what was the duration of the tubercular disease, and whether a greyhound could win a coursing match with tubercles in his lungs?

Master Magrath's last appearance in public was at Altcar, in February, 1871, when he carried off, for the third time, the Waterloo Cup (sixty-four dogs), and gave to Ireland the credit of having reared the most wonderful greyhound that ever lived. In October last he ran a private trial course with his kennel companion, "Master Nat", and beat him so cleverly that he was removed from the stud, and put in training for the Waterloo Cup of 1872.

It appears almost certain that the race in October must have been run when the tubercles had already begun to form in the lungs; and it is very remarkable to note, that surprising muscular efforts are compatible with fatal tubercular disease in the lungs. Amongst ourselves it is well known that the most brilliant brain-work is consistent with fatal tubercle.

The condition of the heart was examined by me with the greatest care; the semilunar aortic and pulmonary valves were tested under high water pressure, and found perfectly staunch; and the tricuspid and mitral valves were carefully dissected, and found to be perfect in every respect; the muscular tissue of the heart, and the pericardium were in every respect healthy. The following measurements were made by me:

1. Weight of heart	9.57 oz. av.
2. Diameter of aorta*	0.732 inches
3. Diameter of pulmonary artery*	0.796 "
4. Mean thickness of right ventricle†	0.20 "
5. Mean thickness of left ventricle†	0.96 "

The average weight of man's heart is 9.39 oz. and the average weight of man is 150 lbs. Master Magrath's running weight was 54 lbs., from which it appears that the celebrated "black" possessed three times the heart force of a man. I believe that Master Magrath's great heart (like the Nazarene locks of Sampson's hair) was the real cause of his extraordinary running powers.

3. *Cephalic Cavity.*—The brain was found to be congested, the result of the pneumonia, and it was found to weigh 3.87 oz. av. On comparing the brain with such other brains of dogs, as I was able to procure, I consider that its convolutions are somewhat better marked than usual.

In conclusion, I request the readers of the JOURNAL to send me the weights of heart and brain of any greyhound they can procure; or, still better, to put the dead greyhound in a box, and forward him to my address, Anatomical School, Trinity College, Lincoln Place, Dublin. I shall return my best thanks to the donors, and gladly pay the expenses of transmission.

PRACTICAL OBSERVATIONS ON OPHTHALMIC AND AURAL SURGERY.

By ERNEST HART, Esq.,

Late Ophthalmic and Aural Surgeon to St. Mary's Hospital.

I.—PHOTOPHOBIA IN SIGHTLESS EYES.

In arranging lately my note-books of the last ten years, I have marked a few cases which seemed to me to suggest some useful hints in practice. I propose briefly to extract a few of these for the purpose of publication.

Photophobia without Vision.

Three hospital cases of which I have notes, in which intense photophobia persisted after sight was destroyed, remind me of a fourth case, in which the want of knowledge that this may occur was the cause of some annoyance to an able practitioner. This gentleman consulted me, at the instance of Mr. Coulson, respecting a child of wealthy parents who had met with a serious accident many weeks before. The right eye had been seriously injured by the prong of a fork. The accident had been attended with great pain, much swelling of the eyelid, and severe photophobia. These circumstances and the somewhat wayward and passionate character of the child had probably prevented a very minute examination of the eye at the time of the accident by the family attendant, who, however, came to the conclusion, after an examination, that the injury to the eye was superficial. Means were taken to subdue the inflammation by leeching, cold applications, etc.; but some weeks passed away, and a good deal of inflammation, with intense photophobia, still persisted. When I was called in consultation, some eight weeks after the injury, there was a good deal of photophobia, some

