surface of the upper part of the iris small nodular masses of lymph were to be seen. The posterior surface of the cornea was also rendered uneven by the deposit of inflammatory lymph upon its surface, and its anterior surface was rough and uneven, and showed evidences of breaking up of tissue. These changes were accompanied by profuse lachrymation and extreme photophobia. The vision was very greatly impaired, the patient being only able to decipher the test dots at 2 metres.

The left eye presented merely a shrunken globe, the result of previous inflammatory action. The organ was very hard to the touch, and palpation caused considerable pain.

April 7th. Two days after admission the left eyeball was removed under chloroform without difficulty. The patient supported the operation well.

April 12th. Immediately after the removal of the offending globe the right eye began to show signs of improvement; the lachrymation and photophobia, which were formerly so excessive, had diminished to a very marked extent; and on this date it is noted that the congestion of the eyeball was rapidly abating. Since the operation the patient was placed on five-grain doses of iodide of potassium thrice daily, and one-sixteenth of a grain of corrosive sublimate twice a day in pill. The cavity of the left orbit was daily cleansed by syringing with carbolic acid lotion.

On the 20th the doses of the iodide of potassium were increased to 7 grains, and the pills were continued.

April 24th. On this date the eye presented the following conditions:—Corneal surface more polished and brilliant; the scleral and conjunctival congestion has abated to a very marked extent; the aqueous is clear; the pupil is evenly dilated, under the influence of atropine, to about 7 mm.; the neoplastic deposits on the anterior surface of the iris are no longer to be seen, nor any traces of pigment deposit on the anterior capsule of the lens to mark the points of posterior synechia. T+2.

By ophthalmoscopic illumination the dioptric media are more transparent, but do not permit of a ready examination of the fundus. No details can be made out. The potassic iodide was increased to 10 grains thrice a day.

The patient continued to make steady progress towards recovery, and on May 8th I noted that all conjunctival, subconjunctival, and scleral congestion had subsided; the cornea had regained its normal transparency; the aqueous was clear; the iris structure

was normal in appearance, and no remains of the neoplastic deposits were visible.

By the ophthalmoscope the fundus can be readily illuminated; the muddy state of the vitreous has almost entirely disappeared; no muscae visibiles; the O. P. is slightly congested, but in other respects the fundus may be regarded as normal in appearance. He is able to count the test dots readily at 4 metres.

On account of the overcrowded state of the ward he was discharged from hospital, and directed to attend in the out-patients' department for further treatment.

In this case the recovery of sight in the right eye clearly hinged on the removal of the left eyeball, which had passed through a series of remarkable changes, and which was producing rapid loss of sight by sympathetic inflammation.

A CASE OF IDIOPATHIC TETANUS: RECOVERY.¹

By J. HEADLEY NEALE, M.B., M.R.C.P. LOND.,

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THE comparative rareness of this form of tetanus in this country induces me to make a brief record of the following case:

On May 5th, 1888, I was asked to see W. B., aged 12, a high-spirited but delicate schoolboy, who was said to be suffering from a "severe cold." I learned that, five days previously, he had been playing with some schoolfellows in an enclosure in front of some houses in a comparatively new and badly drained district, in the outskirts of the town, wherein grew a few young fir-trees; and beneath them nothing but hassocks, showing the marshy nature of the soil. After getting heated in play, he had lain for some time upon the grass among the hassocks. When I saw him, the chief things he complained about were stiffness of the lower jaw, aching all over his body, and intense pain when he attempted to open his mouth. This he could only manage to do with the greatest difficulty, sufficiently to allow of the tip of the tongue to be extruded for about three-quarters of an inch. Once opened to this extent, closure was easily effected, showing the degree of affection of different groups of muscles. I regarded the case as one of rheumatism, and prescribed salicylate of sodium, but I very soon had to alter my diagnosis to that of "idiopathic tetanus."

The symptoms increased in severity; although the jaw was never completely "locked," the report that at night-time he was constantly awakened by his jaws snapping, so that his tongue was severely bitten, and the "risus sardonius" having become well marked, placed the diagnosis beyond doubt. The patient was placed upon full doses of bromide of potassium and chloral hydrate, administered every two hours. Regarding the case as serious, I called in my colleague, Mr. C. J. Bond, who confirmed the diagnosis, while together we made a more systematic examination of the patient.

The disease exhibited, to a well-marked but not exaggerated degree, the type of orthotonos. The abdominal muscles, and notably the inter-transverse portions of the "rectus abdominis," stood out in bold relief, suggesting rather the appearance of a well-trained athlete than of a delicate schoolboy; while the erector muscles of the spine were equally in a state of tension; and we could only lift a leg as a whole, like a rigid stick, for a very short distance, great pain attending the act. The tongue was thickly coated, and the bowels constipated; slight pain was complained of at the xiphi-sternum, but was more marked in the back between the angles of the scapulae; there was some dorsi-flexion of the head and neck, no opisthotonos, but a general condition of rigidity; and absolutely no breach of continuity.

In addition to the treatment mentioned, constant alimentation was kept up with predigested liquid food (milk, beef-tea, etc.), while the bowels were relieved with oil enemata, and a black rubber gag fixed between the teeth at night.

