and left sides of the lip in the usual manner. This having been done, there remains a part redundant and a part deficient. The central part of the lip is redundant; because, being adherent to and deriving its nourishment entirely from the tip of the nose, it cannot be made available in the formation of the lip, and accordingly Mr. Erichsen advises

F

that it be carefully dissected away. The part deficient is the *columna nasi*, and it occurred to me that in the central portion of lip we have exactly what may be used to remedy that deficiency. I would recommend that the operation be divided into two stages, the first consisting of removal of the protruding bone and the junction of one or both nostrils to the central part of the lip, the second being the ordinary operation of hare-lip, and the implanting of the *columna* into the upper part of the lip.

Hitherto I have attempted to remedy the defect by means of a single operation; but in two cases, while the *columna* adhered to the nostrils, and the edges of the lips also adhered to each other, the *columna* did not adhere to the upper edge of the lip, and required a second operation for that purpose. In the last case on which I operated, the child had a violent attack of diarrhoea on the fourth day, and the *columna* ultimately adhered to the left nostril and to the left segment of the lip, but the union between the right nostril and the edges of the lip gave way. The little patient made a very narrow escape from death from diarrhoea, and for the space of two or three months I did not consider her in a fit state for operation. Subsequently I performed the operation as for single hare-lip extending into the cavity of the nostril. The deformity was more completely remedied than in any of the other cases on which I have operated (one of which is represented in figure 4). But the child was of a weakly constitution, and died rather suddenly of diarrhoea a few weeks afterwards, without my having had a photograph taken.

I have thought it worth while to bring forward this subject; because I consider that, in a practical point of view, the saving of the central portion of lip, and converting it into a *columna nasi*, are much preferable to its excision. I have been surprised at the little deformity which remains after the adoption of this proceeding. Secondly, I consider these cases as very suggestive in a biological point of view. Here we have not only the intermaxillary bones separated from the maxillary in the human subject at birth, but they are also carried forward to and beyond the tip of the nose, requiring only the intervention of osseous matter to fill the chasm and constitute the true snout of the lower animals. Is this curious deformity one of the missing links which connect man with the lower order of creation? Or, like the occasional hooflets which, occurring in the horse, are supposed to point to his descent from the fossil hipparion, does it point to our descent from some unknown and remote progenitor, the congener perhaps of the hipparion, in whom the premaxillaries were permanently developed and projected beyond the organs of smell?

SECTION OF THE ORBICULAR MUSCLE AND INTEGUMENT AT THE OUTER CANTHUS, AS A PRELUDE TO EXTRACTION OF CATARACT.

By EDWIN CHESHIRE, Esq., F.R.C.S., Senior Surgeon to the Birmingham and Midland Eye Hospital.

BEFORE operating for extraction of cataract, I have recently been making a section at the outer canthus through the fibres of the orbicular muscle and the integument; and I have found so much advantage from the proceeding, that I wish to submit the plan to the notice of my professional brethren, in order that it may be more fully tested. I have done five extractions on this method at present, and in every case complete success has resulted.

The advantages attending division of the orbicular muscle at the

outer canthus, before making the corneal section, are, more extensive exposure of the globe, which enables the operator to manipulate his instruments, and to make his section through the cornea with greater ease. And the spasmodic contraction of the orbicular muscle being overcome, the operator is left to complete his operation at his leisure; while all risk of sudden protrusion of the lens, followed as it sometimes is by prolapse of the iris and escape of the vitreous is almost entirely avoided; and the contraction of the lids on the globe, which is sometimes a troublesome symptom in the after-treatment of cataract-extraction, is prevented.

With division of the orbicular muscle, the wire speculum, which greatly facilitates each step of the operation, may be used without injury or annoyance to the patient. No sutures are required, as the divided surfaces readily unite, and scarcely leave a trace behind them. All that is necessary to be done is to keep the eyelids nicely in apposition for a few days after the operation by means of strips of court-plaster. All bandages and other coverings after extraction are to my mind objectionable, as it is important to have the fullest opportunity of examining the appearance of the lids without disturbing the patient by the removal of external appliances. Moreover, the support afforded by the lids to the corneal flap, when nicely kept in position by strips of court-plaster, is very agreeable to the patient. Spasm may be brought on, and the partially healed corneal flap may be opened, by the removal of bandages, wool, etc., which may have become adherent to the lids.

The operation is done as follows. A wire speculum is placed between the lids, to enable the operator to make his section through the muscle and integument at the external canthus with precision and ease. I have made no allusion to the mode of extracting, as the plan I propose is equally applicable to all extractions. Suffice it to say, that I always use Graefe's knife; and that Graefe's or Liebreich's operations are selected, as may appear most suitable to the particular case. I never use chloroform or ether in extraction, as the sickness which frequently follows their administration far outweighs any advantage that may otherwise result from the use of anæsthetics during the operation; and with the orbicular section, the globe being more under control, they are still less required. Where great neatness is desired, the section may be made subcutaneously.

