recovery, on August 30th, the pains being chiefly confined to the right ankle and knee; the fever-heat ranged from normal in the mornings, to 101.4° (the highest on four occasions) in the evenings, and the pulse from 80 to 100.

REMARKS.—The case exemplifies in part the failure of salicine to relieve pain, prevent pericarditis, or act as a febrifuge. Three drachms were taken daily for two days; and on the third, the day of the first high temperature (104° in the evening), two drachms were administered. This dose I have generally found adequate, in cases where it suited, to relieve pain and reduce the temperature, although Drs. Mac-lagan, Ringer, and others advise much larger doses, and more frequently repeated. It is a matter for consideration if the diarrhoea, which lasted for two days (July 30th and 31st), and the alkalinity of the urine on August 1st, were in any way connected with the drug. Ringer suggests the possibility of the latter, though he gives no grounds for the suggestion. The chief interest of the case lies in the hyper-pyrexia, and the instantaneous benefits derived from cold applications. The assiduous application of towels wrung out of cold or ice-cold water—a method suggested by Dr. Sydney Ringer—has the following advantages over immersion in the cold bath. 1. The means are ready at hand on every emergency, and can be used without any delay, and without assistants. 2. They do not alarm the patient or his friends. 3. They can be applied without the exposure necessary in a bath, and the pain and fatigue consequent upon being lifted in and out of a bath, and being dried before returned to bed. 4. The reduction of the temperature can be more readily watched and more accurately gauged by cold cloths than by immersion in a bath, and seems to be quite as prompt. In the case given above, it fell from 107.2° to 103.8° in forty minutes (the pulse coming down from 136 to 120), and it continued to fall to 100.6° during the subsequent three hours. Another, and not the least point of interest, lies in the absence of any ill consequences to the inflamed pericardium or joints by the application of external cold.

DERMOID OVARIAN TUMOUR IN A CHILD AGED SEVEN YEARS: OVARIOTOMY: RECOVERY.

By J. KNOWSLEY THORNTON, M.B., C.M.,
Surgeon to the Samaritan Free Hospital for Women and Children.

On April 5th, 1881, I was asked by my friend and colleague Mr. Meredith to see, with him, a little girl seven years of age, the subject of a large abdominal tumour. The patient had been brought from the United States to this country by her parents for further advice; several distinguished physicians who had seen her in the States having given an unfavourable prognosis, both as to the nature of the tumour and as to the advisability of attempting its removal.

We found the right side of the abdomen occupied and much distended by a firm elastic tumour, some parts of which were as hard as bone, while others were quite soft. No distinct fluctuation could be made out. The tumour was most prominent to the right of, and above, the umbilicus; but it occupied the whole of the right side of the abdomen. A narrow band of clear percussion was found between the liver and the tumour, between the pubes and the tumour, and far back in the right flank. The left side of the abdomen was everywhere clear; and along the left upper border of the tumour some distended coils of intestine could be traced, apparently adherent to the mass. The tumour possessed considerable mobility; so that, when the patient turned on to her left side, its position became more central, and the clear area in the right flank was increased. The general health of the little patient appeared very good; and she suffered little, if any, pain or inconvenience from the tumour.

History.—The mother first noticed increase of size in the summer of 1880; and there was then, just above the pubes, a central mobile tumour about the size of an orange. On October 13th, 1880, while running on the grass, the patient fell forward on her abdomen. The fall was not a violent one; but it was followed by some immediate collapse, and subsequently by severe general peritonitis, which began to subside at the end of a fortnight. When the tympanitic distension had quite passed off, a hard tumour was found, nearly filling the right lateral half of the abdomen. Careful measurements showed that this tumour steadily increased in size for some time, and then became almost stationary. Careful examination and consideration of the case led Mr. Meredith and myself to exclude the question of renal or hepatic tumour, and incline to the view that it was ovarian; but we could not decide whether it was a dermoid tumour or a malignant growth—the general health of the child, together with the history, seeming to us to suggest the more favourable view; while the rapid growth and peculiar outline and varying consistency made us fear the possibility of its

proving to be a mixed sarcoma. We advised that a careful antiseptic puncture should be made in the softest portion of the tumour, and that further proceedings should be guided by the information thus obtained. We also advised that Sir James Paget should be asked to see the case with us; and he accordingly joined us next day, and agreed with us both as to alternative diagnosis, and to the advisability of making an antiseptic puncture. Two days later, Mr. Spencer Wells joined us in consultation; and, Mr. Meredith having administered bichloride of methylene, I punctured with a No. 3 trocar under the spray, and obtained a few drops of glairy mucoid fluid, which we all thought to be probably ovarian. The ovarian granule-cells were found under the microscope; as were also some large round granular cells, which did not aid us in our diagnosis.

