out he was not under medical care here, nor did he complain of illness at any time. We trust the above information will suit your purpose, and are, yours faithfully, TANCRED, ARROL AND CO.
—Dr. Byrom Bramwell."

Copy of Letter from Dr. James Hunter.

"The Priory, Queensferry, December 29th, 1887. Dear Dr. Bramwell,—J. G. was a member of the Forth Bridge Workmen's Club, in virtue of which he was entitled to medical advice at any time. Up to the date on which he met with the accident to his eye I had not been asked to see him professionally. Indeed, I am not aware that he was on any occasion absent from his duties at the bridge.—Yours sincerely, JAMES HUNTER."

The details of another case of aneurysm (which is reported in the *Edinburgh Medical Journal* for April, 1888) were also given, in which the patient was able to work for a period of eight years with an aneurysm projecting through the front wall of the thorax.

CASE OF SERIOUS HÆMORRHAGE FROM THE CAVITY OF THE TYMPANUM IN AN INFANT (OTITIS MEDIA HÆMORRHAGICA).

By THOMAS BARR, M.D.,

Surgeon to the Glasgow Ear Hospital; Lecturer on Aural Surgery, Anderson's College, etc.

BLEEDING from the ear may occur in various affections of that organ. Thus it is not uncommon in purulent diseases associated with polypi, granulation tissue, or caries; in these conditions, however, it is rarely more than sufficient to tinge the discharge. A moderate escape of blood is also not unusual in otitis externa and in myringitis, from the rupture of hæmorrhagic elevations, either on the osseous portion of the external canal or on the tympanic membrane. In otitis media hæmorrhagica the source of the hæmorrhage, as the name implies, is the middle ear, especially the cavity of the tympanum, the mucous membrane of which is in a state of acute inflammation. The walls of the distended and engorged vessels give way, blood is poured into the cavity of the tympanum, the tympanic membrane is ruptured, and hæmorrhage takes place externally. The following case is probably unique in respect of (1) the tender age of the patient, and (2) the serious loss of blood. A baby (girl) of 9½ months was sent to me on November 17th last by Dr. Sinclair Kennedy, of Perth. I was informed that, five weeks previously, the baby had become restless, uneasy, and sleepless, apparently from severe pain. These symptoms continued for about a week, and then seemed to be explained by the appearance of muco-purulent secretion from the left ear. There was also noticed a considerable swelling in the neck below the left ear. This escape of matter was on the evening of Friday, and on Sunday night the mother awoke, and was dismayed to find the upper part of the child's dress saturated with blood; she was of opinion that at least a cupful of blood must have escaped. Dr. Kennedy says, in a letter of November 15th, "I was sent for at 5 A.M. on Monday, when I found the child deluged with blood from the left ear. I used a weak injection of acetate of lead, and enjoined rest. The bleeding returned once or twice during the day, but not to so great an extent. I had Dr. Bramwell seeing her with me in the afternoon, and we tried to see the state of the tympanum, but she was so restless we left her alone. We thought she must have had some inflammatory mischief of the middle ear, with rupture of the membrane. Under the ear there was a swelling as large as a walnut, and tender to touch, with a brawny feeling around. She had no pain over the mastoid process, but did not like to be touched over the head of the lower jaw-bone. She was put on iodide of potash, with liq. hydrarg. perchlor. and tinct. of iodine. Iodoform was put into the ear on cotton-wool, and iodoform and vaseline applied to the swelling under the jaw. Some hours after the first bleeding a troublesome dry cough came on, without any chest symptoms, and so we concluded it was aural. The bleeding again returned on Tuesday morning, and I put her on gallic acid internally. From this time there was no return of the bleeding. In a few days the swelling under the jaw went completely away. The discharge from the ear by Thursday, the 21st, was colourless and odourless. On her recovery I tried to examine the ear, but she was restless with me. However, I felt satisfied. I saw a ragged tear of the under half of the tympanum."

