paired; the opening near the inner angle of the orbit was discharging; a quantity of bare bone could be felt with a probe.

March 2nd. The eye read Snellen $6\frac{1}{2}$ at eighteen inches and Snellen 50 at twenty feet. The ophthalmoscope showed nothing to account for the impaired vision. The movement of the globe upwards was much improved. Sensation was quite restored in the parts supplied by the supraorbital nerve.

October 12th. All movements of the eyeball were perfect; the globe was pushed somewhat downwards and outwards, but not protruded. There was a sinus at the inner angle of the orbit discharging pus; two small pieces of bone had come away; there was now a small piece, loose, some distance within the sinus. A quantity of bare bone could be felt upon the inner wall and roof of the orbit. Vision was the same. This patient attends occasionally. At his last visit in June, the condition was the same as at last report.

CASE VII. *Tumour of Lower Eyelid, resembling Epithelioma: Removal: no Return after Eleven Months.*—James F., aged 70, was admitted July 7th, 1876. Five years previously, he first noticed a small pimple upon the skin of the right lower eyelid, close to the inner canthus; the pimple gradually increased in size, and began to ulcerate; it was never painful.

On admission, there was a hard nodulated growth, extending outwards from the right inner canthus, involving the inner two-thirds of the lower eyelid. The growth affected principally the skin, but implicated the conjunctivæ close to the inner canthus. Ulceration had occurred in some part of the cutaneous surface of the growth. The edges of the ulcer were thick and everted. The affected conjunctiva had a warty appearance. The growth was freely movable with the eyelid, but appeared somewhat fixed down at the inner canthus.

July 10th. The growth was excised, together with the greater portion of the eyelid. The gap was filled with skin from the cheek; the margin of the upper lid was pared and united to the flap of skin taken from the cheek; the wound in the cheek was closed with hare-lip pins and sutures.

July 13th. The wounds had healed by primary union.

July 31st. Firm union had taken place between the upper lid and the flap of skin replacing the lower lid. The growth, after hardening in Müller's fluid, was found to be made up chiefly of gland-tissue. It contained many spaces filled with cylindrical epithelium, and others in which the epithelium had broken down. It did not infiltrate the skin or deeper tissues, but was intimately connected with the former around the margin of the ulcerated area.

October 19th. The union between the lids was divided. There was some dragging upon the lower one, which had a tendency to become everted.

June 1st, 1877. There was no return of the growth.

REMARKS.—Case I was probably a simple serous cyst, formed by degeneration of a blood-clot. It quickly refilled after simple tapping, but would no doubt have been easily cured by removal of a portion of the cyst-wall, or even by a free incision. The case is interesting as explaining the cause of congestion of the optic disc: "choked disc or ischemia of the disc", as it is called. The condition was here evidently due to obstruction of the venous circulation by pressure, upon removing which the ischæmia disappeared.

Case II is an example of a very rare form of orbital tumour. It is published in the present volume of the *Transactions of the Clinical Society*. There were no points in the history or progress of the case which could in any way lead to a correct diagnosis. The symptoms seemed to point to some deposit in the orbit, which became inflamed, and eventually suppurated. Puncture of the tumour gave only negative evidence, that it was not an abscess. Its nature could hardly have been ascertained until it was removed.

Cases III and IV are instances of a not uncommon form of orbital tumour, which, however, almost invariably commences in the eyeball. It has been said that the sarcomata often affect eyes which have been lost for some time. It would appear, however, that in many cases the growth causes the loss of sight; it commences in the choroid, grows slowly, presently causes detachment of the retina, and with it total loss of sight. As time goes on, the eyeball becomes more or less filled with the growth; at length the tumour bursts, or grows through the sclerotic; it immediately begins to increase rapidly, infiltrating the tissues of the orbit, and causing rapid protrusion and impairment of mobility of the eyeball.

Case V has been introduced to show how sight may be destroyed by a sarcomatous tumour without the presence of any such growth being suspected. This case was looked upon as one of lost, glaucomatous, and painful eyeball; and an operation was accordingly performed, in order to reduce the tension and relieve the pain. Had it succeeded in

its objects, the tumour would have continued to grow until its existence became evident, and it might have then been said to be an instance of sarcoma affecting an old lost eyeball. But as it was, the operation was unsuccessful; the eyeball was excised, and it was found to have been blinded by a tumour the existence of which was not suspected.

Case VI presents no features of peculiar interest. It is an instance of what is known as ivory exostosis, and shows the difficulty to be encountered in the removal of such a tumour, especially if it exist in the orbit. The great danger to be feared was that, on account of the extensive connection of the growth to the roof of the orbit, fracture might occur during its removal. Such an accident would be followed by no untoward results, should it occur in the walls or floor of the orbit; but, in its roof, would very probably lead to most disastrous consequences.

Case VII is an example of follicular sarcoma. It is chiefly interesting on account of its resemblance to epithelioma. Such growths are said to spring from the lacrymal sac; in the case reported, there was a deep attachment in the position of the sac.

MALPOSITION OF TESTIS.*

By A. W. STOCKS, M.R.C.S.Eng., Salford.

THIS interesting case is brought forward rather on account of its rarity than for its being of any great or special practical value. The subject of the peculiarity is a young man aged 24, a policeman, the father of three children. He always fancied that he had only one testicle, and it was only some months ago, when he received an injury to the abdomen in the execution of his duty, and became troubled with symptoms of hernia, that the true nature of his condition was discovered.

The left testicle, which is fully developed, occupies the whole of the normal scrotum, the raphe being placed exactly in the middle line of the testicle, as if it were the natural condition that it (the scrotum) should be occupied by a single testicle only, whereas the raphe usually occupies a position midway between the two testicles. The right testicle, which is only partially developed, occupies (as is shown in the photographs which I have the honour to pass around) a pouch or additional scrotum, separate and distinct from the scrotum proper, situated between the scrotum and the right thigh, and lies upon the descending ramus of the right pubes. The right spermatic cord leaves the abdomen by the usual route through the external abdominal ring, and can be traced down to the abortive gland. A hernia, at the time of the injury above referred to, was protruded from the abdomen and followed the course of the misplaced spermatic cord. This is completely relieved by the application of a truss.

Four cases of irregularity in the progress of the testicle have lately come under my observation.

In the *first*, no testicle ever descended into the scrotum of a youth, aged 19, who died of a large lympho-sarcomatous tumour in the abdomen. Both testicles, which were only partially developed, were found after death resting on the brim of the true pelvis near the bifurcation of the common iliac artery. In this case, both inguinal canals were pervious throughout the whole course.

In the *second* and *third* cases, the testicles, one on the right and one on the left side, were retained within the abdomen, and in both instances a hernia had descended through the patent canal.

The *fourth* case is the one before us.

It would appear, from a consideration of these abnormalities, that the changes which occur during the development of the body have a distinct relation to, and a mutual dependence upon, each other, even where there seems to be little, if any, connection, vascular or otherwise, in the parts implicated in those processes. Thus, in the second and third instances mentioned, the closure of the inguinal canals seems to have been interfered with by the non-transmission of the testes through them.

In the present case, the remarkable irregularity in the course which the testis took in its endeavour to reach its proper destination seems to have depended upon the arrest in the development of the testis itself, and, in the other instances, the patency of both inguinal canals does not seem to have a more rational explanation than that it depended upon the non-descent of the testicles into the scrotum, and their retention in the abdomen was influenced by the non-development of the glands themselves.

* Read in the Section of Surgery at the Annual Meeting of the British Medical Association in Manchester, August 1877.