As regarded the probable termination of the case, two factors enabled me to venture upon a favourable prognosis. (1) Throughout the whole illness the temperature was never much above 100° F., and (2) the muscles of respiration were not seriously involved. The little patient successfully tided over the supposed critical twelfth day, and made an uninterrupted recovery, so much so that I ceased attendance on June 2nd, or thirty-three days from

¹ Read before the Midland Medical Society, Birmingham.

the first onset of the symptoms, and he had then been for more than a week on tonic treatment.

REMARKS.—As regards etiology, the telluric influence supposed to have so large a share in the production of the disease was well illustrated by the nature of the ground upon which the boy had lain. My case can, of course, throw no light upon the pathology of the complaint. Rheumatism may have played an important part in this individual case. Whatever may be the cause, it is undoubtedly an irritative lesion, but whether an explosive discharge from the multipolar cells themselves, or, what is much more probable, a peri-neuritis involving the tracts of their efferent fibres, it is impossible to say. As regards treatment, chloral hydrate is our only sheet-anchor, and Mr. Bond has published in the JOURNAL a case of traumatic tetanus which recovered under the exhibition of this drug.

SURGICAL MEMORANDA.

ENCHONDROMA OF CHEEK.

E. H., aged 90, a widow, came under my care four years since with an enchondromatous growth on the right cheek, which she

From a photograph by Mr. S. Grey, 13, St. James's Street, Brighton.

informs me commenced over forty years ago. Soon after I first saw the case, in consequence of the great pain caused by the pressure probably on the facial nerve, an opening was made at the apex about two inches long, and a quantity of broken-down structure removed, after which much relief was obtained. The opening never healed and the growth steadily increased to its present size, now probably four or five pounds in weight, and measuring 16 by 13½ inches, and about six times as large as when I first saw it. At the commencement a small pimple was observed on the cheek, half an inch in front of the tragus. Possibly the tumour originated over some portion of Steno's duct, which may have had some defect in it. Occasionally a discharge of a purulent cha-

racter comes into the mouth, and at times there is excruciating pain in the head, and an offensive sanious discharge continues to ooze from the tumour. The health is good, intellect clear, and memory excellent. No satisfactory reasons are given for not seeking relief in the early stages of its growth. The photograph was taken in February.

C. H. WELCH, F.R.C.S.

Brighton.

CLINICAL MEMORANDA.

HÆMATOMA AURIS OR "THE INSANE EAR."

IN the recent contributions under the above heading, views and facts have been brought forward which have been for years the common property of aural surgeons, as may be seen by reference to almost any well-known work on diseases of the ear. As, however, it has been found necessary and instructive to call attention to the etiology of hæmatoma auris, it is perhaps surprising that even Dr. Strahan, in his sensible summary, has omitted to mention the interesting scientific evidence on which the possibility and probability of non-traumatic othæmatoma is based. Brown-Séquard produced hæmorrhage into the auricle in guinea-pigs by section, and by irritation of the restiform body of the same side. This appears to me to suggest that hæmatoma auris is sometimes a peripheral trophic lesion, and comparable to analogous peripheral lesions met with in morbid conditions of the central nervous system—as, for example, in Charcot's disease. On this hypothesis, the restiform bodies might be regarded as either trophic centres for the auricles, or, at all events, intimately associated with such centres. On this view, such slight traumatism as habitually sleeping on, for example, the left ear (especially if the pillow were hard) would act as an exciting cause of hæmorrhage in the auricle of an individual predisposed to degenerative changes.

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IS SYPHILIS INCURABLE?

WITH reference to the correspondence which is at present being carried on in the JOURNAL as to the curability or otherwise of syphilis, the following case, which is at present under my care, may be interesting.

Private G. W. contracted primary syphilis in March, 1882. In September, 1883, he was admitted into the station hospital, Bangalore, with secondary syphilis. At this time there was a well-marked rash on the body and legs. Under treatment by alteratives he recovered and was discharged to duty. During June, July, August, and September, 1884, he was again under treatment, and during this time suffered from disease of the nasal bones, condylomata, nodes on the tibiae, and ulcers on both legs.

He was treated with mercury, iodide of potassium, and tincture of iodine at different times. On September 12th, 1884, he passed an invaliding board, and was sent to a hill station for change. During 1885 he had four admissions for secondary syphilis, spending a total of 136 days in hospital. Since 1885 he has been free from syphilitic manifestations, but there still remain well-marked syphilitic scars over both tibiae. In January, 1889, he again contracted primary syphilis, and was admitted into hospital with a typical Hunterian chancre. This has been followed by induration of the glands in the groin, a roseolar rash, and ulceration of the throat. Since his present admission he has been treated with perchloride of mercury and iodide of potassium, and under this treatment the symptoms are rapidly disappearing.

No one can dispute the truth of Dr. Althaus's assertion that "it is now generally accepted, whatever views may be entertained by different observers about the nature of contagium, that whoever has syphilis cannot acquire it. A single well-observed case of reinfection in the same individual, therefore, clearly shows that syphilis is at least occasionally cured."

In the case given above the facts are indisputable, as they have been carefully recorded in the man's medical history sheet by the different medical officers under whose care he has been. It seems strange that such eminent authorities as Drs. Gowers and Drysdale maintain that syphilis is an incurable disease. Had they stated that we can never declare with absolute certainty in any individual case of syphilis that the patient is completely cured, no one would have questioned the statement. When, however, they maintain that syphilis is incurable, it is quite a different