In Ireland, where granular ophthalmia and consequently entropion and trichiasis are so common, we have such a large field for testing the value of any operation of the sort, that it is natural we should try various modifications in the details as well as in the larger features of the method. The operation, as at present performed at St. Mark's Ophthalmic Hospital, is what I purpose describing, and I shall not delay to mention the various modifications by which it reached its present form. It will be obvious to anyone who cares to compare the two that the details differ materially from those described by Van Millingen in the *Ophthalmic Review*, vol. vi, p. 309.

The operation is of necessity a somewhat tedious one, and simplicity of manipulation has always been our endeavour. "The St. Mark's Hospital operation" consists in: 1. Splitting the affected lid along the whole length of its free border with a small scalpel, or a broad cutting needle, or a Beer's knife. The incision must be made so that all the cilia, both normal and abnormal, are in the anterior or skin flap, and all the conjunctiva is in the posterior flap. The making of this incision is by far the most difficult and important part of the operation. It is best accomplished by using Knapp's modification of Snellen's clamp, and the larger the instrument that can be inserted into the palpebral aperture the better will be the result. By using this clamp all hæmorrhage is prevented during the operation, and the line of the incision can be accurately made so as to avoid the hair bulbs in the lid, and also the depth of the incision can be more easily estimated. The incision should run obliquely through the tarsus, and extend into the subcutaneous tissue of the lid, otherwise the wound does not gape freely and the transplanted flap is squeezed out of its place by the rigid lips of the incision.

Before considering the section complete it is advisable to use a pair of fairly fine-bladed scissors along the incision, so as to completely divide any remnants of the tarsus that escaped the scalpel. The splitting of the lid being now completed, the clamp is not removed, but a pledget of cotton wool, wet in boric lotion, is laid over it. Another large clamp is then taken and applied to the lip—upper or lower, according to taste—and screwed tightly down. The lip being then everted, two parallel incisions are made the full length of the incision in the lid, and from 3 to 5 millimetres, or even 6 millimetres, apart, if the deformity to be corrected is very great.

These incisions converge rapidly at each end, so as to leave pointed extremities to the flap, which is then dissected up with a pair of scissors. The worm-like flap of mucous membrane so obtained is then turned, with its submucous surface upwards, upon the operator's left hand, and the submucous fat and areolar tissue removed with the scissors.

While this is being done by the operator an assistant puts in a couple of sutures loosely into the lip wound, and then, removing the clamp, these are brought together. This is by no means essential, but facilitates the healing of the lip. Pressure is then kept up on the lip by the assistant, who uses a pledget of boric wool over the wound for the purpose.

When the flap is freed from its fat, etc., a fine waxed silk suture is passed through, close to its pointed extremity, from mucous to raw surface; the needle is then passed through the lid at the angle of the incision, from raw surface to lid border, and tied into position. By making a large knot on the suture a few inches from its end, the point of the flap can be drawn closely into the angle of the incision and kept in close apposition with it. Another similar suture is applied to the other end, and two, three, or four sutures are used to keep the edges of the flap in close apposition with the lips of the lid wound.

These sutures are not absolutely essential, but our experience shows that they do no harm whatever, and greatly add to the security of the flap in its proper position and the consequent certainty with which it lives in every part.

When the flap is fixed in position, with as many sutures as the operator cares to use (I generally apply six altogether), the clamp is unscrewed. The operation up to that had been practically bloodless, but the moment the clamp is removed a very brisk hæmorrhage ensues, which, but for the sutures, would undoubtedly displace the flap. Pledgets of cotton wadding, wet with boric lotion, applied over the lids, speedily cause the hæmorrhage to diminish, and soon to cease altogether.

At first we had apprehensions as to the consequences of

leaving the clots that form about the wound, fearing they would interfere with the vitality of the transplanted flap; but here again experience proved our fears to be groundless. In no case (though I have seen some with very severe and long continued hæmorrhage) can I remember to have seen trouble from this cause.

When the bleeding has fairly well abated, a dressing of iodoform ointment on lint, and wet boric wool over it, is applied to the eye; a small portion of oiled silk and some dry cotton wool is placed over this, and the whole is kept in position by a light bandage. This dressing is reapplied night and morning. The sutures are removed after three or four days (or sooner if there is any reason for so doing), and soon after the sutures are removed the bandage is left off.

The changes in colour which the transplanted flap undergoes are remarkable. When first transplanted it is almost white and utterly bloodless. After twenty-four hours it turns a peculiar dark, almost black red, like an old blood clot, and in another twenty-four it becomes a bright, healthy-looking pink colour, which it retains for ever after.

