new flap like a watch-glass. The skin required for the formation of this eyelid was two inches in length and one inch in breadth, which I took from the forearm. To test the principles above indicated, I divided my flap into three portions. The first I removed, along with the cellular tissue, as close to the dermis as compatible with the integrity of the flap. The other two portions, after removing them from the forearm, I turned up; and with a cataract-knife I sliced off the areolar tissue, leaving a white surface, which I applied to the eyelid. The difference between these flaps was very remarkable. The two flaps, which were previously prepared, healed by agglutination, without exhibiting even the slightest tendency to desquamation of the cuticle. Twenty-four hours after the operation, the surfaces looked pale; but the next day the temperature was normal, and appearance healthy; whilst that part which was applied without previous preparation looked rather livid the first day, improved the next two days; the fourth day, it began slightly to suppurate; and, after a hard struggle for life, a portion of it only remained, while the rest shrank. This, however, will not compromise the result of the operation, which may be considered satisfactory.

The dressing consisted of gutta-percha tissue applied next to the skin, a graduated lint-compress, and a bandage to maintain immobility of both eyes. The union was so rapid and so perfect, that I separated the upper from the lower eyelid on the fourth day.

This figure was taken eight days after the operation, when union was complete. The thicker upper dotted line represents the elevated dissected edge, and the thinner lower dotted line shows the point of insertion of the new skin. The vertical lines mark the division of the flap. The two outer and larger portions have been prepared before application; while the smaller, placed at the inner canthus, has been applied without previous preparation.

In conclusion, I would recommend this method to the profession, from its simplicity and safety, for trial, not only in similar cases, but also for the cure of congenital blotches on the skin of the face, which are not amenable to any other treatment.

CASE OF MENINGEAL APOPLEXY.*

By GEORGE F. HODGSON, M.R.C.S.Eng., Brighton.

ON the 19th of last March, about mid-day, I was asked to see a widow, aged 42, a cook in a private family, who had then been suffering for about two hours with severe pain in the back of her head and neck, which she declared "must drive her mad if it could not be relieved soon". This was considered by her mistress and myself an exaggerated expression, as the woman was known to be of a very irritable temper, and also of a highly nervous temperament, especially since the death of her husband, which took place suddenly (twenty years previously) whilst in bed by her side. In the condition of her tongue, pulse, etc., no departure from health was present to offer a clue to the nature of the severe pain; but as it transpired that she had, twice in her life, been laid up with rheumatic fever, and that on the day previously she had been out for two hours in the piercing north-east wind, the attack was apprehended to be rheumatic; and accordingly I prescribed a potash saline draught every four hours, together with five grains of chloralhydrate, and seven grains of bromide of ammonium.

Next day (March 20th), I was informed that, within two hours of my having seen her yesterday, and before the first dose of the medicine, she had become "stupid", and had been more or less so ever since. The word "stupid" was not altogether inapplicable, although evidently her state was one for which she was not responsible, unless she had been "drinking"; but there was no history of such a habit. She still complained of the pain; answered questions, and put out her tongue reluctantly. She had taken her medicine; had had some sleep; and had taken both milk and gruel, though not without much persuasion. In

other respects, she was much as on the previous day. She was ordered to go on with the medicine.

On the 21st, she was rather worse. She was sick once last evening. The bowels had been moved each day. The urine was clear, and not albuminous. Pulse 80, firm and full. The heart's impulse was rather strong; an aortic *bruit* was heard with the systole. The tongue was becoming furred and dry. Temperature 101 deg. She was still in a semi-stupid state; but complained of the pain in the back of her head. She could put out her tongue, but seemed obstinate and intractable about taking her food and medicines. The catamenia occurred a fortnight ago. An empty bottle was found in one of her drawers, labelled and smelling of "paregoric". Her medicine was stopped. On the 22nd, she seemed more ill; pulse 90, bounding. Temperature, 104 deg.; tongue white. She passed urine, and her bowels were moved. She complained less of the pain; and the stupidity was not so great, although she was still very "queer". On her mistress pressing me for an opinion, I replied that I could only guess that she was suffering from rheumatism of the membranes of the brain, or possibly from typhoid fever; and from this vagueness on my part, especially as to the issue of the case, her mistress decided on moving her into the Sussex County Hospital. On one of the other maids asking her where she kept her clean night-gowns, she replied she would get one herself, and therewith got out of bed, went to her drawers, and took one out.

On March 23rd (at the Hospital), she became violent, and was restrained by a strait waistcoat. Her physician did not venture on a diagnosis; and prescribed simple saline draughts. Subsequently, hemiplegia (left) occurred of the arm and leg; the cranial nerves were not involved; and, on the 27th, death ensued.

A necropsy was made the next day, of which the following notes are all that I have been able to obtain, viz.: "Brain remarkably congested throughout. The subarachnoid space round the medulla oblongata (especially on the right side) filled with recent clot of bright coloured blood, probably about an ounce and a half in bulk. Arteries extensively atheromatous. Heart much hypertrophied; valves healthy; commencement of the aorta much dilated and roughened by atheroma."

