any attempt at operative interference. It is worthy of note that, in the recorded cases in young children, the tumours have been, as in this case, dermoid, and probably congenital.

I have recently heard that my little patient is in all respects strong and well.

A CASE OF COMPLETE SYMBLEPHARON SUCCESSFULLY TREATED BY OPERATION.*

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I AM induced to bring the following case before the notice of the profession on account of its comparative rarity, and because, until within a recent period, when Mr. Pridgin Teale of Leeds suggested his ingenious method of conjunctival transplantation, complete symblepharon was found to be practically incurable.

J. S., aged 19, was admitted to St. Mary's Hospital on the 20th of June last. His right eye presented the appearance figured in the accompanying sketch, which was made before his admission. The

centre of the lower lid was firmly and extensively adherent to both the cornea and sclerotic, so that there was a condition of complete symblepharon; and it was impossible to pass even the finest probe between the attached surfaces. The movements of the globe were consequently extremely limited, causing a painful dragging sensation, and the eye was practically useless. The cause of this condition was an extensive burn from lime, which the eye had sustained nine years previously. I felt sure that any attempt to separate the lid from the globe without covering the raw surfaces with some protecting membrane would inevitably result in a firmer and more contracted adhesion than before. I therefore determined to adopt, with some slight modifications, the method of conjunctival transplantation which Mr. Teale had not only suggested, but successfully practised.

The patient having been placed under the influence of an anæsthetic, I carefully dissected the lid from the cornea and sclerotic, continuing my incision as far as the retrotarsal fold. I then separated two flaps of ocular conjunctiva, the width of each being rather more than a quarter of an inch, and I was careful not to include the subconjunctival tissue. The first flap, taken from the inner and upper surface of the eye, was gently brought round and across till it covered the raw surface on the sclerotic, and was united with very fine silk sutures to the cut edge of conjunctiva which had been created by the original incision. The second flap, taken from the outer surface of the eye and at a lower level than its fellow, was made to cover the wound in the sulcus at the bottom of the lid, and was there fixed *in situ*. I had still, however, to unite the free conjunctival edges on the upper and inner surface of the lid; and this proved somewhat difficult to accomplish, owing to the wide separation between the opposing margins. By slightly freeing from its attachments the conjunctiva which lined the lower lid, and being ably seconded by my assistants, who carefully approximated the borders of the wound with forceps, I at length succeeded in uniting the cut edges of the conjunctiva. This led to a slight puckering of the lid, but the parts rapidly accommodated themselves to the situation, so that, in the course of a few days, this condition was no longer apparent.

The result of the operation was to secure a complete and permanent separation of the lid from the globe of the eye to the normal extent. In effecting this object, I found it desirable to insert no fewer than nineteen sutures, composed of the finest silk; and this of necessity rendered the operation somewhat tedious.

* The patient was shown, six weeks after the operation, in the Ophthalmic Section of the International Medical Congress.

The patient made an excellent recovery, the parts uniting rapidly and completely; and the globe has regained its natural powers of free movement.

The points of difference between my operation and that originated by Mr. Teale are: in the first place, that I dissected the adherent lid in its entirety from the surface of the cornea, instead of, as he recommends, commencing my incision at the corneal margin, and so leaving part of the lid adherent to the cornea; and, secondly, that I accomplished my object partly by transplantation and partly by co-aptaion.

THERAPEUTIC MEMORANDA.

IS SALICYLIC ACID A SPECIFIC FOR ACUTE RHEUMATISM?

THE fact that great divergence of opinion exists with regard to the effects of salicylic acid in the treatment of acute rheumatism, induces me to call special attention to this question, and to ask whether, in those cases in which—after a sufficiently large dose—the remedy has appeared to fail, or unpleasant symptoms have followed its administration, these may not have been due to the use of artificial salicylic acid, prepared from carbolic acid, and possibly contaminated with carbolic acid or with paraoxybenzoic acid? The artificial acid is, I believe, largely used in various London hospitals; and possibly the use of this preparation instead of the true acid, obtained from oil of wintergreen, may explain the difference. I have been careful not to prescribe the artificial acid; and, after nearly five years' experience of the effects of the true acid, and since giving it in sufficiently large doses, I am thoroughly satisfied with the results, regarding it, in fact, if given in a proper fashion, as such a specific for acute rheumatism as quinine is for ague. At Addenbrooke's Hospital, I prescribe it in doses of twenty grains every hour until the head is affected and the patient's joints can be moved without pain. The dose is made up into six pills, with a little glycerine and pulvis acacie. From eighty to one hundred and twenty grains must generally be given, before the physiological effects show themselves. The following day the same amount is usually administered; and, after the temperature has declined to the normal point, forty-five to sixty grains are daily administered until all risk of a relapse has passed away. With such an experience, then, I should be glad to see full reports of cases in which unpleasant symptoms—such as sickness, collapse, etc.—have followed the administration of the true acid, in doses such as I have above mentioned, for I must confess myself to be somewhat of an unbeliever in their existence.

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SALICYLIC ACID IN ACUTE RHEUMATISM.

OF late years, few subjects have received more attention than that of the administration of salicine, salicylic acid, and salicylate of soda, in acute rheumatism. I believe we may safely conclude that the efficacy of these drugs, especially the last, in rheumatic fever, is now fully established. There have, however, lately come under my care several cases in which these remedies have not only proved useless, but positively injurious; and I have, therefore, been led to the conclusion that we should not prescribe them indiscriminately, or without taking into consideration the nature of the case and the constitution of the patient before us.

The following is a good example of one of the classes of cases in which salicylate of soda is not applicable, or at least in which it should be used with extreme caution. In February 1880, J. C., aged 22, came under my care suffering from acute rheumatism with endocarditis. The patient was of a slight build and delicate constitution, and had had a previous attack of the disease; but it had not left any organic lesions behind. When I saw him, the joints were only slightly affected; and pyrexia was not very marked, the temperature being only 101.5°. He, however, complained greatly of oppression about the chest, of difficulty of breathing, and of considerable tenderness over the præcordia on stethoscopic examination. On auscultation, there was heard a distinct systolic murmur over the apex; and this was also distinguishable in the left axilla, and at the inferior angle of the left scapula. As the disease had only appeared two days previously, I placed him on fifteen-grain doses of salicylate of soda. From this time, low typhoid symptoms began to manifest themselves, and on the third day of treatment he appeared in an almost moribund condition. He was semicomatose, had low muttering delirium, and presented all the other symptoms of the typhoid state—viz., dry brown tongue, rapid feeble pulse, subsultus tendinum, etc. With very little hope of