The advantages of this operation over all that preceded it for the cure of entropion and trichiasis are too obvious, and have been too often stated to make any repetition of them by me necessary.

Our experience at St. Mark's Hospital is very large in the class of cases that require this operation, and I can state, without fear of contradiction, that no other operation has ever given us at all the same perfection and permanence of result as we have obtained by the blepharocheloplasty operation.

TREATMENT OF CANCER OF THE UTERUS BY EXCAVATION AND CAUTERY.

By J. STUART NAIRNE, F.R.C.S. Ed. (Exam.),
Surgeon to the Glasgow Samaritan Hospital for Women.

In the summer of 1887, that is nearly three years and a half ago, I received a letter from Dr. Thomas Keith, recommending a lady patient to me with a "bad cervix." She had had excessive bleedings, there was fœtor with the discharge, and she had been attended by her own medical man, who had done all he could think of to cure her. She was 42 years of age, and in all other respects seemed a very healthy person. The disease was very readily diagnosed as cancer, a diagnosis which inspection afterwards confirmed.

Dr. Keith's straightforward, unhesitating advice at that time was to pull well down and cut off as high up as possible, and she would likely be saved "for a time." I have no idea how long "for a time" may be, but I know that cases such as this one was have usually a very short time indeed, and I have no doubt that the same knowledge as to the course of the disease was in Dr. Keith's mind when he wrote and that "for a time" meant problematically a short time. At any rate, the operation was done. But in addition to pulling well down, which in this case was no easy matter, and cutting off by the scissors as high up as possible, I applied most freely, a spectator said most barbarously, the actual cautery. I used a good substantial cautery, as thick as a poker. Times without number before that time and since that time, I have gone through the same process. It may be barbarous and it may be "monstrous bad surgery;" but to refer only to this one case, what is the report to-day? She has remained in perfect health ever since; I examined her about seven weeks ago, and there is not the slightest trace of disease about her. What could be done better in such a terrible disease? As a very pronounced advocate of this treatment in properly selected cases, and having for several years in succession laid a list of such cases before the meetings of the British Medical Association, I feel bound to defend the practice I follow, attacked as it has been in Dr. Keith's recent paper in the *BRITISH MEDICAL JOURNAL*. I do not think it is "monstrous bad surgery." It has good results, and therefore as far as it goes it is good surgery.

Let the cases be selected properly and the work done thoroughly, and the benefit to the sufferer will, I know, be sufficient to justify the treatment. Dr. Keith objects that the part cauterised cannot be clamped, and that the action of the

cautery, therefore, cannot be limited. Well, what of that? The part cannot be clamped, certainly not. If it could be clamped as readily as the pedicle of a tumour, we would make short work of the whole uterus. And that the action of the cautery cannot be limited is partly right and partly wrong. A rapid and strong application of a red hot iron will char effectually without the heat being conveyed very deeply, while a long continued application of a lesser degree of heat will convey deeper inflammatory action and destruction. Nothing but experience in the use of the cautery will enable a man to decide how he should use it in any given case.

As to vaginal hysterectomy, I quite agree with Dr. Keith that it is not a difficult operation—that it requires no special clamps, no special knowledge, in fact, if the uterus is movable and can be drawn down; and we are all well aware that this is often *not the case*. When the body of the uterus is implicated in such a manner as to involve enlargement, hyperplasia, showing a complete engorgement of the organ by malignant growth, who would think of doing anything else than hysterectomy, either by the vagina or by abdominal section? I do not think anyone would dream here of performing any partial operation of either excision or excavation with or without the use of the cautery. I must say again that in properly selected cases the removal of all the diseased tissues as far as possible, with the subsequent effectual application of the cautery, will show results in this terrible disease that not only justify the style, but form an argument for its adoption in preference to most or perhaps any other methods.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, Etc.

CASE OF LOCOMOTOR ATAXY TREATED BY HYPNOTIC SUGGESTION.

C. W., aged 53. Disease began about fifteen years ago, and was characterised chiefly by the intensity of the pains in the legs and abdomen. Patient attended the Queen Square Hospital for two years as an outpatient, and was five months in the Soho Hospital, but was not benefited. Eight years ago patient began to be unable to walk without assistance, and for nearly five years has been confined to bed. The legs are atrophied, and there is total anaesthesia below the knees. For the last twelve years he has had absolutely continuous and agonising pain—sometimes in the limbs, often in the abdomen and chest. His cries often disturbed his neighbours, and morphine in one-grain doses, repeated once or twice, has no effect on the pain. The bowels were obstinately constipated, requiring strong purgatives to move them, and he slept very badly.

