which had remained behind, probably detained in a sacculle of the bladder. The fragments removed weighed 237 grains. The patient made an excellent recovery.

CASE III.—A gentleman aged 77, whom I saw in consultation with Mr. Hakes in December 1880, for some time past had suffered from an irritable bladder, but refused to be examined until his symptoms became suddenly and most acutely painful. I found two calculi. As I have before stated, it was found necessary, in consequence of the extreme urgency of the symptoms, to attempt removal without delay. On December 21st, in the presence of Mr. Hakes and Dr. Lee, without any difficulty, I cleared the bladder of two uric acid calculi; the fragments weighed one hundred and eighty grains. The course of the cystitis appeared in no way altered by the operation, and death took place on December 24th.

CASE IV.—J. O., aged 64, was admitted into the infirmary under my care in December 1880. Under ether, I crushed a phosphatic calculus three-fourths of an inch in diameter, and evacuated the fragments. The patient left the infirmary fourteen days after the operation.

EMPHYEMA: DEATH UNDER THE USE OF ETHIDENE.

By ALBERT MOUILLOT, M.B. Dub.,
Pathologist to the General Hospital, Birmingham.

SAMUEL H., aged 45, was admitted to the General Hospital, Birmingham, on Thursday, February 17th, suffering from effusion in the right pleural cavity. On the 24th, a hypodermic needle was inserted into the thorax for diagnostic purposes, and a syringe of pus withdrawn. Dr. Simon decided on having the empyema opened by two incisions, and a drainage-tube applied. In the evening of the same day, I was asked to give an anæsthetic, which, owing to the man's general condition, I was reluctant to do. However, I decided on giving ethidene, believing its action to be mid-way between that of chloroform, which was too depressing for the case, and ether, which was contraindicated by the trouble of the lung. During the administration, the patient struggled a good deal, but nothing alarming occurred until he was "under", when it became necessary to turn him on the left side to make the incision. He had not been in that position more than two seconds, when I found the pulse and respiration failing; and a glance at the pupils showed them to be widely dilated. The patient was immediately turned on his back; artificial respiration was commenced; and stimulants were applied to the heart—first, by slapping the cardiac region with the hand; and afterwards, by the needle and galvanic current. The only result was to get one long inspiration, which flattered us with hope that he would recover.

At the *post mortem* examination, held on February 26th, I first opened the abdomen, and found the liver pushed down as far as the umbilicus, and crossed by the transverse colon. A trocar with cannula was next inserted in the right side, and seventy-two ounces of pus were withdrawn. The sternum was then removed; and the right lung was seen to be adherent to the ribs, about three inches from the sternum—so that no empyematous cavity could be seen from the front. The apex of the heart reached the sixth interspace. The right auricle and ventricle contained much dark fluid blood; the tricuspid valve admitted four fingers. The left ventricle was empty. The right lung was adherent to the anterior chest-wall and diaphragm. The pleura was much thickened, and covered with shaggy lymph. The lung was collapsed, or airless. About ten ounces of pus remained in the cavity. The lung was much engorged with blood. A pyramidal abscess was found in the portion of the lung corresponding to the middle of the axillary line, which abscess was surrounded by a patch of pneumonia. A small abscess, connected with the periosteum of the frontal bone, was seen when the scalp was removed. All the other viscera were normal. Microscopic examination of the heart showed no fatty degeneration.

REMARKS.—I do not bring this case forward as any argument against the use of ethidene—an anæsthetic which, since the report of the Glasgow Committee appeared, I have used frequently; but I should like to elicit opinion on the advisability of administering any anæsthetic in these cases. The operation is painful, and sometimes prolonged; but, on the other hand, the danger is great, particularly when, as in this case, the other lung is diseased. My own experience extends only over three other cases. In one, ether was given, but had to be stopped on account of cough. In the second, a young girl of twenty, chloroform answered very well. The third, a middle-aged man, took ethidene, and had respiratory trouble during administration.

COLOBOMA OF THE CHOROID AND IRIS.