When I examined the patient, there was neither discharge from the ear nor perforation of the tympanic membrane; but a small cicatrix on the antero-inferior part of the membrane indicated the recent existence of a perforation. The membrane had not the ordinary lustre, and the vessels of the manubrium were somewhat injected. The Eustachian tube was permeable. I had no doubt that a perforation had recently existed in the tympanic membrane, and that the hæmorrhage had its source in the middle ear. The child was decidedly anæmic, but, according to the statement of the parents, the pallor was much less than it had been soon after the bleeding, when the face was quite blanched.

In regard to the explanation of the hæmorrhage in a case such as this, it has been argued that the dilated and engorged arterioles in the tympanic mucous membrane give way under the influence of the partial or complete vacuum produced in the tympanic cavity from the closure of the Eustachian tube. It is urged that just as rarefaction of the air in the tympanum may so act upon the blood-vessels of the mucous membrane of the middle ear as to produce a serous exudation (*hydrops ex vacuo*), so when acute inflammation exists with, as a consequence, dilated and engorged arterioles on the surface of the mucous membrane, the suction may in time lead, not simply to transudation of serum through the coats of the vessels, but to their rupture, with free hæmorrhage into the cavities of the middle ear. In this case, however, there was probably perforation of the tympanic membrane two days previous to the hæmorrhage, which would remove the vacuum, unless, indeed, which is quite conceivable, the aperture in the membrane was afterwards closed temporarily by inspissated secretion, so as again to lead to partial rarefaction of the air. But while admitting the possibility of the vacuum theory, it must be pointed out that such conditions frequently exist—in every case of otitis media, a very common affection—without hæmorrhage; and therefore it is probable that in cases attended by hæmorrhage there is, in addition, some peculiar weakness of the walls of the vessels of the middle ear. Such weakness may be the result of morbid changes due to Bright's disease, and several cases are on record of hæmorrhage from the mucous membrane of the tympanum associated with, and probably the result of, chronic Bright's disease, corresponding, as has been suggested, with the retinal hæmorrhage of the same disease. In this child there was no evidence of the existence of Bright's disease, and, indeed, the age was quite opposed to the supposition of changes in the arterial coats from chronic Bright's disease. Apart, however, from Bright's disease or any other chronic affection, there was probably in this child a hæmorrhagic tendency which predisposed to the hæmorrhage. Just as ophthalmic surgeons recognise a form of retinal apoplexy in the young, due simply to a hæmorrhagic tendency, so may such a case as this (tympanic apoplexy) have its origin mainly in the same predisposition. The immediately determining cause may have been the action upon the dilated and engorged vessels of the partial vacuum in the cavity of the tympanum. In view of the predisposition to the hæmorrhage which probably existed in this child, the parents were instructed to use every precaution in order to avoid, if possible, future inflammatory attacks in the ear.

The following authors may be consulted by those interested in the literature of this subject:—

Dr. Roosa's *Practical Treatise on Diseases of the Ear*; Politzer on the Membrana Tympani (p. 95), translated by Drs. Mathewson and Newton; Schwartze in a paper in *Archiv für Ohrenheilkunde*, entitled "Ein Fall von Bluterguss in die Paukenhöhle bei Morbus Brightii." Bd. iv; Dr. McBride on Otitis Hæmorrhagica in *Archives of Otolaryngology*, vol. xv.

LUMBAR COLOTOMY; THE CAUSES OF FAILURE IN FINDING THE COLON, AND HOW THEY MAY BE OBVIATED.

By HERBERT WM. ALLINGHAM, JUN., F.R.C.S.,

Surgeon to the Great Northern Hospital; Demonstrator of Anatomy at St. George's Hospital.

MANY surgeons commence the operation of lumbar colotomy under the impression that it may be impossible to find the colon, and almost all of us have seen the best operators experience difficulties and even failure in finding the gut. Cases, too, have been reported in which the small intestine has been opened by mistake. Knowing this, and having read Mr. C. B. Lockwood's interesting