It was now agreed, in a consultation in which Sir James Paget and Mr. Spencer Wells took part, that an exploratory incision should be made antiseptically; and that, if the tumour proved to be malignant, nothing more should be done.

I entered in my case-book the following diagnosis: 1. Dermoid ovarian tumour, probably with twisted pedicle, and certainly with rupture and consequent adhesions; 2. Sarcoma of ovary, bone-cartilage, etc., alternating with small cysts.

On April 14th, Mr. Meredith again administered bichloride of methylene; and, in the presence of Sir James Paget and Dr. Meyer of Copenhagen, and with the kind assistance of Mr. Spencer Wells, I performed ovariectomy. Commencing with a three-inch incision above and to the left of the umbilicus, but nearly in the median line, I gradually extended it to six inches, and exposed a dermoid ovarian tumour covered with adherent omentum. Tapping yielded some colloid material mixed with lumps of white fat. Having enlarged the trocar-opening, I introduced my hand, but could not reduce the size of the tumour much, as the cysts were numerous and small, and my hand everywhere encountered large masses of bone. Having gradually cleared the tumour of numerous masses of adherent omentum, some very close to intestine, and divided some very dense adhesions to the parietes on the right side, and temporarily secured them all with Wells's pressure-forceps, I raised the tumour out of the abdomen, and exposed a long, thin, and broad pedicle to the left of the uterus, doubled up, but not twisted. I transfixed it with No. 3 silk; and, tying the inner loop first, to save loss of blood, I tied the outer half separately. I then carried one loop round the whole, and, cutting off the ligatures close to the knots, cut away the tumour. Numerous fine silk ligatures were applied on the omental, mesenteric, and intestinal adhesions, including the appendix cæci; and a large mass of adhesions on the right parietes was treated by a ligature run in and out, and tied up bag-mouth fashion. Altogether, there was a good deal of exposure to the spray and sponging. The right ovary and uterus were quite healthy. The wound was closed with a dozen fine silk sutures, and my usual carbolic gauze dressing was applied. The tumour weighed 4 lbs. 3 oz.; the operation lasted one hour. The patient had ten minims of tincture of opium in a little starch administered by the rectum as she was placed in bed. The temperature was then 97.0°, pulse 120, respirations 36. There is little to record in the after-progress of the case. The temperature remained over 100° Fahr. for two days, and then gradually fell to normal on the third day, and did not again rise above 99.0°.

The catheter was used for the first twenty-four hours. Tincture of opium and bromide of potassium were given *per rectum*, as indicated by the condition of the patient. The only period during which the case gave any anxiety was during the third twelve hours after the operation (*i.e.*, the afternoon and evening of the first day). During this time, the skin was inclined to dry; the patient was restless, and suffered a good deal from mucus in the chest, which was with difficulty expectorated; the temperature for four hours was 102.4°, the pulse 130 to 140, respirations 36. Hot water used as an emetic cleared the lungs, and the other unfavourable conditions rapidly subsided. Flatus passed well from the first, and there was very little sickness; but for some days I thought it well to feed by the rectum. On the third day, she began to enjoy milk, and on the fifth began solid food. The bowels acted after an enema on the sixth day. The wound was dressed for the first time, and all the sutures removed, on the tenth day; the patient was out of bed on a couch on the fifteenth day; and two days later she was allowed to sit up and to walk about.

The case is interesting, as one of a very small number on record in which an ovarian tumour has been found in so young a child, and the still smaller number in which ovariectomy has been performed. It was an unusually difficult one as regards diagnosis; the balance of probabilities was, however, in favour of its being a dermoid ovarian tumour. The result of the operation proved the wisdom of the decision at which we arrived, to make an exploratory incision. It would, indeed, have been a calamity, if the little patient had been allowed to die without

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.*

By ANDERSON CRITCHETT, M.A.CANTAB.,

Ophthalmic Surgeon to St. Mary's Hospital, and Lecturer on Ophthalmic Surgery at St. Mary's Hospital Medical School.

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 retrolarsal 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-aptation.

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.

P. W. LATHAM, M.D., F.R.C.P., Downing Professor of Medicine in the University of Cambridge.

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