who was in a worse condition than herself, to come and undergo the treatment. The sister, however, was too ill to be moved, and going to see her at the house, I found she was very far gone in a most rapid form of disease. I persevered with her, but could never find that she benefited in any way, and she died three weeks from the time that I saw her first. The sister continues to keep well.

The fourth case was that of a sailor, aged 53, with a bad family history. There was advanced disease in both lungs, and extreme prostration, and loss of weight had been very rapid. When first put under treatment, he improved somewhat, but soon aphthous patches appeared in the mouth, the unhealthy condition of which seemed only to be aggravated by the spraying of putrid matter into it, and he died in less than a month.

The fifth case, a lady living in Lancashire, I have never seen, but her medical man has minutely described her condition to me, and has sanctioned her undergoing my treatment; she has been suffering for some years, and had nursed a brother dying of the disease shortly before she herself became affected. She has most religiously and minutely followed all my directions, but though her general health has slightly improved, her medical man states there is no improvement in the physical signs of her chest, but rather the contrary. The conclusions I draw from a trial of this treatment are, that the forced deep inspirations necessary are very beneficial in some conditions of the chest; that when diarrhoea is present it checks it, improving the appetite as a rule; that it has a tendency to diminish expectoration, and an influence for good in cases not too far gone, but that in rapid forms of the disease, and where much excavation exists, it is useless.

TOBACCO AMBLYOPIA IN WOMEN.¹

By A. HILL GRIFFITH, M.D.,

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I WISH to make some remarks on a form of bad vision caused by the use of tobacco, and will call your special attention to seven cases occurring in women which I have observed at the Manchester Royal Eye Hospital. All complained of a rather rapid deterioration of vision, and the fundi were either quite normal or only showed very insignificant changes. How then was the diagnosis made certain in these, as it is in all cases of tobacco amblyopia, by the presence of a central colour scotoma? This test is easily applied by causing the patient to cover one eye, while with the other he or she gazes steadily at the eye of the examiner, who then brings a small piece of red or green paper, fixed on the end of a pen, into the centre of the patient's field, and notes the presence or absence of the patient's perception for colour in that part of his field. This test, so easily applied, is, I believe, an infallible test of bad sight produced by tobacco; and, further, I have never met with a central colour scotoma in a person who did not use tobacco, though I ought here to say that some such cases have been recorded. In my experience, then, a case of central colour scotoma is synonymous with tobacco amblyopia. I cannot too strongly insist upon the necessity of applying this test in all recent cases of failure of sight, whether in men or women, where the ophthalmoscope reveals a normal, or nearly normal, state of the fundi, and you will be astonished how large a proportion of such cases will fall under the head of tobacco amblyopia. Hardly a day passes at the Royal Eye Hospital without a case turning up. We must not be thrown off our guard by any slight changes we may find in the fundi, and at once conclude that they are the cause of the defective sight, for they may be only accidental changes in a case of tobacco amblyopia, and have little or nothing to do with the bad sight. For example, in three cases I have seen a solitary retinal hemorrhage confined to one eye, the vision being equally diminished in both; in several, fine vitreous opacities; in others high degrees of myopia with posterior staphyloma, and in one woman I at first imagined the bad sight to be due to the presence of a few very minute white ticks at the maculae which were only made out with difficulty by the erect image. In this case I afterwards found a colour scotoma, and elicited the fact that the patient smoked. Again, I have seen two cases in patients with well-advanced locomotor ataxy, and have no hesitation in saying that it was tobacco, and tobacco alone, that was the cause of the bad sight. Professor Hirschberg, in a paper on Tobacco and Alcohol Amblyopia, in the second volume of the JOURNAL for 1879, says "we never meet with the disease in women," and the only cases I have seen recorded besides my own were published by Mr. G. A. Berry in the *Ophthalmic Review*, April, 1884. I may further add that at the Royal Eye Hospital the first diagnosis of the affection in a woman was made rather less than twelve months ago.