By W. C. ROCKLIFFE, M.A., M.D., Ophthalmic Surgeon, Hull.

CONGENITAL deficiency of the choroid being a somewhat uncommon occurrence, any case differing in the slightest from the accepted usual conditions is of interest.

A. B., a male child, aged 4, was brought to me by his mother, who stated "she wished to know whether her fears were correct"—viz., that the child was permanently blind. His family history was good, and I could elicit no case of affected vision (other than presbyopia) in any other member or branch of the family. He had three brothers, and one sister, perfectly healthy, and free from any malformation. According to his mother's statement, "from infancy, the two first years of his life were despaired of, he being almost continually delirious, and apparently blind; suffering from, as his medical attendant described it, 'water on the brain'." Since this time to the present date (two years), the child had enjoyed perfectly good health, and was most intelligent. When I first saw him, he had a well-fell healthy appearance, with somewhat a large head; but no visible signs of disease or defect, except coloboma of the right iris, and nystagmus in both eyes. The cleft in the iris had been noticed since birth. The vision was not easy to test, but seemed somewhat myopic in the left; while there was no perception of light in the right eye, except possibly at the extreme periphery.

Ophthalmoscopically, there was a slightly myopic appearance, with some haziness in the lower half of the fundus in the left eye. In the right eye, there was a large coloboma of the choroid, presenting the usual white surface, glistening from the lower part of the fundus, and extending upwards, embracing the disc and yellow spot; anteriorly reaching nearly to the cleft in the iris. The bulging backwards of the sclerotic appeared uniform throughout, and the retina in apposition, except at two small spots; while the boundary of the coloboma was most distinct, with a dark claret-coloured margin, round which the retinal vessels wound, and beyond which the fundus gradually merged into a healthy appearance, which latter condition was only seen at the extreme periphery. The disc was altogether indefinable; and the vessels twisted in an irregular and disconnected manner all over this white space. Where the coloboma of the choroid approached that of the iris, was a dark narrow band, possibly small rudimentary ciliary processes, as suggested by the late Mr. Soelberg Wells.

The general appearance (although larger) much resembled the engraving in Liebreich's *Atlas of Ophthalmoscopy*, except that the vessels crossing the coloboma appeared shorter, more tortuous and disconnected, and the coloboma whiter.

The coloboma of the iris was situated, as usual, at the lower and inner portion of the iris; pyriform in shape, the base toward the pupil. It was confined to the right eye, and was associated with no other congenital deficiency except that of the choroid.

This case is of interest in that it deviates somewhat from the usual, although by no means certain, conditions. 1. The macula lutea and optic nerve were both implicated and indefinable. 2. The coloboma affected only one, and that the right eye; it having been stated that usually both eyes are affected, or if only one, the left. 3. No deficiency or arrested development presented itself in any other portion of the body; and it was associated with no congenital cataract or defect except nystagmus.

HASTINGS.—The population of Hastings is now estimated at 40,400; and amongst this number of persons, there were 1,097 births and 734 deaths in 1880, equal to rates of 27.15 and 18.16 per 1,000, against rates of 26.97 and 16.84 in 1879. The infant mortality is still very high, those dying under five years of age numbering no fewer than 285, or more than one-third of the total deaths. The reason unquestionably is, in Mr. Ashenden's opinion, the increasing use of artificial foods, which are really little better than common starch. The deaths from zymotic diseases were considerably above the average, no fewer than 60 persons having died in the June and September quarters from diarrhoea alone. "Teething, want of breast-milk, and injudicious feeding, were credited with the specific origin of the disease." In consequence of the prevalence of scarlet fever in the suburbs of London, cases were continually cropping up in different parts of Hastings, chiefly among the middle and upper classes of visitors. Mr. Ashenden, while admitting the usefulness of the existing sanatorium, urges the provision of a building more capacious and better adapted for the treatment of more than one zymotic disease at a time. Constitutional diseases caused 135 deaths, local diseases 362, and developmental diseases 111. A good deal of unpretending sanitary work seems to have been got through,