In two hours after I left her, and six hours after the removal of the placenta, she again complained of pains, and I was again sent for. On my arrival, I found the head of the third child at the perinæum. This was also a female, but a much stronger child than any of its predecessors, weighing over seven pounds; the combined weight of all the three being over twenty pounds.

After the separation of the placenta, the tumours were now about equal in size, and quite distinct the one from the other, neither of the two occupying a middle position, but each taking its own side.

I examined my patient lately, and I found that the external os was single, the opening very much elongated from side to side; but, upon tilting it forward, the dividing septum was distinctly seen. I also introduced an uterine sound into each cavity. The septum could also be felt by the introduction of the finger.

This case may only be interesting in an anatomical point of view, as there was little skill or dexterity in manipulation required during the confinement; but, as such cases are rare, I concluded that the case would not be altogether void of interest to the members of the Association.

SYMPATHETIC OPHTHALMIA:

A HISTORICAL CORRECTION.

By J. VOSE SOLOMON, F.R.C.S., Birmingham.

MR. CARTER, in his recently published work on *Eye-Diseases*, in treating of the channel through which sympathetic irritation is conveyed, makes the following statement in reference to myself.

"Mr. Vose Solomon accuses the optic nerve, but only on the ground that, in a single instance, sympathetic ophthalmia followed enucleation of the eye in a patient of his own, whose optic nerve, on account of some imperfection in the scissors employed, was bruised at the place of division, instead of being cut."

My reply to these statements is, that not only such case has *never* occurred in my own practice, but, so far from its being considered by me that the optic nerve is the channel through which irritation is *primarily* conveyed, I contributed in February 1863 to the *Dublin Quarterly Journal*, page 58, a short article and illustrative case to prove that such hypothesis was untenable. (*Vide* also Braithwaite's *Retrospect*, vol. ii, 1864, p. 275.) The following is an epitome of the case with remarks: the latter are unabridged.

A man, aged 36, lost his left eye from a burn. In two months, sympathetic irritation affected the right. The left was excised, with great relief to the symptoms in the best eye. A bridge having formed between the lid and conjunctiva of the empty orbit, a glass mask was inserted, with the effect of reproducing the same train of symptoms as existed in the right before excision was performed. A retrocession of the sympathetic disturbance followed the removal of the mask, but, on its reinsertion, the symptoms returned with the addition of *photopsys*.

"English authors on ophthalmology have hitherto attributed the occurrence of sympathetic traumatic ophthalmia to the (existence of the) commissural arrangement of the optic nerve-fibres. The phenomena presented by the preceding case do not appear to afford a *locus standi* for such theory, inasmuch as the optic nerve on the side of irritation had been severed; but they may be satisfactorily explained, on the supposition that the irritation from the eyeless orbit was conveyed by the ophthalmic division of the fifth pair to the centre, and thence reflected to the opposite side. This view derives support from examples of reflex traumatic disorder, wherein the symptoms are those purely of hyperæsthesia of the fifth, and which yield almost *instantaneously* on removal of the original source of irritation; of this class of cases, some account is given in a paper of mine in the *BRITISH MEDICAL JOURNAL* for June 13th, 1857.

"Careful observation of a large number of instances of reflex ophthalmia has led me to the following, among other conclusions: that the *primary* traumatic irritation is conveyed to the sound eye through (sensory) branches of the fifth nerve; that soon afterwards, and sometimes simultaneously, the vaso-motor nerves (trophic) take on disordered action, and, as a consequence, intraocular congestions and their results occur; that if the disease be not arrested, the optic nerve-fibres become inflamed, or affected with such changes as induce atrophy, and which lead to similar degeneration of the opposite nerve. In this stage of the complaint, the commissural arrangement of the optic nerve-fibres is probably the channel through which the disorder is conveyed. Where there is an advanced amaurosis (of the eye affected sympathetically), the usual signs of atrophy of the optic nerve are revealed."