weeping, and excoriation of the cheek. The child was very passionate, and resented any attempt at forcible separation of the lids and examination of the eyes, in which she was supported by the parents. I of course declined to prescribe for an unseen malady, and was allowed to fix the head of the child between my knees, and to separate the lids by retractors, so as to afford a good view of the globe of the eye—the only way in which a satisfactory examination can be made under such circumstances. Greatly to my surprise, after the history given, and to the indescribable consternation of the medical attendant, it was then apparent that the eyeball was shrunken, the cornea much atrophied and opaque, and the ball entirely sightless. He was in no way prepared for this; and, indeed, relying upon the intensity of the photophobia as indicating visual acuteness, had not prepared the parents for any loss of sight, but led them to expect the contrary condition and an early and favourable termination of the case. The position was very embarrassing, and we got out of it as well as we could, by a little cautious temporising, and ultimately without any damage to his credit.

But I have found since that a similar belief to that which misled him prevails more generally, and is sometimes productive of similar annoyance. I saw, about two months since, with my able friend Dr. Fyfe of Brompton, a patient who had suffered a recent injury to the eye. There was loss of vision, owing to the traumatic opacity of the lens, but great photophobia; and the intolerance of light had led to the impression that sight was not and would not be lost. It was, however, a case in which the ultimate prognosis was in many ways unfavourable, and we had to correct the promise of vision which the extreme sensitiveness to light had induced. A somewhat similar case I saw just before, in consultation with a medical friend of Dr. Bradley of Blackheath; and in this case also the extreme photophobia, following a smart blow from an exploding percussion-cap, had led to an impression that the sight was not injured, and that useful vision would return. The lens was displaced and opaque; the iris was matted with lymph, altered, discoloured, and opaque, and adhering to the corneal wound. The treatment had been quite judicious, but the prognosis too sanguine.

These cases have left on my mind the impression that a caution will be useful in some cases against drawing any deductions as to visual capacity, or prognosis as to the restoration of vision, from persistent sensibility of an injured and inflamed eye to light. This sensibility is enhanced by any injury to the sensitive surface of the eye, and is not only unconnected with the functions of the optic nerve or integrity of the optical apparatus, but is compatible with, and frequently accompanies, the destruction of the eyeball and total loss of vision.

OBSTETRIC MEMORANDA.

RETROFLEXION OF THE UTERUS.

DR. ATTHILL has mistaken the gist of my paper, if he think that I objected to the stem recommended by Dr. Beatty on the ground that it "increased the flow of catamenial and other discharges". All stems do this. It is the boxwood pessary to which I object. If the straight stem would remain *in situ* without any "flat boxwood pessary" in the vagina, I should never have proposed a "self-retaining stem", which is intended to do away with any such obstruction to discharge, lotion, examination, etc. I have not found the spring stem produce more irritation than any other kind, and I still believe it is the best mechanical support invented.

PERCY BOULTON, M.D.,

Physician to the Samaritan Hospital.

Seymour Street, January 6th, 1872.

EARLY RUPTURE OF THE MEMBRANES.

DR. THOMAS SAVAGE is incorrect in saying that all men engaged in obstetric practice must have observed cases in which the membranes ruptured upwards of two months before delivery. I have asked many obstetricians—Dr. Lloyd Roberts and Mr. W. Whitehead among others—and have not met with any one who has even heard of such an occurrence; neither am I aware that there is any mention made of the phenomenon in obstetric works. Dr. Savage is no less incorrect in the cause which he assigns; viz., verticality of the uterus. At least, it is certain that such was not the cause in the case I recorded, as the uterus was even slightly retroverted, a circumstance which was noted by Mr. Whitehead, who kindly examined the case with me. It is obvious that, if the uterus be vertical, the membranes over the os uteri must sustain a more than usual degree of pressure, and that they will consequently be liable to early rupture; and it is equally obvious that an unusual thinness of the membranes themselves will also tend to render

* The diameters of these arteries have the correct relative proportion for health.

† In order to obtain the mean thickness of the left ventricle, I took three equidistant measures; viz., 1, 1.05 inches; 2, 1.19 inches; 3, 0.64 inch; average, 0.96 inch. The right ventricle had an uniform thickness throughout.