I saw him first on October 28th, 1890, and, having in mind Dr. Lloyd Tuckey's now almost historic case, I determined to try and relieve him by hypnosis and suggestion. On the first attempts I failed to influence him, but, on November 5th, I hypnotised a woman before him, and again tried him. He passed into the third stage of Bernheim. I rubbed his legs where the pain then was, and suggested it should cease. Next day he reported that he had been freer from pain, and had slept better than he had done for years. Since then he has been hypnotised daily, and has been quite free from pain, except for a few hours one day. He is simply amazed at the change in himself. The bowels have moved naturally since suggestions were made to that effect, and he sleeps very well at night. His appetite has improved, and he has sat several times in a chair by the fire—a thing he had not done for some years. He has lost the depressed feeling he used often to have.

I do not say this improvement will continue, as the disease is not checked, but the fact remains that the man says that for the last fortnight he has enjoyed life, while for many years previously his constant prayer had been for release by death.

I quote this case as one of the most instructive of the many cases I have treated with benefit by hypnotic suggestion.

East End Medical Mission.

R. ARTHUR, M.A., M.B.

A CASE OF CAT ASTHMA.

It is a well-known fact that in some individuals asthmatic affections are induced by contact with various substances which to most people are harmless. Sufferers from hay fever and hay asthma are common enough, and many of us have met with persons in whom *ipecaacuanha* excites paroxysms of dyspnoea. Cases of asthma induced by the presence of, or contact with, animals are not so often recognised and described, although in medical literature we meet with references to instances of the kind, the offending animals being sometimes horses, sometimes deer, dogs, cats, hares, rabbits, or guinea pigs. The following case is of interest as a typical case of cat asthma.

The patient is a man, aged between 30 and 40; there is no history of a family tendency to this or allied diseases. He believes that he first suffered from spasmodic asthma at the age of 14, and remembers being confined to bed in his boyhood for several weeks with almost constant dyspnoea and wheezing, attended by a doctor who gave him plenty of antimony, and with a favourite cat sleeping at the foot of the bed. Later on, he is said to have been subject to hay fever; at all events, he had violent attacks resembling that affection when he went to stay with relations in the country during the hay season; but it is a curious fact that his distinct recollection is that he never suffered when out of doors, but always in the house, and also that the people of that house were extremely fond of cats. Neither he nor his friends had at that time the least suspicion of the exciting cause of his malady, which has only been traced within the last few years.

The onset of an attack is usually heralded by violent sneezing, followed by excessive secretion from the nose, lachrymation, and itching of the conjunctivæ in the neighbourhood of the caruncles. My patient describes a curious symptom which has been noticed in other similar cases—a peculiar sensation of itching under the chin, and also great coldness of the hands and feet. The rapidity of invasion of these symptoms is very remarkable. The onset is almost as sudden and violent as it would be if he were exposed to an atmosphere laden with snuff; and he declares that very soon, with saturated pocket-handkerchief, irritated swollen eyelids, and cold damp extremities, he is reduced to a state of abject misery, physical and mental. A few minutes later, if he continues to be exposed to the influence, and sometimes even if he escapes from it, he experiences the familiar oppression of the chest, respiration becomes laboured, and accompanied by sibilant sounds in the bronchial tubes; and unless relief is afforded, all the symptoms of severe asthma supervene. Profuse diuresis is usual at this stage. As a general rule, the respiratory troubles disappear entirely after a sleep, always supposing the patient to be far removed from cats; but sometimes, after long exposure to their influence, he may suffer even for several days from slight oppression, with unusual secretion of bronchial mucus.

There are several varieties in the attacks; sometimes he only suffers from coryza without the asthma, and sometimes the presence of the enemy induces asthma without coryza; there are marked differences, too, in the intensity of the paroxysm in different attacks; but the above may be taken as a true and faithful account of the normal type. This disagreeable influence may be due to irritating particles thrown off by the fur. My patient, in common with all the similarly affected people of whom I have read, finds that to touch his eyelids with a hand that has just stroked a cat sets up violent irritation. The actual presence of the foe is not, however, necessary; he suffers, though not severely, when he is in a room commonly frequented by cats, though they may be absent at the time. The nearer he is to the animals, and the more numerous they are, the more severe are the symptoms. He believes that cats differ in the potency of their influence, and that the long-haired kinds are the most poisonous. The skin of a dead cat has no effect upon him. The larger members of the tribe excite his symptoms; he was lately driven from the lion house at the Zoological Gardens by violent sneezing.

Whatever it may be, the emanation that causes cat asthma is not a smell. It is the sensory nerves of the nasal passages, not the olfactory nerves, that are irritated, and from which the irritation is transmitted to the nerves supplying the bronchial muscles. My patient has always been fond of cats;