Since writing the above, my attention has been drawn to a valuable and carefully written article on this subject in the *British and Foreign Medical Review* for January 1868, in which my case and physiological views are adduced, as supporting the opinion that the vaso-motor nerves are the channel of communication; and if reference be made to the dates of publication of the author's works, which the reviewer has ably analysed, it will be found that my views, which were formed quite independently, possess priority of publication.

A NEW METHOD OF PERFORMING PLASTIC OPERATIONS.

By J. R. WOLFE, M.D., F.R.C.S.Ed.,
Surgeon to the Glasgow Ophthalmic Institution; Lecturer on Ophthalmic Surgery in Anderson's University.

IT is now nearly three hundred years since Tagliacozzi published his great work on *Plastic Operations*; and, notwithstanding the admiration which the work of the Bologna professor had elicited, it is remarkable how comparatively little has since been done for the cultivation of plastic surgery. The reasons are obvious. The fact is that, in operations on the nose, eyelids, and face—the most interesting regions for improving deformities—Tagliacozzi's method of taking flaps from the arm has been generally abandoned, on account of the extreme discomfort which it involves; and the practice of taking flaps from the forehead or face having been the only one in vogue, the procedure came to be considered more serious. In addition, when we take into account the elements of failure, from shrinking of the flap, from erysipelas or gangrene, it is not to be wondered at that surgeons are generally chary of resorting to the expedient, except in great emergencies. It amounts to this: we are to cut skin off the face to repair the face; and, in doing so, we run great risk of failure. To render plastic operations on the face more acceptable, and to bring them within a wider scope of utility, the following conditions must be fulfilled. 1. We must take a flap from the arm, or from any other part but the face. 2. We must seek to eliminate the elements of failure. I propose, in this short communication, to indicate the means of fulfilling both these conditions.

First, Tagliacozzi laid down the rule, which has ever since been considered as the primary law, and *sine quâ non* to the success of the operation, that the flap must retain its connection to the adjacent living structure by a pedicle which is to be severed only after complete union and cicatrization of the raw surfaces. This pedicle has, in my opinion, been a source of great embarrassment to surgeons, and tended rather to retard the progress of plastic surgery. From my observations on transplantation of structures from the lower animals and on skin-grafting, as well as on plastic operations, I have long held it demonstrated, that in most cases the pedicle is not essential, if indeed it do contribute anything, to the vitality of flap. This being once established, we are henceforward free to choose our bit of skin from any part of the body we may find suitable.

My next endeavour has been to eliminate the elements of failure. The principal cause of failure I find to be in the subcutaneous structures. If we wish a skin-flap to adhere to a new surface by first intention or agglutination, we must be sure that it is cleared of all areolar tissue, and properly fixed in its new place. The following case will illustrate the points referred to.

Formation of the Lower Eyelid with Skin from the Forearm.—P. C., aged 25, a quarrier, was admitted into the Glasgow Ophthalmic Institution, with his face, eyes, and eyelids injured by an explosion of powder. I showed the man recently to the Edinburgh meeting of the Association, as an instance of conjunctival transplantation from the rabbit.* The right upper eyelid, which was strongly everted, I partially succeeded in correcting by skin-grafting. The lower right eyelid being completely everted, its integument totally destroyed, and the skin of the face consisting of discoloured cicatrices not by any means suitable for plastic operations, I formed a new lower eyelid in the following manner. The edges of the upper and lower eyelids having been vivified, I introduced three ligatures into the border of the lower eyelid, which I entrusted to my assistant. By means of these ligatures, he used traction, whilst I dissected the whole of the cicatricial tissue, and thus liberated the subjacent structure. The ligatures were then introduced into the upper eyelid, and the edges of the upper and lower eyelids were thus united. I then elevated the edges of the wound, preparing them to receive the

* This patient had to undergo several operations before his eyes were rendered serviceable and his face presentable. Left eye: 1. Artificial pupil; 2. Conjunctival transplantation from rabbit. Right eye: 1. Paracentesis for onyx and hypopion; 2. Skin-grafting on upper eyelid; 3. Plastic operation on lower eyelid. All these operations were done without chloroform.

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.