REMARKS ON PSORIASIS.

By A. S. MYRTLE, M.D.,

Consulting Physician to the Harrogate Bath Hospital.

WHEN I hastily penned the remarks which I made on psoriasis, and ventured to differ with Mr. Balmanno Squire when he published the view he holds that it is the leprosy of Scripture, I had no idea that my comments should have rendered it needful for me again to request a little space.

With all deference to Mr. Squire, his reply is, in my opinion, no answer to my letter, and does not say one word in further support of his "dogma"—very much the contrary; for what are we to understand by the fact that, whilst in his first letter he bases his argument on the assertion that "psoriasis is the only disease I have seen that fairly corresponds to such a description"—namely, "a leper as white as snow"—the disease most dreaded by the Jew, because, according to the Levitical laws, its existence deprived the individual of all social privileges and estate,—in his second letter, when passing judgment on my statement regarding the presence of psora acting as a barrier to a girl's full intercourse with her fellows, or to her entering into marriage, he speaks of it as if leprosy were of no importance whatever, and chaffingly asks the question, "Are blooming healthy individuals at such a discount, even with the drawback (*if it be one*) of a patch or two of psoriasis?" Does he mean to say that the presence of these patches may prove ornamental? I am at a loss to know what he means.

I am equally at sea when he says, "If it be not profane to think that the constant maintenance of the varied and undeviating laws of Nature is a greater miracle than any conceivable deviation from them." Is he speaking of the laws regulating the heavenly bodies, or those affecting the skins of his Jewish acquaintances and patients? and, if the latter, are they undeviating?

I never heard before of emotional eruptions of psoriasis, and cannot see what connexion there is between abortion through mental influences and cutaneous diseases.

Because I hold very different views regarding psoriasis, and decline to accept a dogma which Mr. Squire brings before the profession, am I bound to furnish him and the readers of the JOURNAL with the means which I have had at my command whilst investigating the sub-

ject, to enlighten him as to the number or nationality of my patients? or do I give him any cause to charge me with "voluntarily putting myself into any other attitude of mind than that of assuming", when I say that, as far as I have been able to ascertain, race has nothing to do with it (psoriasis)?

The remarks upon the present London fashionable toilette are, to a country practitioner like me, most novel and instructive. Unfortunately, in this primitive district we are still in very low-bodied frocks and very short sleeves; and it may be years before square-cut bodies—the *de rigueur* of evening dress which Mr. Squire so artistically describes—may reach us. Meanwhile, we shall live in hope.

I quite believe Mr. Squire has met with too many persons who have steadily persevered with a course of Harrogate and many other mineral waters for months without benefit; but may I ask him kindly to take into consideration this one circumstance? Each and all of these patients had persevered for years with the usual remedies before they tried mineral waters. One patient presented himself to me the other day. He produced a bundle of what he styled old and new prescriptions, commencing October 3rd, 1864, and terminating August 1872. During this time he had been ringing the changes on mercury, antimony, arsenic, iodide of potassium, colchicum, with less potent drugs, such as iron, sarsaparilla, nitric and other acids, alkalies, etc., under the able advice of the late Mr. Startin, not only without benefit to the eruption, but with the loss of general health.

REPORTS

OF

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS OF GREAT BRITAIN.

UNIVERSITY COLLEGE HOSPITAL.

ACUTE PULMONARY TUBERCULOSIS WITH ALMOST COMPLETE ABSENCE OF PYREXIA.

(Under the care of Sir WILLIAM JENNER, K.C.B.)

J. W., a dressmaker, aged 40, single, was admitted on September 3rd. She had suffered from cough in winter for several years, and for the last year or two a slight dry cough had persisted during the summer. She had always lived well, and, although never very strong, had enjoyed good health until about two months before admission, when her cough became more troublesome, the expectoration more abundant, and she began to perspire at night. She soon lost strength, and was obliged to give up work. Her father died of phthisis. On admission, the patient was much emaciated and very weak, and of well marked tubercular build. There was some dyspnoea. On examining the chest, there was found marked dullness at the right apex with bronchial breathing and occasional coarse crackling; below there was harsh breathing with finer *râles*, except at the base posteriorly. There was deficient resonance over the whole left lung; absolute dullness at the apex, where also the breathing was almost tubular with large *râles* at the end of inspiration; below this there was bronchial breathing with moist *râles* down to the base. She rallied a little after admission, but soon began to suffer from occasional attacks of diarrhoea, lost ground slowly, and died on January 12th.

The remarkable feature of her case was her temperature. Up to December 6th it was occasionally below 98 deg., but never above 99 deg.; she had then a slight febrile attack which lasted three days, but the highest temperature was only 100 deg. Again, from December 20th to December 30th, the thermometer varied from 99 deg. to 100.6 deg.

