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.