I presume that the hæmorrhage occurred on the first seizure of the illness on the 19th; but the case, both at its onset and in its subsequent course, illustrates the excessive difficulty there is sometimes in diagnosing apoplexy. This has been my chief object in recording the case.

CASES OF PALPITATION OF THE HEART DUE TO EPILEPSY, WITH REMARKS.

By WM. L. LANE, M.B., etc., Crossgates, Dunfermline.

THE following cases, which I shall describe in a summary manner, are somewhat interesting in showing how palpitation of the heart may be due to a cause hitherto unobserved, viz., epilepsy.

CASE I. Michael B., aged 42, a strong healthy man in appearance, has been complaining for the last three years of a constant pain at the cardiac region, which is not increased by pressure, and is accompanied by a strong impulse of the heart. This pain and beating, which are never entirely absent, get more severe upon any excitement or exertion. The pulse is 78 a minute, and strong. The heart has no valvular lesion nor any hypertrophy, although its impulse is stronger than normal. Lately, that is, within the last eighteen months, he has had some attacks of epileptic vertigo and two or three severe fits of epilepsy (*grand mal*). He describes the attacks of epileptic vertigo, or, as he terms them, attacks of "giddiness", thus: "the beating of the heart and the pain over it, which are worse than usual for a day or two before the attack of giddiness, suddenly, a few seconds before the attack, become much worse; he then fixes his eyes upon a spot from which he cannot move, loses his senses, staggers, or falls down, and then immediately recovers consciousness (the attack altogether does not last longer than a quarter or half a minute), feeling his head sore and his memory confused. The beating and the pain, which I stated as being more troublesome some time previously to the attack, continue so for some hours after it."

CASE II. Wm. B., aged 31, is a healthy strong man; his aunt was epileptic at one time; her son (his cousin) is a great epileptic. Wm. B.'s father was insane at one time. Wm. B. has never had any fits. He complains of an uneasy pain in the cardiac region and a strong beating of his heart. He feels very anxious about his condition. I examined his heart with the utmost care, and found it healthy in every respect. There is no tenderness upon pressure over the cardiac region, but the cardiac impulse is stronger than normal. The pulse is strong, and 72 a minute. Respiration is normal. His appetite is good. His

* Read at the East Sussex District Meeting at Lewes.

bowels are open regularly. The pain and cardiac beating are worse at times, and are aggravated by mental excitement or bodily exertion.

CASE III. Mrs. D., aged 50, who has a strong and healthy appearance, has been suffering from a beating of the heart and a pain at the cardiac region for the last twelve months. The heart's sounds and size are normal, but its impulse is stronger than normal. A few days ago, while she was at the railway station here, apparently in excellent health, she had a fit and fell upon the ground. Her face was severely hurt by her fall. She states that lately she has a few attacks of dizziness (most probably epileptic vertigo), which pass away very quickly. Her appetite is excellent; her bowels are regular. She has ceased menstruating since she was forty-seven years old.

REMARKS. — The predominant symptoms in these cases are the cardiac pain and the strong cardiac impulse, and the feelings of anxiety which these symptoms cause the patients. I may say that they have consulted various medical men in this district and Edinburgh for their palpitation without any benefit. Cases of this kind, which are by no means uncommon, differ from cases of palpitation which we usually meet in many respects. 1. The heart's action is not accelerated, nor is it irregular. 2. The causes which produce palpitation, such as anæmia, indigestion, excessive smoking, alcoholic or tea drinking, could not be discovered in these. 3. The cases occur in individuals strongly predisposed to or suffering from epilepsy. I have often thought that the name "mild angina pectoris" would be a very appropriate one for cases like these, on account of the symptoms somewhat resembling angina pectoris, but being a great deal less severe. I may say that cases of this kind are generally unbenefited by any of the remedies, such as bromide of potassium, belladonna, etc.; that I have used or seen others use.

OBSTETRIC MEMORANDA.

NOTE ON PUERPERAL FEVER.

PUERPERAL peritonitis does not often come under my observation, but in the year 1873 two cases occurred in my practice. I made notes of them at the time; and, as bearing on the question of contagion, the cases seem worthy of a brief record.

I was requested to see, in consultation with her medical attendant, Mrs. F., on the day week of her delivery of her sixth child. Four days previous to our visit, she had a shivering fit, which was quickly followed by the usual symptoms of peritonitis. She died on the day following our visit. Fifteen days after the death of this patient, I was requested to visit Mrs. B. She had been confined three days before of her second child, and went on well until the day before I saw her, when she had an attack of shivering. The patient, when seen, was suffering great agony from abdominal pain. She died on the day following. Both these women were patients of the gentleman referred to. The one who died first was delivered by him; but, although he visited the other, no examination was made by him, and the woman was delivered by his assistant.

It might be supposed that the precautions taken were sufficient to prevent the action of contagion in the second of these unfortunate cases; yet it is impossible to avoid the conclusion that both deaths were in some way due to the same cause—namely, contagion conveyed by the medical attendant or his assistant. Whether these gentlemen had any recent experience of puerperal fever previously to the occurrence of the first case, I am not aware.