¹ I have written more fully on this subject in a paper on "The Field of Vision," *Med. Chron.*, November, 1885.

ACUTE PERITONITIS: OPERATION AND RECOVERY.

By JOHN W. TAYLOR, F.R.C.S.,

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THE subject of acute peritonitis and its treatment is always interesting. The following case is, I think, especially so from the completeness of its history, the promptness shown by the medical attendant in his diagnosis of the patient's condition, and the success attendant on the operative measures adopted.

On Friday, November 12th, Dr. Leslie Phillips asked me to see a married lady, aged 21, whose previous history was as follows. Her first labour occurred on September 28th, 1886. Forceps were applied for uterine inertia. Three days after delivery, she developed pain and tenderness in the left iliac region, with fever. From this date until the end of October, when the lying-in attendance ceased, she had intermittent feverish attacks, with pain and tenderness in the same situation. On vaginal examination, there was a feeling of resistance on the left side of the cervix, but this was not well marked.

On November 11th, at 11 P.M., while lying quietly in bed, nursing the baby, she was attacked by a sudden pain in the left side of the belly, which caused her to vomit; she continued in pain all night. Dr. Phillips saw her at 12 noon, diagnosed escape of matter into the abdomen (thinking it a phlegmon of the broad ligament, or a pyosalpinx), and, a few hours later, requested me to see the patient with a view to opening her abdomen. At our consultation we found the patient very feverish, her temperature being 104° Fahr., and her pulse 140. There was some distension and great tenderness of the abdomen, and, on examination by the vagina, an ill defined swelling was found behind the uterus, acutely tender to the touch. The uterus itself was fairly mobile, and of normal size. No vomiting had occurred since the morning, but the countenance was anxious, and the condition evidently grave.

Some peritonitis was undoubtedly present, and in all probability this was of pelvic origin. In view of the mobility of the uterus and the absence of continued vomiting, I hardly thought that the symptoms justified a more accurate diagnosis, but, as the sequel showed, the original one formed by Dr. Phillips, of rupture of an abscess on the left side, causing acute peritonitis, proved to be entirely correct. We advised early operation as the only proper treatment for the patient's condition, and her husband very wisely readily consented.

The next morning, November 13th, at half-past nine, I opened the abdomen (Dr. Phillips assisting me, and Dr. Potts giving ether). I found that the lower part of the abdomen and pelvis contained sero-purulent fluid, which welled up into the incision as soon as the peritoneum was opened. The appendages on the left side, together with the intestines, omentum, and uterus, were matted together into a mass in which it was difficult to distinguish the different structures. The omentum and tube were first differentiated, and the Fallopian tube, much thickened and inflamed, was brought to the surface. The corresponding ovary, which was adherent to the top of the uterus, and had therefore been beyond the reach of vaginal examination, was carefully separated, and both tube and ovary were withdrawn outside the incision. The ovary was then seen to contain an abscess in its substance, which had broken by two small ulcerated openings, from which thick yellow pus was freely oozing. The affected ovary and tube were then removed; the broad ligament pedicle, which was very thick and fleshy, being transected and tied in two halves with silk. The ligature cut through the tube, but held the rest of the stump well, so that but little hæmorrhage occurred after the ligature was applied. As the appendages on the right side appeared to be perfectly healthy, these were not interfered with. The abdomen was well washed out with warm water; and, before closing the abdominal incision, a drainage-tube was inserted in the pelvis.

The progress of the case since the operation has been very satisfactory. The drainage-tube was removed on the third day. The patient is now (November 28th) convalescent, her temperature and pulse are normal, and her appetite is good.

To recapitulate briefly the leading features of the case: We have a history of recurrent febrile attacks, with left iliac pain following confinement. Seven weeks after the labour, a sudden attack of acute abdominal pain, accompanied by vomiting, and passing on into symptoms of general peritonitis, in which, however, the febrile element was unusually marked. Proof, on laparotomy that a burst abscess was the cause of this, and rapid recovery on removal of the abscess-sac and cleansing of the peritoneum.