Necropsy, January 13th.—The lungs were everywhere firmly adherent. On section, the right lung was studded with tubercles, which were far more abundant at the apex than at the base. The apex contained a few small cavities, the largest not bigger than a small bean; the tissue between solid and pigmented, containing opaque and softening tubercles. Lower down the tubercles were grey, semitransparent, and firm, evidently recent; the tissue between was crepitant, and here and there emphysematous, especially at the base; no appearance of recent pneumonia; lung-tissue everywhere tough. The left lung was small and contracted; there was a cavity of the size of a small apple at the posterior part of the apex, more tough, solid, non-crepitant tissue than in the other, and fewer distinct grey granulations. The spleen was somewhat large and soft; it weighed nine ounces. The other organs were tolerably healthy.

In the course of the *post mortem* examination, Sir William Jenner made the following remarks.

The relation of pyrexia to phthisis is a point which has been hotly disputed, and probably will be for some time to come. The question whether tubercle is itself a product of inflammation, or whether the inflammation is only a secondary process, has given rise to much difference of opinion amongst pathologists; but there is another aspect of the question which is of far greater importance to us as practical physicians—viz., is fever an invariable and necessary companion of acute tuberculosis? can we ever diagnose from the presence or absence of elevation of temperature that tubercles are or are not in process of formation within the body? Some have asserted that the mere fact that a person's temperature was found, after careful observation, to keep within the normal limits, was absolute proof that the patient was not the subject of active tuberculosis. The truth of this statement has lately been questioned, and, I think, justly. It is in reference to this point that the records of cases like the present are valuable. Here is a woman who, after suffering for several years from pulmonary catarrh, becomes at last, as so often happens, the subject of acute deposition of tubercle, which carries her off in about six months. Yet during the four months she has been in hospital there has been an almost complete absence of pyrexia. Her temperature has been taken at least twice every day, and until the last month it has been uniformly below 99 deg. Only during the last four weeks has she had two febrile attacks, lasting a few days each. I must say that now I see the state of the lungs, I am myself somewhat surprised; I should scarcely have thought that such an amount of tubercle could be deposited with so little elevation of temperature. No doubt a continuance of pyrexia without evident cause is of value in leading us to watch for evidence of the presence of tubercle; but, after what we have seen to-day, I do not think that any of us will be likely to rely too much on the absence of pyrexia as conclusive evidence of the absence of tuberculosis.

BIRMINGHAM GENERAL HOSPITAL.

SEVERE AND CHRONIC ODONTALGIA CURED BY A SINGLE LARGE DOSE OF QUININE.

(Under the care of Dr. WADE.)

MATILDA W., aged 17, a domestic servant, was admitted on November 1st, 1872. For three months she had had very severe pain in the teeth. At first, those of the upper jaw were mostly affected. During the three weeks preceding her admission, the pain had been confined to the left half of the lower jaw. The pain always precluded all hope of sleep if it came on in the evening. The teeth were very defective in the upper jaw. On the right side all but the incisors were wanting; on the left the first bicuspid and first molar were absent. In the lower jaw, on the right half the first and second molar, and on the left half the second molar, were wanting. All that remained of the other teeth were simple stumps, much decayed and discoloured. The general health of the patient had been pretty good; the various functions were well performed. She was ordered to take at once a draught containing twenty grains of sulphate of quinine, with dilute sulphuric acid, in an ounce of water. The draught produced cinchonism, with speedy and great relief to the pain, which in the course of thirty-six hours had entirely subsided. She remained as a patient for a fortnight, when she was discharged, having taken no other medicines, and having had no return of the pain.

Dr. Wade drew the attention of the students to the success of the treatment in this case, and stated that a sufficiently large dose of quinine will almost invariably cure odontalgia, even when the teeth are destroyed to so great an extent as they were in this case. Over odontalgia caused by inflammation, or abscess at the extremity of a fang, quinine exerts no influence. The dose required to remove the pain and produce cinchonism varies considerably from fifteen to thirty grains; and it is worth notice that, whereas a sufficiently large dose will cure the odontalgia, an insufficient one, although a large dose, will not alleviate the pain at all.

ACUTE BRONCHOCELE.—In the *Archiv der Heilkunde*, vol. xiv, No. 6, Ludwig (of Pontresina) describes the case of a gentleman who, after suffering from violent paroxysms of cough for some days, was suddenly seized with a swelling on the front of the neck, which impeded respiration. There was found to be an elastic swelling extending downwards from four centimeters below the middle of the thyroid cartilage nearly to the sternum, and to the sterno-mastoid muscle on each side. In the course of a few hours, it increased to the size of a child's head; the dyspnoea became more intense, and deglutition was difficult. There was no pulsation in the tumour. Soon, however, it began to diminish; and the next day it had entirely disappeared. Ludwig regards the case as one of acute hyperæmia of the thyroid body, but cannot assign a cause.—*Berliner Klin. Wochenschr.*, March 3rd.