ARTHUR LEARED, M.D., F.R.C.P.

CASE OF PUERPERAL FEVER CAUSED BY EXPOSURE TO THE CONTAGION OF ERYSIPELAS.

THE numbers of the JOURNAL containing a report of the Obstetrical Society's interesting debate on puerperal fever have just reached me. In connection with that discussion, the following case, which occurred in my practice only a few weeks ago, may perhaps appear worthy of publication.

During the last two months there have been three cases of erysipelas in this generally healthy village. In two of these cases, the head and face were attacked; in the third, it commenced round a fistulous opening in the abdominal wall. One of these patients, who had a rather severe attack of erysipelas of the head, followed by abscesses below each eye, and a large one in the right forearm, was attended throughout her illness by her daughter, a Mrs. V., the wife of a farmer living about twelve miles from this village. On June 22nd, Mrs. V. returned home, having stayed with her mother, now convalescent, exactly a

month. Mrs. V. was at this time four months pregnant; she was about thirty years of age, had been married seven years, had one child, and thought she had a miscarriage at the second month about a year ago. On June 25th, without any apparent cause, she had a miscarriage, and remained in bed. On the evening of the 26th, she had rigors and complained of great pain and tenderness at the hypogastrium. Next day, she was much worse; I was sent for, and found all the symptoms of peritonitis. I carefully examined the uterus for any pieces of membrane or clots, but found nothing. I was again summoned on the 29th, and found her sinking fast; she died on the morning of the 30th. Mr. V.'s sheep-farm is healthily situated in one of the healthiest districts in this colony. There had been no sickness on the farm previously, and I have heard of no case of puerperal fever occurring within a hundred miles of this for months. When I saw Mrs. V. on the 27th, I noticed lying in the room some of the clothes she had worn while nursing her mother.

The connection between the erysipelas and the puerperal fever in this case can, I think, scarcely be doubted.

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ABDOMINAL PRESENTATION.

ON May 11th, 1875, at 7.45 A.M., Mrs. W., who had had several children, sent for me to attend her with all expedition; she had been in labour for some hours. The medical man whom she had previously engaged had been sent for at 6 A.M., and, not feeling satisfied with the presentation and progress of the case, was anxious for a second opinion. Upon my arrival, he decided to leave the case in my hands, which responsibility I at once accepted. On vaginal examination, I found what I felt assured was an abdominal presentation. The presentation was considerably low down and perfectly immovable, pressure being exerted in various directions without any success; considerable efforts at dislodgement were made until 11 A.M., the patient's strength in the meanwhile remaining little, if at all, impaired. About this time it was just possible to feel the knees, and the hand could be passed sufficiently high up to seize one leg; the other quickly followed, and the child was delivered as in an ordinary case of turning. Unfortunately, the child was born dead from asphyxia, from pressure upon the cord, but the patient made a rapid recovery, and up to the present has suffered from no ill effects.

R. J. MAITLAND COFFIN, M.R.C.P.
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PUERPERAL ECLAMPSIA.

I WAS called in at 6.30 on December 26th to see Mrs. P., a primipara, who had been in labour eight hours. I was told she had had three fits of a very severe character, which quite alarmed her friends. A few minutes after my arrival, she had a convulsion, her face becoming suddenly livid and distorted, directed first to the left shoulder, afterwards to the right; the fit ended in opisthotonos, lasting quite five minutes, followed by a comatose condition. After the fit, I made a vaginal examination, and found the head presenting at the brim normally, and the os well dilated. Without unnecessary haste, I delivered with the long forceps, and forcibly removed the placenta, which was adherent. She still continued to have convulsions of a severe character, and I ordered full doses of bromide of potassium and cannabis Indica, combined with diuretics, as, on inquiry, I elicited that no urine had been passed to the knowledge of anyone present. This fact led me to examine the bladder, but I found it empty. I saw her at 11 A.M.: pulse, 100; temperature, 104. At 4 P.M., I saw her again: pulse, 110. She had some more convulsions, and stronger, remaining longer comatose; the pupils were more dilated. I emptied the bladder of five ounces of highly albuminous urine, specific gravity, 1.028. I ordered ten grains of chloral every two hours. At 5 o'clock, I saw her in conjunction with Mr. Knight. Pulse, 120; temperature, 109. I had the bowels emptied by injections and croton-oil internally. I ordered sinapisms to be applied to the calves of the legs and neck, and the chloral to be continued throughout the night. At 10 P.M., she had had no more convulsions since the first dose of chloral. She was still perfectly unconscious under the influence of the drug, as well as comatose. On the 27th, she was much calmer, but not yet conscious; she passed fæces and urine in bed. I saw her several times during the day. The pulse was coming down; temperature lower. There was slight consciousness as the effects of the chloral passed off in the evening. She took beef-tea and milk. Temperature, 100. She recognised her husband and myself for the first time since the convulsions commenced. On the 28th, the pulse was 90; temperature, 98. She was improving rapidly, and had no more